South East London Integrated Care System

NHS South East London

South East London 2024/25 Joint Forward Plan

February 2024 v2

South East London Integrated Care System

NHS South East London

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What is the Joint Forward Plan

Our Integrated Care Board Joint Forward Plan sets out our **medium term objectives and plans**, at both a borough level and from the perspective of our key care pathways and enablers at ICS system level, to ensure that we are developing a service offer to residents that:

- **Meets the needs of our population.**
- Demonstrates and makes tangible progress in **addressing the core purpose of our wider integrated care system** - **improving outcomes** in health and healthcare, **tackling inequalities** in outcomes, experience and access, **enhancing productivity and value for money** and helping the NHS support broader **social and economic development**.
- Delivers **national Long Term Plan and wider priorities**, all of which resonate from a SEL population health perspective.
- Meets the **statutory requirements** of our Integrated Care Board.

Our Joint Forward Plan provides the following:

- A strategic overview of our **key priorities and objectives for the medium term,** through our integrated borough, end to end care pathway and enabler programmes.
- A high level summary of the **short term actions** that we will take, working with partners, to ensure the key milestones that support us in meeting these medium term objectives are secured, with further underpinning detail to be included in our annual operational plans.

We published our first Joint Forward Plan in June 2023. This our refreshed Joint Forward Plan for 2024/25 which:

- Takes account of implementation and outcomes over the previous year, including any learning to be applied to our future plans.
- Reflects any changes required due to new or emerging issues or requirements, be they related to population health, feedback from our communities and service users or service delivery issues and opportunities. **This includes an increasingly challenging context – with our system facing significant underlying** financial, population and performance challenges.

What is the Joint Forward Plan

The Joint Forward Plan builds on the work we have been doing as a wider system and is driven by:

- Our **Integrated Care Partnership integrated care strategy.** It includes clear commitments around our Integrated Care Board delivery of the strategic objectives, outcomes and priorities we have collectively agreed as a wider partnership to working collaboratively to secure.
- Our **borough based Local Health and Wellbeing Plans**, and the work our Local Care Partnerships will take forward to secure these plans, harnessing the benefits of joint working and integration to do so.
- A consideration of the full breadth of underpinning **care pathways and enablers** that we will need to develop, improve and transform to meet these priorities.
- A focus on **national priorities for the NHS**, including the planned **delegation** of key services to Integrated Care Boards from NHS England.
- An assessment of delivery against the ICB's **statutory functions and duties.**

In taking our Joint Forward Plan forward we are committed to:

- **Improving population health and reducing inequalities.**
- Improving and **standardising our core service offer**, quality and outcomes across primary care, community, mental health and acute services, plus across our key care pathways such as urgent and emergency care.
- Taking **action to secure a sustainable health system**, with a particular focus on finance, workforce, quality and performance.
- Developing the supporting **system architecture and infrastructure** required to secure success and embed sustainable change.
- Pushing the boundaries with regards evidence based **innovation, transformation productivity and efficiency.**
- Doing so in **partnership with our communities, patients and service users** to ensure coproduced approaches and solutions that are patient and service user centred. Our integrated care strategy was developed with extensive engagement and the feedback received, plus wider on-going engagement feedback, has been used to inform our Joint Forward Plan.

How does it all fit together

Overall context of the SEL System plans

The SEL Joint Forward Plan sits within a suite of strategic and operational documents and plans developed by our Integrated Care Board and wider Integrated Carew Partnership. These have differing objectives but importantly are interlinked with a clear golden thread across them.

Integrated Care Strategy

- Integrated Care Partnership developed plan covering the NHS and Local Authorities.
- Work supported by significant engagement over summer 2022 and beyond.
- Medium term focussed - 3-5 year timeframe.
- Secures an agreed vision, mission and the identification of 5 key strategic priorities for the SEL integrated care system, with further detail around the 5 priorities now developed.
- Gives overarching consideration to key enablers and ways of working.

Published February 2023
2023/24 work to develop the detail around our five strategic priorities.

Joint Forward Plan

- Integrated Care Board medium term NHS focussed plan - 3-5 year timeframe.
- Sets out ICB response to the integrated care strategy identified priorities
- *PLUS plans for*: meeting wider population needs, securing the key objectives of ICBs, delivery of national and local priorities and allocative approaches (medium term financial plan), with a focus on short term delivery milestones across all key areas of the ICB's planning functions.
- Plan published in July 2023 - current refresh focuses on a stocktake of 23/24 delivery and confirmed or refreshed medium term objectives, with no material changes with regards objectives.

First Joint Forward Plan published in June 2023. Refreshed plan published April 2024, as part of annual refresh.

Operational Plan

- Integrated Care Board operational plan – an overarching ICB plan and underpinning plans for the ICB's five major NHS providers.
- Short term 2024/25 focussed plan, building on the plan from 2023/24 and encompassing:
  - Actions to secure the milestones for our integrated care strategy and Joint Forward Plan.
  - National planning priorities and targets.
  - A financial plan for 2024/25, inclusive of the agreed application of the ICB's allocation.
  - Detailed activity and workforce planning and performance trajectories.

Draft plan due for submission end of March 2024, final submission expected May 2024

How we have built our 24/25 Joint Forward Plan

Our Joint Forward Plan has been developed bottom up – from our **Local Care Partnerships**, our **care pathway programme and transformation boards** and our **enabler programmes**, with work having taken place to ensure a read and link across these key building blocks.

Borough Plans

- **A plan for each of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark boroughs.**
- Driven by local health and wellbeing and local care partnership plans.
- Set out the key objectives and actions that will be taken forwards on a borough basis.
- Reflect needs of the population and a focus on reducing inequalities in access, experience and outcome.
- Connection and opportunities between the borough plans and the care pathway/service plans, with boroughs responsible for delivering key aspects of these SEL plans, tailored to the particular needs of their borough population.

Care Pathway/Service Plans

- **A plan for prevention, urgent and emergency care, mental health, children and young people, womens health, learning disability and autism, planned care, maternity, cancer, long term conditions, primary care and palliative/end of life care.**
- Sets out the SEL vision, objectives, framework and approach for particular pathways and population groups.
- Key to driving forwards our commitment to reducing inequalities in service offer and experience, improving outcomes and value across our system.
- Recognises that delivery of agreed commitments and change will then be taken forwards in different ways through our 'SEL system of systems' e.g. within boroughs, with their delegated responsibility for community-based services and through providers and our provider collaboratives.

Enablers

- SEL objectives and plans for key enablers - **workforce, estates, digital / data** plus our approaches to **population health management, sustainability, the green agenda, wider social and economic development and the development of our integrated care system.**
- Our **Medium Term Financial Strategy** that sets out our planned allocation of ICB funding over the next five years.
- Set out overarching programmes of work, key connections to borough and care pathway plans plus enabler support for the delivery of the commitments made.

*Plus a cross check against the **ICB's statutory functions and responsibilities***

South East London Integrated Care System

Overview of our people and communities

NHS South East London

- Southwark is ranked amongst the 15% most deprived local authority areas in the country
- Southwark has the third largest lesbian, gay and bisexual communities in the country
- 46% of Southwark's population are from a Black and Minority Ethnic background

- Lambeth is ranked amongst the 15% most deprived local authority areas in the country
- Lambeth has the second largest lesbian, gay and bisexual communities in the country
- 60% of Lambeth's population are from a Black and Minority Ethnic background

- Lewisham is ranked amongst the 15% most deprived local authority areas in the country
- 22.6% of children in Lewisham live in low-income families
- 47% of Lewisham's population are from a Black and Minority Ethnic background

- Greenwich is ranked amongst the 15% most deprived local authority areas in the country
- 21.8% of children in Greenwich live in low-income families
- 38% of Greenwich's population are from a Black and Minority Ethnic background

- 16% of Bexley's population are aged 65 and over
- 16.3% of children living in Bexley live in low-income families
- Life expectancy is 7.9 years lower for men and 6.7 years lower for women in the most deprived areas of Bexley, compared to the least deprived areas

- 18% of Bromley's population are aged 65 and over
- 13.2% of children living in Bromley live in low-income families
- Life expectancy is 8.1 years lower for men and 6.1 years lower for women in the most deprived areas of Bromley, compared to the least deprived areas

Overview of our integrated care system

About our Integrated Care System

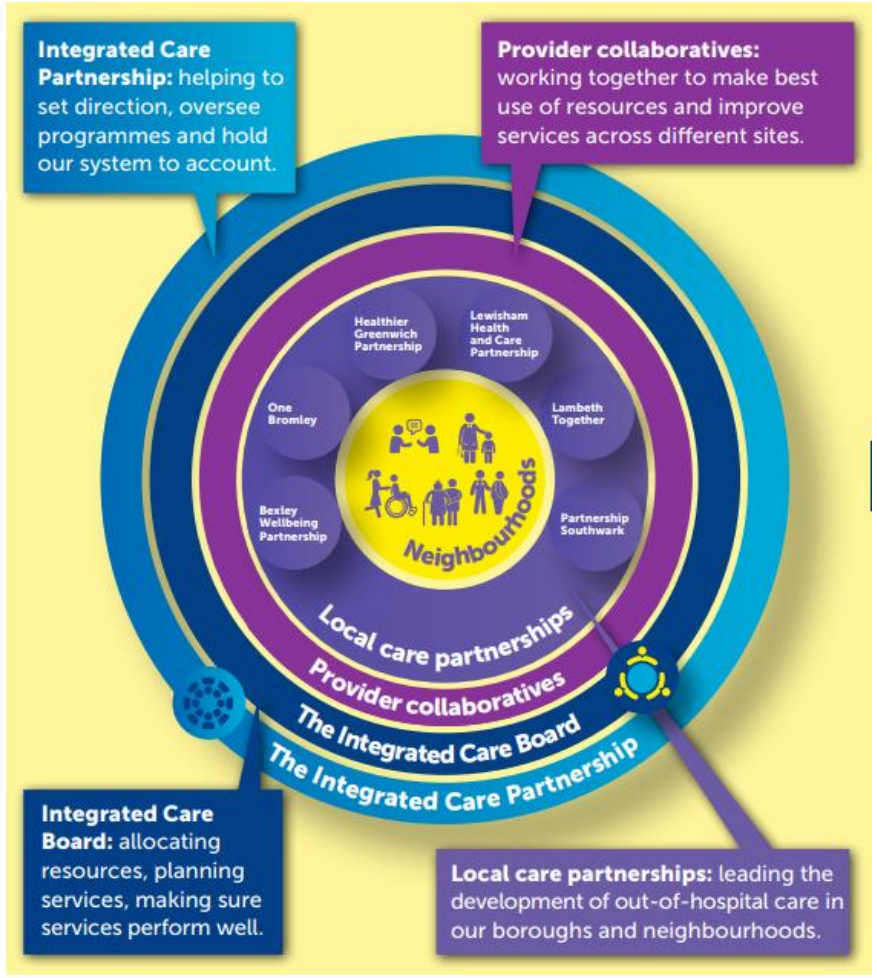
On 1 July 2022, we set up a new Integrated Care Board and a new Integrated Care Partnership, bringing together the leaders of health and care organisations across south east London to plan services and improve care for our population of almost two mission.

Our new board and partnership are responsible for supporting the many organisations delivering health and care services in south east London, which we call the South East London Integrated Care System (ICS). We have four overarching objectives.

1. Improving outcomes in population health and healthcare;
2. Tackling inequalities in outcomes, experience and access;
3. Enhancing productivity and value for money; and
4. Helping the NHS support broader social and economic development.

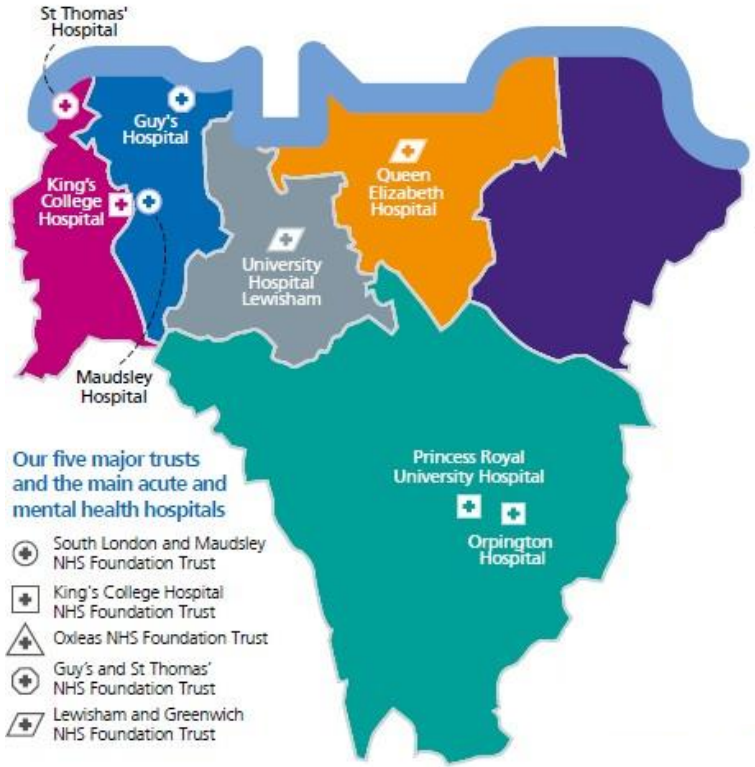
Our new arrangements are based on partnership working, bringing together the range of skills and resources in our public services and our communities, They are also based on the principles of trust, taking decisions at the right level in our system, giving partnerships and organisations within our system the power to lead and improve their services and working in partnership with our service users.

The diagrams on this slide give an overview of our partnership working within our system, and an overview of NHS provider provision within south east London.



Note: NHS England is expected to ask integrated care boards to commission some specialised services in the future

Our System of Systems



NHS provider landscape in South East London

Joint Forward Plan – challenges & opportunities

System challenges	→	Opportunities through our Joint Forward Plan

Population Health and Inequalities

- High levels of health need, with a clear link across to the relatively high levels of deprivation and population diversity found in south east London.
- Life expectancy for south east Londoners is below the London average for all boroughs except Bromley.
- Differences in life expectancy are more marked for those born in the least and most deprived areas across south east London.
- These factors drive significant inequalities, with a variance across boroughs including higher levels of need, challenge and opportunity across our inner south east London boroughs, but with clear inequalities and an inequalities gap evident within each of our six boroughs.
- Known risk factors that drive poor health outcomes plus drive inequalities.
- Inequalities evident in terms of access, experience and outcomes.
- Cost of living crisis has further exacerbated inequalities.

- Each of our **borough based and care pathway plans** have been part driven by an understanding of population health and inequalities – we are building our PHM approach through an inequalities framework, to support a systematic approach to population health and inequalities driven actions and outcomes in our planning and delivery.
- Our Medium Term Financial Strategy ringfences funding to support **targeted investment in inequalities** over the next five years – this funding is focused on prevention and early intervention (see below), ensuring parity for mental health and children and young people, and delivery of our strategic priorities. We recognise that if we are to **tackle the underlying causes of poor population health, outcomes and inequalities** we will need to secure a genuinely collaborative effort across the NHS, Local Authorities and our communities, given the interplay of health and socio-economic risk factors.
- Our **focussed work on prevention**, in terms of both our overarching prevention priorities but also embedding a prevention, early detection and intervention focus in all our programmes of work will enable us to start tackling SEL's key underlying population risk factors.

Joint Forward Plan – Challenges & Opportunities

System challenges → **Opportunities through our Joint Forward Plan**

Sustainable, high quality services that meet national performance standards

- Historically south east London has struggled to meet national performance targets, particularly those associated with access and waiting times.
- These issues were exacerbated by the Covid-19 pandemic, which saw a significant increase in waiting list backlogs and waiting times compounded by pent up demand across many services, plus a deterioration in our underlying productivity and efficiency.
- We have also struggled to secure the operational bandwidth and workforce required to drive forward key care pathway changes and improvements on an embedded and sustainable basis, with the focus, driven nationally, regionally and locally, on a multiplicity of initiatives over the last few years adding to the bandwidth challenge.
- Our service offer demonstrates significant variation - in the offer itself for the same service and in access, experience and outcomes, including variable quality and performance and productivity and efficiency.
- Our performance and quality challenges are driven by a range of complex and interrelated drivers, including workforce, demand and capacity imbalances, the impact of constrained growth or investment across estate, infrastructure and revenue funding, plus bandwidth to drive and secure sustainable change and productivity and efficiency improvement – our context is one of on-going challenge and minimal sustainable improvement. .

- Our JFP sets out our vision and objectives for services, and the **key actions we will take to address the drivers of our challenges and deliver on the opportunities identified** to secure our objective of sustainable, high quality services that meet national performance standards. This includes taking due account of 2023/24 outturn plus the national planning guidance and delivery expectations for 2024/25, in the context of the NHS Long Term Plan. There is therefore a direct read across the ambition set out in our JFP and the **detailed planning contained within our operational plan** and constituent performance trajectories.
- As we take forward our medium-term actions we will:
  - Take action to **systematically understand demand and capacity** with a commitment to right sizing our capacity to meet current and forecast demand, after taking account of the productivity and efficiency opportunities available to us.
  - Invest in our **population health management infrastructure and expertise** to ensure our approaches tackle the underlying drivers of our demand, quality and performance challenges and that as we improve our quality and performance outcomes we are also demonstrably improving equity of access, experience and outcome and a focus as much on prevention as treatment.
  - Ensure that we identify and understand the **productivity and efficiency** opportunities available to us and that our plans focus on demonstrably securing these as we tackle our underlying challenges.
  - Ensure that our care pathway redesign work in founded upon **evidence based best practice**, a collective understanding of a **'core service offer**' to address unwarranted variation and an understanding of and ability to secure the **transformation and enabler resource** required to drive and embed delivery.
  - Ensuring a focus on **culture and behaviour** as key to driving change alongside ensuring that we enable and **incentivise change** through our planning and contracting processes.

Joint Forward Plan – Challenges & Opportunities

System challenges → **Opportunities through our Joint Forward Plan**

Reducing our deficit to secure financial health sustainability

- The NHS financial position in south east London, which includes the entire financial health of providers located in south east London, is one of overall recurrent underlying deficit.
- Some of these deficits are long standing, but with an underlying and forecast position that is deteriorating.
- Financial challenge has increased over the last couple of years:
  - Funding increases during the covid pandemic have been reducing.
  - An overall loss of cost containment and loss of pre pandemic productivity and efficiency.
  - Increased cost drivers including inflation and excess energy costs, meeting demand and diagnostic and treatment backlogs, workforce bank and agency costs, plus over 2023/24 the cost impact of Industrial Action.
- Challenges in securing recurrent cost out, clear and sustainable productivity and efficiency improvement and a demonstrable return on investment.
- A historic funding approach that has been driven by expenditure and financial bottom lines and cost pressures rather than population driven investment and outcomes.
- Future national allocation formula changes, which will increase these underlying challenges, with shifts to population based budgets for specialised services, more fragmented funding flows for specialised services and cost and volume funding arrangements for elective services.

- Our Medium Term Financial Strategy provides clarity as to planned investment for the next five years, including an **allocative approach aligned to our strategic objectives** that **targets inequalities and prevention,** mental health, children and young people and community-based care.
- Care pathway plans that seek to ensure that we are optimising the opportunities associated with care pathway transformation and strategic commissioning across health and care**,** to improve **productivity and efficiency**, reduce duplication, ensure patients access the right service first time, and have clearly specified outcomes to enable us to collectively assess and secure a return on investment.
- The implementation of our south east London review of **savings opportunities** over the next 2-3 years, with the establishment of associated **efficiency programmes** and the baking in of identified savings in our plans.
- Demonstrable year on year progress, including **delivery of our 2024/25 operational plan** commitments and associated efficiency targets (at 4% for 2024/25).
- Further work during 2024/25 to assess and **identify the scope for further savings**, including a focus on more fundamental system and collaborative savings opportunities, alongside further productivity and tactical savings.
- An MTFS ambition around **a break even position by end 2027/28.**
- **Risk identification and mitigation for specialised services** delegation..

Joint Forward Plan – Challenges & Opportunities

Thinking, behaving and acting differently

- South east London is thinking differently about the **sustainable solutions** to the underlying challenges we face across **population health and inequalities** and our ambition around securing **high quality, high performing sustainable services and finances.**
- In many areas, there will only be so much partners can do through individual action to improve the productivity and efficiency of existing care pathways.
- Sustainability will also require us to take a **population approach** that understands the drivers of demand and tackles these in new ways, for example through risk-based approaches founded on **prevention**, **early detection and intervention** that, over time, would help us manage demand, improve population health and reduce inequalities.
- A different approach is needed, one that focusses less on marginal changes across care pathways and more on starting and finishing with an understanding of population health and a **proactive approach to population health management**. In doing so we need to frame a new and different **relationship with our population and communities** so our solutions are co-produced and responsive and bring in a range of different views and providers, such as the **voluntary and community sector**.
- We also need to take collective and concerted **action to tackle the underlying drivers of our position**, to right size capacity, develop and retain the workforce required to meet demand, improve our estate and wider infrastructure and develop our digital offer, whilst also doubling down on ensuring value for money and the best use of the resource available to us on a system basis.

Integration

- *Development of integrated neighbourhood teams*
- *Integration across health and care*
- *Integrated and joined up care pathways, from prevention through to specialist care*
- *Holistic service offer*

Collaboration

- *Collective commitments and delivery around a shared purpose/goal*
- *Collaborative networked approaches across providers*
- *A collaborative coproduction approach with our communities*

Transformation

- *Evidence based best practice*
- *Outcomes driven focus on prevention, early detection and intervention*
- *Continuous quality improvement approaches*
- *Enabling infrastructure*

The SEL Integrated Care Strategy – which is reflected in our JFP

Our Integrated Care Partnership has agreed its mission, vision and strategic priorities – set out in our January 2023 SEL Integrated Care System Strategy.

The strategy identified five key areas of priority - these areas have been selected on the basis of a number of criteria, including requiring cross system working to make demonstrable progress. Our Joint Forward Plan sets out the ICB's contribution to delivery of these priorities, and the slide reference below each priority sets out where this information can be found within our overall JFP.

These five strategic priorities are a sub-set of the work the ICB will be progressing within these pathway areas; for example the mental health (MH) section of our JFP covers work we will be progressing in addition to priorities around "ensuring quick access to effective support for common MH challenges in children and young people" and "making sure adults have quick access to early support". In addition, the ICB will be progressing work outside of these care pathways / population groups, in line our overall ICB responsibilities.

Engagement informing the South East London Joint Forward Plan (1)

How we have engaged with local people and stakeholders

The Integrated Care System has carried out a range of engagement activities during 2023 – 2024 building on engagement activity that took place in in the previous year. The newly established South East London People's Panel has been a key source of insight on what is important to people when thinking about their health, where people get advice and information about health and care services and views and experience of the NHS 111 service, which is still being analysed.

Another key project providing insight at a south east London level was the Anchor Alliance listening campaign on what is stopping people and their communities from thriving which took place during summer 2023. Other projects include engagement around digital access, overprescribing and maternity services. Further detail about these projects and detailed findings can be read on relevant project pages of the south east London on-line engagement platform, let's talk health and care in south east London.

The ICS has a MSK Community Lived Experience Group in place which was involved in helping identify barriers and opportunities on the self-referral process, the role and benefits of personalised care approach as well as planning direct patients' involvement in their care decision making process. The group also co-designed the MSK Community Day - Muscle and joint health - exploring your options. There is more detail at https://letstalkhealthandcareselondon.org/msk. People with direct experience of ENT have informed the development of the service specification for the new community service and took part in the procurement process. There is more detail at https://letstalkhealthandcareselondon.org/ent

Key insight from engagement from across partners is also published at What we've heard from local people and communities - South East London ICS (selondonics.org) with the purpose of easily sharing insight across programmes and partners to align and maximise the value of engagement as well as avoid duplication of effort and engagement fatigue within the community.

Key themes arising from insight gained through engagement are summarised over the next few slides. They have informed the development and refresh of our Joint Forward Plan. Additional insight from borough level engagement has further informed the development of Local Care Partnerships' health and care plans.

Engagement informing the South East London Joint Forward Plan (2)

Key feedback from system-level engagement between April 2023-March 2024

- We heard that **loneliness** is a key issue for many people with younger people and older adults in particular reporting feelings of loneliness.
- **Cost of living** and **low wages** are key issue for many south east London people.
- **Financial stability, better access to healthcare and waiting times, improved mental health services, an improved local housing situation and friends/family/community support** are areas of support people have told us they need to live a happier and healthier life.
- **Lack of institutional trust** continues to be an issue for many south east London residents along with experiences of systemic discrimination and language barriers.
- **Lack of youth provision** and **bullying in schools** has been highlighted by young people as issues affecting them.
- When in need of help and/or advice when unwell or injured many people are confident in knowing where to go and often **self-care**, **use their medicine cupboard** or **go the pharmacy,** however, many people have still attended A&E for non-life-threatening emergencies.
- People who have used the **NHS App** generally find it **easy to sign up and to find the information** they need. However, the lack of functionality to book GP appointments directly was also noted.
- People who have used on-line forms tend to use them for **booking appointments, medical advice** or **ordering repeat prescriptions.** Other benefits noted were to do with being able to **upload photos**, **express concerns without being judged** and **save time** though **inconsistent response times** was also raised as was the lengthy nature of the forms due to numerous questions and concern about **access for people who are non-digital**.
- The importance of **active dialogue and communication** between patients, doctors, and carers about their medicines including professionals being able to listen and patients and carers being empowered to raise issues was raised as an issue to address. The importance of **shared decision making** with patients and their health professional was seen as important area to develop as patients are not always confident to give their views, particularly if not invited to do so. Informing people about **medicines reviews** was also seen as an important area to promote.
- In maternity care v**ariations in care** and **barriers to access** experienced by **migrant and asylum-seeking women** and birthing people was highlighted as a key issue. Barriers include challenges with **language and communication**, as well as limited understanding of the healthcare system. Barriers also include a **lack of culturally sensitive and linguistically appropriate services.**
- Inconsistent access to antenatal and postnatal care and the impact of the **absence of family support** and **financial constraints** on wellbeing during the postnatal period were highlighted as issues that affect women and birthing people particularly from under-served communities.

Engagement informing the South East London Joint Forward Plan (3)

What we heard from local people during engagement on the Join Forward Plan: April – June 2023

- People highlighted the importance of **accessible, timely, and personalised services.** Suggested using technology effectively to facilitate this for people who are confident in using it, thus freeing up time for people who need face to face appointments.
- There is a need for partners in the system to work better together to **support prevention** as well as address **urgent needs**. Working **in partnership with the voluntary, community and social enterprise (VCSE) sector** is seen as particularly important as they have a key role to play in preventing ill-health, and the need to build and support the workforce across the system to support people holistically was also noted as being important.
- Better **coordination of care and records** across the system was seen as important as many people particularly people living with multiple long terms conditions and carers struggle to navigate the system and need the system to be simpler. The need for **clearer information and better communication** about how to find your way around the system was raised including having **named coordinators or coordinating teams** to contact easily when people's health deteriorates as people can feel 'lost'. This would support people not having to default to urgent and emergency care services or people not being admitted into hospital as they approach end of life care.
- **Support for carers**, including early support, was highlighted as a very important area which needs to be more visible. Carers are a vital part of the health and care system with approximately 122,000 carers across south east London with 33,000 self-identified as providing more than 50 hours a week of care which impacts on their mental and physical health. Providing timely support to carers helps maintain their health and the health of the cared for person, which can enable independence and people staying in their own homes for longer. Information is also important to help carers navigate the complex system. Public Health England have argued that caring can be seen as being a social determinant of health. Carers UK note that carers health is often worse than non-carers due to the pressures of the caring role.
- Some comments were received about the need for an accessible, plain language **summary of the plan** as the language used often does not resonate with or be easily understood by local people.
- Further information is needed on **benchmarking** and **targets** as well as how we might use **patient outcome measures** to measure progress.

Engagement informing the South East London Joint Forward Plan (4)

What we heard from local people during engagement on the integrated care strategy: July-November 2022

- In terms of future ambitions for the health and care system, we heard that **people want joined-up, responsive and proactive services**.
- People are experiencing **significant issues accessing health and care services**, particularly primary care, mental health services and community services. We were told, "there needs to be a **'no wrong door' approach**".
- People want an **increased focus on prevention**, the **'whole person**', as well as give more consideration to a person's **wellbeing and other wider causes of health issue**s. We must understand what outcomes matter to people, and have a trauma-informed approach that accounts for culture and gender.
- People want **high-quality care for all**. As one person told us, "services should be equitable, no matter who you are or where you live".
- People also want to **receive care and treatment in the most suitable environment and close to where they live**. We were told, "You cannot underestimate the privilege of being able to travel for an hour to get to a service".
- We heard that, as well as the areas we have discussed with local people, **other priorities include improving maternity and women's services, joining up health and social care, improving end-of-life care, and reducing and removing systemic racism and racial inequalities.**
- The **five strategic priorities are the right ones**, welcoming the focus on early action, health and wellbeing, and mental health.
- Some raised **concerns about how we will deliver these priorities** given the challenges we face, such as limits on funding. Delivery is also contingent on improving our IT systems, making it easier for partners to share people's records, and improving communication between services and with people.
- The **importance of a happy, well-trained workforce** was raised, as well as **using our workforce more flexibly**. We need to recognise the vital role carers play and provide better support for them. We heard of the importance of peer mentors to support people from our most under-served communities.
- We need to **work more closely with schools and other public services** (such as the police), as well as local people themselves. We need to better understand and **make use of the assets in our communities**. We need to improve how we **work in partnership with voluntary, community and social enterprise sector (VCSE) organisations**, especially specialist providers who support health inclusion groups, to help build trust and support people to take up services.
- Our delivery plan must **recognise and reduce the inequalities experienced by some communities** living in south east London, and we must understand social issues and barriers which make it difficult for people to access services, such as the cost-of-living crisis and systemic racism.
- There are areas of **good practice** which could be rolled out across south east London, including **safe surgeries, pride in practice and inclusion health tools** to help some of our most under-served communities to access services.

Engagement informing the South East London Joint Forward Plan (5)

Key feedback from system-level engagement between April 2020-May 2022

- **Trust and cultural sensitivity**: Trust in public services is low, especially in people from Black, Asian and Minority Ethnic and under-served communities. Some people in south east London face stigma regarding their lifestyle and culture (for example, Gypsy and Roma Traveller communities, the Rastafari community, people living with or affected by HIV and people who use drugs and alcohol). Stigma resulting from a lack of cultural awareness has shown to lead to poorer health outcomes for Black African and Black Caribbean communities, including during pregnancy and when giving birth.
- **Access issues**: People have told us that they do not know how to access services or where to go for support, and that getting a GP or dentist appointment is particularly difficult. The move to online services since the pandemic is welcomed by some but has created access issues for others. For example, those with language difficulties, people who are disabled and people from migrant backgrounds tell us this is a significant barrier to accessing health and care services. People from migrant communities tell us that a lack of information and confusion about paying for health and care services means many people do not get support when they need it, allowing health issues to worsen.
- **Mental health**: People have told us they struggle to access mental health services, because they don't know how to or because there is a lack of suitable mental health support for them. We heard that often people must become acutely unwell before they can access services. There are widespread health inequalities in access to mental health services and some communities experience worse outcomes than others.
- **Long-term conditions and complex needs**: People have told us they are not being seen as a person, but instead as individual conditions. We heard how important peer support is in improving outcomes for people with long-term conditions.
- **Partnership working**: A lack of partnership working and communication between services creates issues and barriers for people, particularly those with long-term conditions. We heard that we need to work with local people to provide services that meet their needs, and we should work with local trusted voluntary and community sector organisations to form partnerships with communities that are not usually listened to by public sector organisations. No communities are 'seldom heard', and we need to change how we involve them in our services.
- **Wider causes of health and social issues**: Wider causes of health and social issues can make it difficult for people to take up services, particularly prevention services, but these causes are often underestimated by health and care services. We heard that what are often viewed as basic needs such as feeling safe, having somewhere to live and secure employment have a significant effect on people's health and wellbeing.

Personalisation and our goals for how we will work with local people and communities

Summary of our approach to personalisation

The NHS Long-Term Plan stated that "personalised care would benefit up to 2.5 million people by 2024, giving them the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life". We know from our engagement that **people want services that meet their needs, treat them as a whole person, and that they can trust,** so the national ambition aligns with our local feedback.

Personalised care is key to this, facilitating true partnership working with local people and communities in line with our working with people and communities strategy. **We are aiming to embed personalisation across south east London**, and in order to do so there are multiple personalised care initiatives either ongoing or due to start in our system. This includes:

- **Roll-out of the thriving communities platform**, to enable local people to get more involved in shaping the support they receive and promotes peer support. The platform was developed working with GoodPeople and local people in the community.
- Working with Bexley Mind and Disabilities Advice Service Lambeth on access to personal health budgets (PHBs) to **develop a good practice guide and shape how we expand PHBs across SEL.**
- **Embedding the use of the National Association for Primary Care (NAPC) supported self-management tool** to encourage a tailored approach to providing support to people. We aim to continue to **roll-out small personal health budgets for low-level mental health needs** using this NAPC tool, which are linked to social prescribing and focused on prevention, to be used in the instances where there are limited services available in the community.
- Future **peer worker development**, aiming to change current practice and embed people with lived experience in our system to challenge and ensure it works for them. For example, the work we are doing with diabetes services whereby a peer worker works alongside nurses to support more holistic conversations about needs.
- **Expansion of children and young people's social prescribing**, recognising that this needs to be a different model to the model developed for adults.

South East London
Integrated Care System

Local Care Partnership Plans

Building from local Health and Well Being Plans

for each of Bexley, Bromley, Greenwich, Lambeth, Lewisham & Southwark

Bexley Wellbeing Partnership

Our population

The London Borough of Bexley has a population of 244,247. Bexley is experiencing the twin challenges of an ageing population toward the south and a relatively younger, ethnically diverse and deprived population towards the north. Bexley ranks 190 of 326 local authorities for deprivation and is the 9th least deprived local authority in London. However, there is considerable variation within the borough; 1 in 7 people live within the 30% most deprived areas nationally and around 1 in 6 children and 1 in 9 older people in Bexley are affected by income deprivation.

Health outcomes for our population

Obesity: High levels of obesity, including higher rates of childhood obesity.

Mental Health & Wellbeing: High prevalence of mental health problems and Bexley adults have relatively low self-reported wellbeing compared to London.

Emergency Admissions: Emergency hospital admissions for young children and babies are significantly higher in Bexley compared to London.

Frailty: Up to half of Bexley's population of over 65 years of age is affected by frailty, rising to 65% in those over 90 years of age.

Life Expectancy: Healthy life expectancy at birth for males is significantly higher in Bexley than the London and England averages and healthy life expectancy at birth for females is in line with regional and national averages.

Health Improvement:

Smoking – Less than 1 in 23 women smokers at time of delivery: less than a third of the number 10 years ago.

Cancer screening – For cervical cancer (50 to 64 years) Bexley performs above regional and England average and is third best in London.

Inequalities within our borough

Diversity: Bexley is expected to become more diverse and by 2045 Black, Asian and minority ethnic groups will account for an 30% of the population. Children from a Black minority ethnic background are significantly more likely to be overweight or obese. They are also two and half times more likely to live in the most deprived areas of Bexley, compared to children from a White ethnic background.

Borough Variation: There are stark inequalities in the north of the borough with approximately double the prevalence of reception age children identified as overweight and obesity compared to areas with the lowest prevalence.

What we've heard from the public

Develop and provide clear and simple messages on what and how to access the right services through our Roadmap to health and care:

- Improve access to same day urgent care and the quality of primary care
- Concerned about digital exclusion particularly for some of the most vulnerable communities
- Impact of the cost of living
- Provide services that are closer to where people live

South East London Integrated Care System

NHS South East London

Bexley Roadmap to Health & Care – Our Priorities

The **Bexley Joint Local Health & Wellbeing Strategy (JLHWS)** identified **four points in residents' life journeys**, reflecting the biggest populations health and well being needs.

Improvements are being achieved through delivery of the **Joint Integrated Forward Plan** – the Bexley Wellbeing Partnership local system response to the JLHWS working and co-producing solutions with our local communities. Our approach:

- ❑ **Personalisation and promoting independence**
- ❑ **Focusing on prevention through a proactive approach**
- ❑ **Taking a strengths-based approach, drawing on individuals' resourcefulness and community assets**
- ❑ **Supporting carers and taking a 'think family' approach**
- ❑ **Creating a core and local model of delivery to tailor services around**

Bexley – Our progress to date

Start Well

Key Successes in Delivery in 2023/2024

- We have supported the local Safety Valve Programme by investing in therapy and nursing provision to new school places for Children & Young People (CYP) with Special Educational Needs (SEND).
- Targeted work in schools is in progress on eating disorder prevention (train the trainer model) and engagement on a new support model for LGBTQ+ young people.
- Bexley School Superzones Programme is underway in Thamesmead and Slade Green and includes projects supporting additional community food growing, creating healthier food environments in and around schools in areas of high need.
- Children's Centre staff have been trained in the *Henry* approach to healthier lifestyles as part of our drive to reduce the prevalence of overweight and obesity in the childhood population.
- 5 paediatric *Virtual Ward* beds have been opened for CYP and the team will be trialling the use of *Doccla* remote monitoring having secured additional funding through the national Health Technology Adoption and Acceleration Fund.
- The Bexley Maternity Voices Partnership was relaunched and held a development day in 2023.
- 84 GP practices referrals for patients were supported by our Children and Young people's Social Prescribing service delivered by Bexley Voluntary Service Council in partnership with Counselling Matters, Bexley Moorings, Cribs and Little Fish Theatre.

Key Challenges to Delivery in 2023/2024

- Investments and capacity constraints delayed commissioning and delivery of the Integrated Child Health Model – investment opportunities for 2024/25 are being explored.
- Whilst Child and Adolescent Mental Health Services (CAMHS) waiting times remains challenging, the Bexley CAMHS is restructuring to streamline access to initial assessment and additional investment is supporting this process.

Learning and Implications for Future Delivery Plans

- Renewed consideration of collective resources and investments, which enable discharge from Queen Elizabeth and Darrent Valley Hospitals to support the local health and care urgent and emergency care ecosystem.

Bexley – Our progress to date

Live Well

Key Successes in Delivery in 2023/2024

- Local Care Networks have continued to develop and mature – through integrated neighbourhood system working. The Local Care Networks *Reducing Health Inequalities Programme* in partnership with Public Health several neighbourhood level projects and services have been funded including; Improving Carers Mental Health by providing free counselling sessions; Supporting vulnerable families to improve nutrition and healthy weight on a budget, with cooking healthy food with low-cost ingredients training.
- Our new GP Premium, which supports GP Practices to deliver additional services was launched in 2023. The GP Premium targets reducing health inequalities by supporting residents with Learning Disabilities, improving screening uptake and providing proactive and personalised care to those with long-term conditions.
- We have provided additional investment to our Mental Health Hub, which is delivering on streamlined access to mental health services working in partnership with Oxleas NHS Foundation Trust and Bexley Mind.

Key Challenges to Delivery in 2023/2024

- Our Primary Care Networks continue to deliver on improving access to core primary care services and have been successful in ensuring that 75% of all GP appointments are face to face. Primary Care Networks continue to provide some of the highest levels of appointments overall – however the challenge remains in ensuring that residents receive consistent access and messages on how to access primary care services.
- Whilst our Primary Care Networks and Community Pharmacies have delivered over 37,000 COVID-19 booster vaccinations and continue to perform well on immunisation programmes – additional work is underway to support the national measles and MMR call and recall campaign, including targeted events in conjunction with Bexley Children's Centres to improve immunisation rates.

Learning and Implications for Future Delivery Plans

- Our expert communications and engagement team and programmes have enabled us to successfully reach many of our marginalised communities, the learning from these programmes will be embedded into future plans.
- The Bexley Wellbeing Partnerships ambition to reduce health inequalities at Local Care Network (Neighbourhood) level through population health approaches, requires significant support and engagement with our local communities – resources and expertise to ensure success and meaningful co-production are a prerequisite.

Bexley – Our progress to date

Age Well

Key Successes in Delivery in 2023/2024

- Our *Virtual Wards* provided 25 additional beds during Winter, enabling over 1,000 frail older people and those at the end life to be cared for in their own home.
- We successfully bid for additional funding for the *doccla* remote monitoring platform, which will be used increase the efficiency of the model. We have funded new *Home First* roles supporting Queen Elizabeth Hospital, signposting people to alternative support and early identification of complex care needs.
- We have provided additional investment Mental Health Hub, which deliver is delivering interventions and have provided streamlined access to mental health services working in partnership with Oxleas NHS Foundation Trust and Mind.
- We have been successful in improving Diagnosis rates for residents with Dementia, which is above the national target, work is underway to improve post diagnosis support.

Key Challenges to Delivery in 2023/2024

- The recruitment and retention of the necessary skilled workforce across all sectors continues to be a challenge
- Increased demand pressures for the local health and care ecosystem coupled with financial challenges impacted on the local systems ability to deliver meaningful and sustainable transformation programmes.

Learning and Implications for Future Delivery Plans

- Our integrated local health and care system reviewed our District Nursing Services and developed an action plan to ensure that our patients get the right care at the right time by the right health and care professionals. However, our review demonstrated that additional consideration will be required in developing support and services that meet the needs of our older population with frailty challenges.

Bexley priority action 1 – Start Well

Giving Children & Young People the best possible start

Children and young people were disproportionately impacted by the pandemic. We want all children and young people in Bexley to have the best start in life and recognise the importance of those early years in laying the foundation for future physical and mental well-being. Post-pandemic period there has been a worrying increase in the number of serious safeguarding incidents involving babies and children and young people. A joint approach to strengthening universal and targeted 0-19 years services and to hearing women's voices on maternity pathways with our three key maternity providers.

How we will secure delivery

Actions for 24/25

- Pilot Primary Care Networks Integrated Child Health Model
- Development of Single Point of Access for Child and Adolescent Mental Health Services.
- Local authority *Emotional Literacy Support Assistant* (ELSA)
- Ensure transition pathways for autism are reflected in the joint Autism Strategy
- Implementation of children's diagnostics and clinical management pathways for Asthma using Asthma nursing
- Establish working group to review pathways for 16-25 years transition for care leavers
- Subject to funding increase capacity of community the Sickle Cell service

Actions for 2025+

- Subject to funding, implementation of a single point of access for CAMHS
- Roll out Primary Care Networks Integrated Child Health Model targeting long-term conditions
- Focus on infant feeding, creating an environment for breastfeeding
- Developing Perinatal mental health support services

Intended outcomes in 5 years time

- Reduced waitingg time for Child and Adolescent Mental Health Services
- Improved support for Children & Young People (C&YP) with long-term conditions, both physical and mental health
- Reduction in hospital admissions for C&YP
- Reduction in the numbers of woman smoking during and after pregnancy and of a healthy weight
- Better access to psychological therapies with specialist perinatal mental health services
- C&YP with special educational needs and disabilities (SEND) are identified early, reducing the need for escalation to more specialist services and are supported to access education in the borough
- C&YP are immunised against preventable diseases
- C&YP and their parents and carers, report feeling engaged in the process of assessing their needs and the criteria used to make decisions

Bexley priority action 2 – Age Well

Supporting frail and older residents to age well

Proportionally, Bexley has the **third-highest** age 65+ (41,000) population in London. There are an estimated **23,500** people in Bexley (50+) with **frailty**. Around **17,000 mild**, **4,300 moderate**, **1,800 severe**. Bexley has the **second highest** rate of emergency admissions for **falls** in London for people aged 65+. We will continue to closely evaluate our *Home First* approach to ensure that treatment and care is available in the right place at the right time and to ensure that people have timely access to reablement therapies to enable a return to an independent life. Our programme over the coming years will focus on: **1. Living well at home and reducing falls, 2. Living well in a care home, 3. Carer wellbeing, 4. Appropriate use of acute hospital provision, 5. Dying with dignity at home, 6. Service development.**

How we will secure delivery

Actions for 24/25

- Develop statutory and non-statutory sources of information so that people can more easily access care, support, and advice including self-help, peer support and actively contributing to their communities, reducing social isolation and increasing
- In collaboration with relevant stakeholders (staff, residents and carers) develop a falls awareness and prevention toolkit with associated training and clinics for teams to be used in care homes and by unpaid carers. choice and control for residents
- Deliver new Trusted Partner model of reablement

Actions for 2025+

- Deliver targeted communications campaigns which promote opportunities to reduce social isolation and loneliness. Develop an integrated approach to technology enabled care
- Ensure that commissioning arrangements give greater protection to residents from eviction
- System-wide implementation of risk stratification tools and Comprehensive Geriatric Assessment to identify and assess those most at risk of hospital admission
- Review progress on delivering palliative end of life care priorities

Intended outcomes in 5 years time

- Reablement outcomes continue to improve (as measured by Adult Social Care Outcomes Framework)
- Fewer hospital attendances and admissions
- Frail older people are safely discharged in a timely manner
- Reduction in falls for frail older people
- Better identification of people with moderate and severe frailty
- Increase in recording of advance care plans
- More people can die at home or in the community with multidisciplinary support
- Expansion in the range of housing options to support Bexley residents later in life
- Increased uptake in physical activity by people with dementia and, separately, by carers
- Carers report good access to support in the community, including to address their physical and mental health needs

Bexley priority action 3 – Live Well (1)

Transforming Community Mental Health Services

Around 15,000 people in Bexley live in areas among the 20% most deprived in England, which is associated with at least a doubling of the risk of mental health problems. Prevalence of serious mental illness is Bexley is also associated with deprivation. People with serious mental illness in Bexley are more than 4 times more likely to die before the age of 75. Our community mental health services (CMHS) transformation plan takes a wellness approach to care planning. There is no 'wrong front door 'into services – movement between primary and secondary care should be seamless. We will take a multidisciplinary approach to assessing needs and use brief interventions and social prescribing to facilitate access to mainstream resources and activities. Our programme will prioritise**: 1. Personalised care closer to home for people with acute mental health needs, 2. Living well and working in the community, 3. Mental health and Local Care Networks, 4. Living well with dementia and 5. Support for those at risk of suicide**

How we will secure delivery

Actions for 2024/25

- Expand neighbourhood hubs to enable to access timely personalised support to prevent a crisis
- Improved community out of hours crisis services
- Progress development of mental health rehab capital programme
- Improve housing options for people with mental health issues
- Expand care homes support for people with dementia
- Ensure people with severe mental illness have personalised care planning and there is communication with their families/carers to improve their physical health and normalise their life expectancy
- Early support for people living with dementia including teaching strategies to live with cognitive impairment, developing habitual patterns of behaviour for support through the life course, carers support and use of technology

Actions for 2025+

- Deliver plans to ensure the supply of housing solutions and community rehabilitation in line with the borough's mental health needs trajectory
- Embed a sustainable and resourceful VSCE sector to support people with mental health needs and reduce mental health inequalities across the borough, including at Local Care Network level

Intended outcomes in 5 years time

- Residents with acute mental health needs will receive personalised care in the right place and the right time closer to home
- People with severe mental illness will have personalised care planning to improve their physical health and normalise their life expectancy Carers/families of people with acute mental health needs feel engaged and involved
- Residents with mental health needs and their carers are supported to live well and work in the community for as long as possible Residents who are clinically ready for discharge will be supported to appropriate housing solutions and community rehabilitation
- Community mental health services are embedded in Local Care Networks, and providers work in partnership to intervene early an
- People living with dementia and their carers feel well and in control of their lives Dementia and diagnosis support is equally accessible to all our communities prevent escalation
- Reduce the number of suicides and increase support for those affected by suicide

Bexley priority action 3 – Live Well (2)

Supporting people to maintain a healthy weight

Obesity is one of the biggest health challenges for Bexley and is a family issue. Children living with obesity are more likely to become adults living with obesity and thus increases the risk of obesity for their own children later in life. Close to two-thirds of adults are overweight, with more than a third of 10-and 11-year-olds being obese. Just under 1 in 4 (22.9%) children starting primary school are obese or overweight; Prevalence of obesity is significantly higher than in London and England, which is more apparent in the north of the Borough. 1 in 3 (38.5%) children leave primary school obese. Bexley 1 in 6 children who enter primary school not overweight leave primary school overweight. Our local health and care system action plan has 3 key priorities; **1. The food and physical activity environment 2. Embedding healthy lifestyles, and 3. Support for individuals**

How we will secure delivery

Actions for 24/25

- Explore opportunities around Healthy Streets for new developments, including encouraging active travel
- Upskill community health champions to signpost residents into appropriate areas of support
- Implement the Football Foundation Playzone programme and activate the spaces with the community
- Develop a segmented communications plan on healthy lifestyles with communities and other stakeholders
- Using school health profiles consider what additional support can be provided to schools with high rates of obesity
- Focused work with the Local Care Network (LCN) with the highest rate of obesity, aiming to reduce inequalities
- Integrated weight management offer within the new 0-19s Public Health Service, supporting families and primary school age children.

Actions for 2025+

- Develop a wider food action plan / strategy for Bexley
- Explore opportunities for local employers to support a healthier workplace
- Evaluate tier 2 adults weight management service at year 2

Intended outcomes in 5 years time

- Reduction in the rate of excess weight in children and adults by a minimum of 2% over five years, with a stretch target of 5%
- Ethnic minority children most at risk and their families are better supported and can access the right services
- Increase in the number of ‘healthy places for all’ in Bexley
- Increase in healthy environments at school, in workplaces and throughout Bexley
- Healthy weight is promoted in all health and care settings
- Improved access weight management services
- Consistent and early identification in Primary Care
- Early identification and support for children and young people in primary care

A practical, systematic approach to addressing these issues in a coherent way, based on extensive application in systems across the country and - over time - was recen
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South East London Integrated Care System

Bexley priority action 3 – Live Well (3)

NHS South East London

Local Care Networks delivering preventative services and improving population health

Bexley Care was established in 2018 and is a consortia between the London Borough of Bexley Council and Oxleas NHS Foundation Trust. Joint integrated neighbourhood teams are delivering services that provide community, mental health and learning disability services, and adult social care – using a matrix approach. The integrated neighbourhood teams deliver services within the 3 established Local Care Networks geographies; Clocktower, Frognal and North Bexley. Our priority action is for the Bexley Care integrated teams to develop and evolve as a neighbourhood 'team of teams' and include the 4 Primary Care Networks and other primary care providers, reflecting recommendations of the Fuller Stocktake. LCNs are themselves a hyper-local partnership of primary, community, social, mental health and acute care, working with the VCSE and their communities. They will be responsible for delivering many of the 'Core' elements of our Integrated Forward Plan and interpreting other elements of Plan to make them more accessible to and effective for their local populations. LCNs will also provide and develop a range of other services based upon local needs, including addressing health and care inequalities and access to primary care.

How we will secure delivery

Actions for 24/25

- Local Care Network Asset Mapping to support understanding and identification of neighbourhood need and requirements
- Adopt a 'Plan, Do, Study, Act' approach in developing of early interventions and services
- Create a bank of evidence-based interventions that deliver better outcomes and reduce inequalities at neighbourhood level
- Implement Year 2 of the Health Inequalities Programme for Local Care Networks
- Co-produce the community activation programme

Actions for 2025+

- Develop estates plan for Local Care Networks to enable the delivery and co-location of services closer to where people live
- Review of *Population Outcomes Through Services* and self-assessment.

Intended outcomes in 5 years time

- Bexley Local Care Network Population Health & Care Profiles are in place and accessible to all
- Primary Care Networks are integral to neighbourhood 'teams of teams' with pragmatic and long-term support established
- The Bexley Local Care Network Operating Model ensures standardised governance and infrastructure to support and empower neighbourhood teams
- Local Care Networks and neighbourhood teams develop interventions and services that support with long-term conditions, addressing inequalities and improve health outcomes for neighbourhoods
- Local residents, community leaders, VCSE and key stakeholders are activated to be engaged and involved in co-producing services and interventions in their neighbourhood

Bexley – Local Delivery

Bexley borough delivery of SEL pathway and population group priorities

The Bexley Wellbeing Partnership is developing its *3 Joint Forward Integrated Improvement Plan*, which represents and reflects its commitment to the Bexley Joint Local Health & Wellbeing Strategy. Local health and care partners will agree a series of meaningful and sustainable 'system' actions that will support improving access and outcomes for residents in the priority areas; Ensuring *Children & Young People start well, Supporting our frail and older residents to age well, Tackling obesity and delivering our Community Mental Transformation Programme.* The partnership is committed to delivering the SEL pathway and population group priorities and some examples of local delivery are shown below.

Example of local delivery – Prevention

Primary Care Network Practitioners will collaborate across primary and secondary care teams to increase uptake of annual health checks for people with **Severe Mental Illness**. This will be delivery through; improved information transfer and recording; and working with local health and care partners will develop referral pathways for further support e.g. healthy weight and drug and alcohol interventions.

Example of local delivery – Health Inequalities

The Bexley Wellbeing Partnership utilising its Health Inequalities Fund has developed programmes at the 3 Local Care Networks geographies – using the Local Care Network Health & Care Profiles developed by the London Borough of Bexley Council. The programmes and interventions have prioritised increasing cancer screening take-up, supporting frail older residents and children and young people and developing the community voice. The **integrated neighbourhood teams**, VCSE and key stakeholders including social housing and community leaders lead on development and delivery.

Example of local delivery – Urgent & Emergency Care

The Bexley Wellbeing Partnership is recommissioning local urgent care services located at **Queen Mary's and Erith General & District Hospitals**, to support development of a; A **simplified same day integrated urgent care pathway** where patients are confident about where to go for treatment, offers **holistic**, consistent quality of care, are **financially sustainable** and continually evolve to **meet the changing urgent care** needs of Bexley.

Example of local delivery – Primary Care

The Bexley Wellbeing Partnership is commissioning a 3 year Personal Medical Services Premium for GP Practices. It will support GP practices with improving take-up rates for; screening for **Bowel and Breast Cancers** – particularly for those with **learning disabilities**, immunisations and providing **personalised** and proactive care for the management of **long-term conditions**.

Bexley enabler requirements

Workforce

Retention: Ensure staff, volunteers and unpaid carers feel valued and empowered to act to do what is right for the people they care for.
Recruitment: Create opportunities for personal development including working across the health, local government and VCSE sectors in neighbourhood teams.
System Working: Maximise the national Additional Roles & Responsibilities Scheme ensuring retention and defined career pathways, supported by wider system and of new model of workforce supports delivery of primary care services.

Estates

System Planning: Rationalisation of current Estate and ensure health and care premises are fit for purpose and in good condition. Increase integrated working where providers and services are co-located.
Securing Investment: Continue to progress optimisation programme across the borough and levering funding for new developments including the Community Diagnostic Centre and neighbourhood hubs.
Primary Care: Maximise funding opportunities to understand the clinical capacity required for Primary Care Networks to inform future investment and priority primary care estates projects to improve access.
Delegation: Primary care estates budget and decision making delegated to the partnership.

Digital

- Developing an integrated approach to **population health**/public health improvement.
- Mapping the different IT systems being used by different organisations and the need for **interoperability** – including hospital data in shared care records and population health data.
- Develop our **business intelligence** capabilities to aggregate a spectrum of demographic, health and care data.
- Create a data driven culture with 'one version of the truth' across the partnership, making evidence-based decisions.
- Creating shared dashboards for **shared outcomes** and joint activities/tasks for the partnership's priorities and within the Local Care Networks.
- Accurate identification of individuals and cohorts across health and social care is needed to ensure success.
- **Artificial Intelligence:** Bexley GP practices are actively piloting Artificial Intelligence (AI) solutions to support with time consuming administrative functions e.g. Healthtech-1 which supports the automation of new patient registrations.

Finance

- Sustainable funding for the VCSE to deliver local programmes and initiatives.
- Development of a **'pooled budgets'** partnership approach to support maximising the ***Bexley £***. Consider funding shifts where Bexley are outliers across the local health and care system.

South East London Integrated Care System

NHS South East London

Bromley borough

Our population

- **Population expected to rise** to 345,350 by 2027. **Second oldest population in London** (17.7%) - expected to grow to 67,400 over 65s by 2030. Life expectancy is 81.3 for men and 84.9 for women, with up to 8.4 years of variation between wards. **People live on average 17.7 years in poor health**. Net growth in child population is in the 11-18 age group.
- Index of multiple deprivation shows Bromley's **east and north west has wards in the most deprived 10% and 20% nationally**, equally Bromley's **central belt and far south west have wards in the least deprived 10% and 20% nationally**.
- The ethnic minority population of Bromley is 19.8% with Black African population the fastest growing BAME group. **19% of 0-4 year olds in Bromley are from BME groups compared to 5% of those post retirement age**. Between 2017 and 2027 the overall **ethnic minority population is projected to rise by 23%.**

Health outcomes for our population

- The main underlying causes of death in Bromley 2016-2020 were **cancer** (29.5% of deaths), **circulatory disease** (27.9%) and **respiratory disease** (13.9%).
- Other areas of opportunity to improve health outcomes for Bromley include:
  - **Obesity** 57% of adults overweight or obese, 340 children obese in year 6 with higher rates of child obesity in north east, north west and Mottingham areas
  - **Diabetes diagnosis rate** of 66.1% is poor compared to England and London, with over 15,000 people diagnosed with diabetes and 30,000 estimated at risk
  - **Dementia** 4,380 people aged 65+ live with it, estimated to rise 50% by 2030. Bromley has higher rates of young-onset dementia than England and London.
  - **Adult mental health** 10.8% of GP patients diagnosed with depression, 6th highest London borough, and higher rates of chronic ill health than general population.
  - **Adolescent mental health** 1,702 pupils with social, emotional and mental health needs, while drug use among young people higher in Bromley than London.

Inequalities within our borough

- **Deprivation** Life expectancy lower in more deprived wards, especially for men. More adults report poor health in Cray Valley & Mottingham and Chislehurst North.
- **CYP** Children in north east & north west and Mottingham have the highest rates of obesity. Teenage pregnancy rates highest in areas of greatest deprivation and where more children live in households with unemployment and financial issues.
- **Substance misuse** Low levels of recorded drug use mask high rates of opiate and/or crack use in 15-24 year olds. Hospital admissions and drug-related mortality highest in most deprived wards.
- **Sexual health** 50% of STIs in Bromley diagnosed in 15-25s; they, plus men who have sex with men, and Black African/Caribbean ethnic groups have the highest rates of new STI. Majority of new STIs in 2017 were diagnosed in the more deprived wards.
- **Learning disabilities** Shortfall in the number of people identified with learning disability who have had an annual health check.

What we've heard from the public

- Strong support for moving more care into the community, including: ease of access at the One Bromley Health Hub, positive response to plans to develop a Bromley Town health and wellbeing centre, Beckenham Urgent Treatment Centre felt essential service for that geographic area; exceptional user feedback for Children's and Adult Hospitals at Home.
- Frustration regarding accessing primary care in general and getting information on waiting times, including at our Urgent Treatment Centres.
- Mixed responses on use of technology for home monitoring: generally positive from those who have used it, but caution when considering establishing virtual wards.

Bromley - Our objectives and priority actions

Our key objectives - what we want to achieve over the next five years

Improve population physical and mental health and wellbeing through prevention & personalised care

- Evidence driven population health improvement by tackling inequalities, improving outcomes and services formed around the needs of service users.
- Patients and carers supported in the management of long term conditions – including transitions between services.
- Meeting the needs of Bromley's elderly population as well as children and young people.
- Influencing the strategy of partners on wider determinants of health.

High quality care closer to home delivered through our neighbourhoods

- Primary care is on a sustainable footing and tacking unwarranted variation in patient outcomes, experience and access.
- Neighbourhood teams based on geographic foot-prints provide seamless services across health, social care and third sector services.
- Improved access by moving services from hospitals and into the community & people's home and delivering new approaches for mental health care and services for children and young people.
- Monitored and maximised the health and care resources for our population.

Good access to urgent and unscheduled care and support to meet people's needs

- Residents have and understand how to use same day and emergency care across Bromley spanning physical and mental health, social and third sector care.
- Services meet the needs of the population and support people into non-urgent care once their urgent needs are met.

Our priority actions

1. Deliver evidence-driven population analysis to support teams in targeting prevention and improving population health outcomes
2. Evolve neighbourhood teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health
3. Implement our care closer to home programmes across Children's and Young People, Community Mental Health Transformation, and Hospital at Home
4. Establish and deliver development plan to support primary care sustainability
5. Coherent system-wide approach to integrated urgent care in a more sustainable model and easier to navigate for professionals and all service users

Supported by a One Bromley culture and wider enablers:

- One culture to help us deliver joined up services
- Asset-based community approach with an engaged population
- One Bromley organisations are tied to the wellbeing of the populations we serve
- Maintaining and securing resources for the needs of children and adults in Bromley
- Workforce, estate, digital tools (including analysis and artificial intelligence) and finance in place to deliver our priorities

Bromley – Our progress to date

Key Successes in Delivery in 2023/2024

- **Launched children & young people and adults mental health single point of accesses**: offering blended voluntary and NHS support services, delivered alongside **reduced CAMHS waiting times**.
- **Initiation and expansion of Bromley Children's Integrated Health Partnership**: 90% of patients avoided referral to hospital – instead, seen closer to home and at least 20 weeks faster.
- **Embedding of health inequalities-funded neighbourhood working**: connecting people with others in similar situations, statutory and voluntary services; alongside trial of **'one stop shop' model in a wellbeing hub**.
- **Hospital at Home services expanded:** providing an additional ward of acute capacity to the Bromley system - delivering holistic, patient-centred care with exceptionally positive patient feedback.
- **Mobilised new urgent treatment centre contract** across two sites in Bromley with key targets now being met.
- Piloted **multi-disciplinary, multi-organisational** review of care and nursing home residents most at risk of admission to hospital and updated patient universal care plans used by London Ambulance Service and others.
- Further embedded use of **Consultant Connect to improve interface between primary and secondary care**: highest call rates of all South East London boroughs.
- Invested in **community champions** to enable more resilient champions able to more confidently share information about our health and care services in communities.
- **Introduced remote monitoring in primary care**, empowering patients in managing long term conditions and using clinician time more efficiently.
- Begun **implementation of modern general practice** models to help manage demand and improve access.

Key Challenges to Delivery in 2023/2024

- Securing **linked patient identifiable data-sets** system to enable proactive prevention and personalised care actions included in this delivery plan.
- Access to **shared patient records** remains a challenge placing pressure on integrated models of care.
- Identifying how to **make best use of community assets** to as part of neighbourhood working: supporting design, implementation and self-sustaining work.
- Challenges resulting from implementation of **new secondary care patient record system**.
- **Organisational capacity and capability for change** given available resources in 2023/24 and onwards, including management cost reductions and time demands on senior clinical leaders.
- **Restricted levels of capital funding** for premises and IT equipment

Learning and Implications for Future Delivery Plans

- Governance in place for 2024/25 to support **neighbourhood development**, dovetailing community and national priorities, providing strategic oversight, challenge and support, including through a suite of tools for successful change delivery provided by and shared between system partners. To include a shared approach to evaluating work.
- **Integrated Urgent and Emergency Care** model will dovetail with 111 procurement, with implications for local and joined up urgent care services for patients.
- Further collaborative development of **sustainable Primary Care model** through 2024/25.
- Doing **more 'once' for One Bromley** – recognising availability of expertise and resources for business as usual and change.

Bromley priority action 1 – evidence driven prevention and population health

Deliver evidence-driven population analysis to support teams in targeting prevention and improving population health outcomes

Establish the evidence and analysis requirements, means of delivery and support to planning and operational teams for evidence driven population health analysis. This will enable population segmentation into actionable groups at place and neighbourhood level, with an initial focus on our areas of greatest population health opportunity: living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and those at risk of emergency admission. Alongside Programme 2, focussed on developing neighbourhoods, this will enable us to work with identified groups, understand the drivers of inequalities and co-design solutions for healthier lives, including the wider determinants of health.

How we will secure delivery

Actions for 24/25

- Population health analysis and local intelligence held by health, care, third sector and SAFER Bromley partners identify those living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and at risk of emergency admission.
- Utilise care closer to home initiatives (Programme 3) to identify and support those we could help the most – e.g. Children's hubs; mental health single points of access.
- Evaluate case management approach for complex and vulnerable individuals to provide more holistic, anticipatory and coordinated care.
- One Bromley taskforce and strategic board deliver early intervention and prevention initiatives, including through our new Health 'one stop shop' in central Bromley.
- Delivery of a new Bromley Mental Health and Wellbeing Strategy (see Programme 3).
- Develop a new universal and targeted service offer for children with identified speech and language needs.

Actions for 25/26

- Engagement through neighbourhoods with communities about the root cause of current levels of utilisation of prevention and screening services and self support.
- Explore need for place-based prevention service supporting health checks and management of chronic conditions at scale, embedded in neighbourhoods.
- Support for staff at all levels and across providers to interrogate, manipulate and interpret service and populations data.
- Expansion of use of care closer to home initiatives for more complex areas requiring greater cross boundary working – e.g. Children's hubs: LGBTQ+ and young carers.
- Influencing partners beyond health and care with evidence from engagement.

Intended outcomes in 5 years time

- System partners working together to identify and support the needs identified.
- People identified through population health analysis have more holistic, anticipatory and co-ordinated care, delivering better health outcomes and managing the growth demand on GPs, mitigating hospital admissions and impacting social care costs.
- Population health analysis platform in place.
- Place and neighbourhood teams utilising population health analysis platform to support identifying and engaging populations with higher health opportunity, then monitoring the impact of our actions.
- Neighbourhoods have clear understanding of, and work hand-in-hand with, their communities.
- Reduced demand for specialist services, due to meeting needs at earlier opportunities.
- Increased screening for diabetes, cancer.
- Services amended to better meet needs of our population living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and those at risk of emergency admission.
- Earlier support for children and adults requiring mental health support.

Bromley priority action 2 – neighbourhood teams on geographic footprints

Evolve neighbourhood teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health

Partners have joint understanding of the purpose, function and geographies of neighbourhood teams, and the roles different providers play within them, to target prevention, tackle inequalities and provide appropriate focus for people with more complex needs. Neighbourhood teams are structured to make the best use of time – that of service users, health and care professionals, voluntary and third sector partners – to deliver service-user-led outcomes. Combined with Programme 3, moving resources out of hospitals to the community, we will support the sustainability of our health and care system in the long term.

How we will secure delivery

Actions for 24/25

- Implement new neighbourhood development governance arrangements supporting the core principles of integrated neighbourhood teams.
- Evaluate early initiatives, such as CYP hubs, wellbeing cafés, diabetes outcomes improvement programme to gain and share learning of joint working.
- Start to organically establish organisations' services, staffing and structures commitment to neighbourhoods – including secondary and mental health consultant capacity to neighbourhood working for target clinical specialties.
- Engage local populations in development of services in neighbourhoods.
- Further tools collated and available to support our staff in working cross-system.
- Commence needs analysis and scoping for improved community access to diagnostics and wider primary care services (dentistry, pharmacy and optometry).
- Implement SEL safeguarding work at Place, including through opportunities presented through new multi-agency multi-disciplinary working on neighbourhood footprints.

Actions for 25/26

- Continued development of neighbourhood working and leadership.
- Co-production skills development with neighbourhood teams to set selves up for future development work

Intended outcomes in 5 years' time

- Neighbourhood structures and governance established to a common minimum standard.
- Workforce, finance, data analysis, organisational development, co-design skills and other enablers to support success of neighbourhood teams in their work is established.
- Target clinical specialties secondary and mental health consultant job plans embed neighbourhood working as a means to delivery of secondary care services - aligning services to core teams at different geographical levels as appropriate for the patients' needs.
- Care and health services operating as part of high-trust integrated neighbourhood teams reducing duplication between services.
- A sustainable, accessible and responsive model of integrated primary care operating across all neighbourhoods in Bromley.
- Initial commissioning of services on neighbourhood geographic footprints.
- Reduce need for hospital referral through greater use of community point of care testing, community diagnostics and primary care / community / secondary and mental health MDTs.

Bromley priority action 3 – implement moving care closer to home

Implement our care closer to home programmes across Children's and Young People, Community Mental Health Transformation, Hospital at Home, and disease pathways

Where it is safe and effective to do so, Bromley will move more care into communities and people's homes. This will mean that hospitals are better able to target their resources for patients needing care in those settings, while improving equity of access to care and outcomes for Bromley residents. These place-level programmes to move resources into the community will be delivered with neighbourhood teams. This will involve sharing workforce and developing new ways of working among professional teams and with service-users, carers and families to support people using services more effectively, with self-care and remote monitoring and support, including with third sector partners. These programmes will interface with and support the Bromley delivery of South East London-wide programmes where relevant.

How we will secure delivery

Actions for 24/25

- Children's Integrated Health Teams (B-CHIP) across all PCNs with impact evaluated.
- Consider adult Hospital at Home and frailty provision as part of a holistic community urgent response offer, including working with care and nursing homes.
- Embed new single points of access for blended NHS, voluntary sector and other partner support for CAMHS and adult mental heath services.
- Mobilise new joint Bromley Council/SEL ICB Mental Health Support@Home service for children and adults with long-term and complex health and care needs, including physical and learning disabilities, and mental health.
- Completion of baseline needs assessment of children, young people and adult's mental health needs in Bromley to underpin the development of a new Bromley Mental Health and Wellbeing Strategy (2025-30).
- Establish strategy for integrated end of life care in Bromley focussed on quality and coordination, bringing clarity for organisations and residents.
- Continue localised delivery of transformation programmes for cancer, respiratory, diabetes, cardiovascular and frailty.

Actions for 25/26

- Continue linking working of care closer to home services with emerging neighbourhood teams
- Commence delivery of Bromley Mental Health and Wellbeing Strategy.

Intended outcomes in 5 years time

- Reduction in waiting times for children's health services.
- Improved access to adult wellbeing early intervention and prevention – particularly in cancer, respiratory, diabetes, cardiovascular and frailty.
- A reduction of clients requiring inappropriate/costly residential and nursing care who could be better supported living independently in their own homes.
- A reduction in the need for children, young people's and adults specialist and inpatient mental health services for those who could be better supported by other services.
- A significant reduction in the level of re-referrals and readmissions for people moving between mental health services.
- Reduced need for adults to attend hospital for acute care.
- Improving the quality and experience of end of life care residents and their families, with more people dying in the place of their choice.
- Reallocation of resources to reflect change in where patients are treated.
- Improvement in Bromley ranking in London for recorded depression.
- Improved outcomes for users of all care closer to home programmes.
- Communities feel that they own the services they have supported build through co-design.

Bromley priority action 4 – primary care sustainability

Establish and deliver development plan to support primary care sustainability

Bromley has a well developed model of collaborative working across the local health, voluntary and social care system, under the umbrella of One Bromley. We will continue to develop models to enable enhanced primary care resilience, develop sustainable operating models and work together with other local health and care services through neighbourhood teams. This will support primary care focussed reduction in inequalities and ensure a sustainable, accessible and responsive primary care offer for Bromley residents.

How we will secure delivery

Actions for 24/25

- Develop and agree future model(s) in general practice through continued collaborative transformation approaches, informing community care and urgent care procurement processes. This will include:
  - Share insights and benchmarked outcomes on delivery of primary care across clinical care and patient outcomes at practice and PCN level, e.g. Clinical Effectiveness, QOF, and other data sources for long term condition outcomes.
  - Continue clinical quality improvement implementation: 1) quality improvement methodologies, 2) reviewing demand and capacity, 3) digital transformation
  - Maximise use of existing estate – focus on fit for purpose and appropriate scale
  - One Bromley Strategic Workforce programme, Training Hub and partners collaborate on attracting people to work in primary care in Bromley and new routes into primary care. Develop Portfolio working model for Bromley to attract GPs.
  - Integrating community pharmacy through neighbourhood working, shifting appointments from general practice through Pharmacy First.

Actions for 25/26

- Continue delivery of primary care development programme
- Delivery of identified responses to support health inequalities – e.g. catch-up clinics for screening
- Plans for fit for purpose estates to enable integrated neighbourhood working
- Deployment of resources to support equitable access
- Commence training for staff on how to work cross organisationally as part of joined-up primary care and neighbourhood teams

Intended outcomes in 5 years time

- Primary care on a more sustainable footing and practices more resilient
- Optometry, pharmacy and dentistry part of One Bromley partnership
- Improvement in equality of primary care access
- Improvement in health inequalities outcomes
- General practice working with partner practices and as part of integrated neighbourhood teams

Bromley priority action 5 – integrated urgent care

Coherent system-wide approach to integrated urgent care in a more sustainable model and easier to navigate for professionals and all service users

We will co-develop an urgent health and social care plan across our partnership and with our communities to simplify same day access to physical, mental health, social support and third sector care when it is needed. Our ambition is people receive the right care, in the right place, at the right time - reducing escalation of need and hospital admission, particularly for our frail, elderly and higher users of services. This will mitigate growth in costs to the Bromley health and care budget while supporting the sustainability of our urgent care providers. It will build on, and augment, our current provision to form a highly integrated and responsive model meeting the population needs using resources available.

How we will secure delivery

Actions for 24/25

- Agree between partners and with our communities an improved integrated urgent care model to meet same-day care needs for patients, offering clearer access and enhancing sustainability – working with developing neighbourhood teams to calibrate activities at Place and Neighbourhood level, clarifying role of general practice and meeting seasonal demand.
- Admission avoidance community: consider role of adult Hospital at Home and frailty provision in same day care as part of a holistic community urgent response service.
- Admission avoidance hospital: front door ED streaming, SDEC services with embedded speciality capacity, mandated heralding of professional referrals to ED.
- Expanded High Intensity User and Complex Case Programme working cross system and supported by population health analysis as available.
- Children's hubs across borough support community response, including improved opportunities to understand and respond to safeguarding needs and vulnerabilities.

Actions for 25/26

- Needs analysis and scoping for improved community access to diagnostics and wider primary care services to avoid hospital attendances.
- Utilise emerging neighbourhood teams to support delivery of self care messaging – with supporting collateral e.g. 'when to escalate' booklets for parents, training course for informal carers of people with long term conditions.

Intended outcomes in 5 years time

- Services refocussed on avoiding hospital admission, particularly frail elderly.
- Where necessary, after urgent episode of care urgent services refer patients onto robust community and third sector services.
- Single Community Urgent Response Service in place which avoids hospital for more complex, frail and elderly patients.
- Residents have better understanding of how to best use same day and emergency care.
- Residents, particularly informal carers, more confident in self care, support available to them and when and how best to escalate acute exacerbations.
- Implementation of guaranteed same-day care for patients where identified need.
- Clarified role of general practice in urgent care.
- Clear, timely, accurate handover of patients from hospital to neighbourhood teams.
- Greater utilisation of step-up same day social and third sector care.
- Reduction in ED attendance as part of urgent mental health pathway.
- Providers and commissioners financially more sustainable in delivery of urgent care.
- Reduced need for hospital referral through greater use of community point of care testing and community diagnostics.
- At any 'point of access' health professional access other help rather than re-refer.

Bromley borough – local delivery

Bromley borough delivery of SEL pathway and population group priorities

Bromley is committed to ensuring our population have equitable access and a consistent quality of services in line with our neighbours across the ICS. We are achieving this by embedding delivery of the key ICS pathway and population group priorities in our place and neighbourhood working. We are building on strong foundations of aligned plans in areas including children & young people and management of long term conditions, while localising pathway plans such as cancer and learning disabilities & autism using feedback from our local population. Correspondingly the core principles of prevention and population health management are at the heart of our plans to transform local population outcomes.

UEC: Enhance our integrated out of hospital offer

Through our refresh of the local Integrated Urgent Care Plan, and building on successful high intensity user work to date, we are using population health management segmentation analysis to support engagement with higher users of emergency care to understand drivers of current service utilisation, including across primary and community providers. This will support the realisation of neighbourhood working through understanding needs and building services that meet those needs in more effective ways.

CYP: Integrated Child Health Models

Bromley has commenced roll-out of the Children's Integrated Health Teams, localising the model and evaluating its operating in all PCNs. This brings health and care services together to improve care co-ordination, support for families and reduce health inequalities while bringing care closer to home. The outcomes will demonstrably reduce emergency department contacts, non-elective hospital admissions and increase user satisfaction, in line with ICS ambitions and ahead of ICS-wide timelines.

Primary care: Develop and embed INTs

Building our neighbourhood model and workforce plan is a core plank of evolving our teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health input. This will be alongside local and ICS agreement on aligning financial and contractual models to support INTs: supporting the shift of organisations' structures and ways of working to neighbourhood footprints.

Palliative & EoL Care: Virtual wards

Bromley Hospital at Home will continue to develop and expand, including considering its role in same day care to better avoid unscheduled hospital attendance for the most vulnerable in our community. This includes piloting the use of ultra-sound point of care testing alongside our existing suite of at bedside diagnostics, and further exploring remote monitoring to identify and respond earlier to signs of deterioration. Our deeply integrated service offers prime opportunity to embed end of life care approaches earlier for more patients.

Bromley enabler requirements (1)

Workforce

- **Support Neighbourhoods plan for and secure the workforce to meet the priorities**
- **Recruitment** (current and future workforce)
  - One Bromley recruitment campaign; One Bromley 'come and work with us' website page on ICS website; Local Recruitment fairs for health and care roles.
- **Retention** (innovative roles, shared roles, wellbeing and skills development)
  - Building staff agreement for joint services; Joint training & wellbeing programmes.
- **System working** (Organisational Development to support wider understanding of the system, working across silos, development of teams employed across the system, system leadership).
- **Widening participation and understanding of careers**
  - One Bromley Springpod, One Bromley Cadet programme.
- **Business intelligence on workforce** – share good practice.

Digital

- **Aligning and integrating systems** used by delivery staff over the medium-long term – to enable effective joined up delivery at neighbourhood level, but requiring action at Place and ICB level to realise this ambition.
- **Securing new tools for clinical staff** – supporting specification development and interdependencies for remote monitoring platform(s) and real-time integrated clinical systems and tools.
- **Clarity on future of non-recurrently funded tools**, e.g. Ardens, Accurex (SMS), e-consult, practice websites.
- **Business Intelligence and shared data** tools made available to local teams to support population health management and clinical decision making
- **Enable mobile workforce**

Estates

- **Local estates planning** with all local partners through the Local Estates Forum, developing the local and primary care estates strategy.
- **Utilisation of estate across Bromley** beyond existing NHS properties, including shared accommodation and hub working.
- **Levering investment** into the Borough to support estates development.
- **Progress the development** of the Bromley Health and Well Being Centre and other capital schemes.
- **Delegation** to Place for decision making and the primary care estates budget.
- **Improve the quality** of existing estate and ensuring robust contractual arrangements in place to provide stability for future use.

Finance

- **ICB supported analysis** - Post-code based analysis and data on NHS and care utilisation, with either place based staff to interrogate, or simple access to SEL based analysis with analytical time for Bromley.
- **Service and programme level reporting** across the system, across providers to support service transformation.
- **Financial support to diagnostics** - Support for greater diagnostic capacity/modality access to community/primary care.
- **Financial support to estates** - Support with capital investment.
- **Consideration to how capacity and capability of VCSE** can be enhanced.
- **Shared financial reporting** across health and social care providers in Bromley to understand the impact of change initiatives on the Bromley pound.

Bromley enabler requirements (2)

One Bromley Culture

- Governance for cross organisational working
  - **Streamlined governance** which supports the building of trust and assurance amongst and between senior leadership teams.
  - **Broaden range of cross One Bromley functional groups** – e.g. Communication and engagement, business intelligence, contracting, strategy leads.
  - **Review what decisions and risk can be held jointly** between partners rather than by each organisation individually.
  - **Review the operational groups** required to enable joined up delivery at place and neighbourhood level, including community voice.
  - **Embedding of One Bromley strategic priorities into organisational priorities**
- Working with SEL partners.
  - **Alignment of Place delegations and resources and decision making authority at Place.**

Communication and engagement

- Communication and engagement **skills training for neighbourhood teams and SEL programme leads** – building asset based community approach.
- **Direct support** to neighbourhood teams community engagement.
- Support building and skilling network of **community champions.**
- **Agreed One Bromley identity and usage requirements.**
- Agreed approach to **internal communication and engagement on One Bromley** and its work programmes.
- **Work hand-in-hand with voluntary, community and social enterprises** as source of insight, intelligence, strategic direction and engagement, especially with marginalised communities.

Royal Borough of Greenwich

Our population

- 289,100 residents live within the Royal Borough of Greenwich, an increase of 13.6% from 2011
- The number of residents in the borough aged over 65 has risen by 15.6% since 2011
- The total number of economically active people in RBG make up 76.2% of the borough
- 5.9% of residents are unemployed
- 58.6% of residents have achieved NVQ4 and above
- 51.8% of households in Royal Greenwich are classified as being deprived in one or more of the following: employment, education, health and disability and housing

Health outcomes for our population

- Prevalence of hypertension in Royal Greenwich (all ages) is 12.4%, this is below the National average of 14.4% (2022/23)
- In Greenwich, over 60% of the adult population is obese or overweight
- Hospital admissions as a result of self-harm (10-24 years) are increasing and getting worse with 2050 counts in 2021/2022
- Mental Health is significant, with growing demand, with long waits particularly for CAMHS
- New referrals to secondary health services (all ages) increasing, above the National average
- Smoking prevalence in adults (18+) in Greenwich has been decreasing steadily. The most recent data for Greenwich is slightly above the national (13.5% vrs 12.7% nationally)
- Cancer is the leading cause of death for people in Greenwich (30.9%) with Heart disease following behind (28.6%)
- Musculo-skeletal conditions and poor mental health have the biggest impact on quality of life (morbidity) in our population
- 52% of people who die in Greenwich do so in hospital and only 14% of people identified as being in the last year of life have an advance care plan

Inequalities within our borough

- In Greenwich, life expectancy is 5-6 years lower in the most deprived quintile when compared to the least deprived quintile
- The biggest contributory diseases to the gap in life expectancy between the most & least disadvantaged is circulatory disease, followed by cancers & respiratory disease
- In 2020-2021, deaths from COVID also contributed to the gap in life expectancy as poorer people were disproportionately affected
- Black, Asian and other minority ethnic communities are overrepresented in our more deprived areas and experience related health inequalities in addition to the direct impacts of structural inequalities and racism on mental and physical health outcomes
- The prevalence of obesity in children aged 10-11 increased sharply during the pandemic years, but has fallen over the last two years in Greenwich and nationally. Inequalities remain a significant factor, with children in the most deprived quintiles having much higher rates than those in the least deprived quintiles.

What we've heard from the public

- Adults and children and young people are struggling with mental health
- Managing money and cost-of-living is impacting mental and physical health
- Linked to the cost of living, housing availability and affordability are required to meet growing needs
- "*We need to make sure our streets are safe for all*"
- Environmental factors are affecting health, need improved use of space and air quality
- Adults are focused on balancing caring responsibilities and personal life
- "*Provide better and varying opportunities for children and young people*"

The Greenwich Health and Care Plan Contents

Resources

- NHS Health Inequalities funding
- RBG funding to strengthen resilience
- Public Health funds
- NHS Greenwich Charitable Funds
- Mainstream monies

Our priorities span a resident's life course

Working together on our ten shared priority areas will produce better outcomes for Greenwich residents throughout their life and will inform our delivery structure for the Healthier Greenwich Partnership.

Support Greenwich residents to **start well:**

- Children and young people (CYP) get the best start in life and can reach their full potential

Support Greenwich residents to **be well:**

- Everyone is more active
- Everyone can access nutritious food

Support Greenwich residents to **feel well:**

- There are fewer people who experience poor health as a result of addiction or dependency
- Fewer adults are affected by poor mental health
- Fewer children and young people are affected by poor mental health

Support Greenwich residents to **stay well:**

- For everyone to access the services they need on an equitable footing
- Effective integrated community teams based in neighbourhoods provide the right support when and where it is needed
- Reduce unfair and avoidable differences in health and wellbeing

Support Greenwich residents to **age well:**

- Health and care services support people to live fulfilling and independent lives and carers are supported

Live Well Greenwich

How we developed our priorities as a partnership

The Healthier Greenwich Partnership (HGP) is made up of organisations and individuals who live, work and learn in Greenwich. We work together to enable high quality health and care outcomes in our local area.

The Healthier Greenwich Partnership is on a journey to partner well. Between Sep-Dec 2022, the partnership co-developed:

- A clear narrative for the partnership and a shared purpose
- A practical and flexible way of delivering together
- A shared set of values and behaviours for enabling effective working together
- A set of strategic objectives and priorities for the programme to develop into a delivery plan
- A developing programme of work to create the infrastructure for shared outcomes
- Greater clarity on the role of neighbourhoods as a delivery vehicle
- Stronger relationships and a greater willingness to openly discuss "thorny" issues

There is a suite of plans that are linked, as follows:

- SEL ICB Joint Forward View (JFV)
- Greenwich Health & Well-being Strategy (HWBS)
- Greenwich Local Care Plan (LCP)

These plans have in common a set of priorities informed by engagement and key workstreams include:

- Scaling the shared identity – bringing staff on the journey
- Working differently – implementing the new delivery structure and agreeing how to manage conflict and apply collective resources in the best way
- Delivering the shared purpose – implementing plans for delivering shared priorities and engaging with wider system partners

The LCP is the key delivery plan for HGP – it contains 10 priorities with 32 High impact Activities (HIAs) that are organised across 5 areas – Start Well, Be Well, Feel Well, Stay Well and Age Well.

During the second half of 23/24 a progress update of the work to deliver against the 32 High impact Activities has been undertaken.

It was evident that good delivery progress was being made against the 32 HIAs, which was very encouraging given that this is a high-level plan to improve outcomes for people across Greenwich over the 5 years from 23/24 to 27/28.

Moving into 24/25, leads for each HIA have been looking at the activities and refreshing things so that they remain relevant for 24/25. They have equally considered the outcomes and metrics that we are collectively working towards achieving and make any amendments here too.

The HGP Board received a report on progress in Nov 23 and will receive another on the refreshed content in Apr 24.

Greenwich - Our objectives and priority actions

Our key objectives - what we want to achieve over the next five years

For our Citizens

- Peoples' health supports them to live their best lives
- Living longer, more equitable and rewarding lives
- Better and more equitable access to services
- Timely care with fewer hand-offs and referrals
- Integrated care – with a united care record
- Only having to tell their story once, and without experiencing structural inequalities and racism
- Feeling empowered and responsible for self-care
- Can access health and social support, including peer support, without stigma

For our frontline staff

- To have a workforce fit for the future
- Better retention and values-based recruitment
- To have a different, sustainable workforce model rooted in our communities
- To have genuinely integrated teams for Greenwich, with local staff, supporting our neighbourhoods
- To have strong communication with the public, sharing challenges and positive stories
- Greater job satisfaction and to understand where they fit and how they contribute

For our Healthier Greenwich Partnership

- All partners to feel valued and trusted in a community of equals; enabling, convening, devolving
- Meeting people where they are and being better at working with communities
- To share our resources better
- To have effective means of communicating
- To track what we want to do and manage it
- To celebrate our success and learning
- To be catalysts for change in new ways of working
- To have trust at the heart of our work

Our priority actions

Support Greenwich residents to **start well:**

1. Children and young people (CYP) get the best start in life and can reach their full potential

Support Greenwich residents to **be well:**

2. Everyone is more active
3. Everyone can access nutritious food

Support Greenwich residents to **feel well:**

4. There are fewer people who experience poor health as a result of addiction or dependency
5. Fewer adults are affected by poor mental health
6. Fewer children and young people are affected by poor mental health

Support Greenwich residents to **stay well:**

7. For everyone to access the services they need on an equitable footing
8. Effective integrated community teams based in neighbourhoods provide the right support when and where it is needed
9. Reduce unfair and avoidable differences in health and wellbeing

Support Greenwich residents to **age well:**

10. Health and care services support people to live fulfilling and independent lives and carers are supported

Greenwich – Our progress to date

Key Successes in Delivery in 2023/2024

All High Impact Activities have progressed - there is too much to celebrate to list everything in a comprehensive summary, so following is a flavour of what has been achieved during 23/24:

Start Well - 3 Family Hubs launched, specification for the Integrated Therapies Service is in place, additional capacity to increase ASD assessments, successful SEND inspection.

Be Well - 11 “School Streets” schemes, Park Runs increased from 2 to 5, 5 second-hand bike markets, Strong and Steady Falls Prevention classes, 17 Health Walks, HAF programme sessions 3482.

Feel Well - increase in babies born smokefree, improved quit rate, one of the first Lung Health Check Programme pilots, reduction in CYP waiting for initial CAMHS assessments, MH and WB Hub is live.

Stay Well - PCNs submitted Capacity, Access and Improvement Plans and signed up to NHSE Diabetes Outcomes & Improvement Programme, mobilised new UTC, work with the National Hub and Cancer Alliance to target non responders and DNAs to a breast screen.

Age Well - mobilisation of the new LNCS Homecare provider contracts, established a Carers’ Partnership, recruited two people with learning disabilities as Experts by Experience to support development of options around meaningful activities.

Key Challenges to Delivery in 2023/2024

- Unlocking the full potential of residents requires proper outreach, engagement and funding opportunities that meet people where they are.
- Good community engagement is ultimately built on trust (slow to build and easy to lose) and requires on-going investment of time, resource and budget.
- Agreeing a shared vision based about our approach and desired outcomes of neighbourhood development in Greenwich, e.g. community-led versus system-led, with agreed metrics to answer challenges from national, regional and SEL leadership

Learning and Implications for Future Delivery Plans

Good partnership working is built on strong communication and regular network meetings, where partners can stay abreast of progress, contribute at both a strategic and delivery level, and share learning (e.g. especially between commissioners and providers). This requires on-going investment of time.

Significant programmes of work are underway that build on years of community development. Valuing all people in the community as key partners brings new and creative approaches to work and is key to focusing on outcomes that matter.
It is important to have a shared change philosophy and an underlying approach that guides how we work in partnership (with our community and each other), which requires trust and transparency, clarity of purpose and objectives, and needs to include an agreed set of values and principles to work to.

Greenwich priority action – Start Well

Children and young people (CYP) get the best start in life and can reach their full potential

We want all children and young people in Greenwich to experience a safe, healthy and happy childhood where they enjoy family life and school and feel a part of the community. Our aim is to ensure every child growing up in Greenwich will begin, continue to develop and move into adulthood well. We will strive for all children to have a happy and healthy start to life - founded on support and love from parents and carers – by providing easy access to key services from the outset. We will work hard to ensure every child has a successful start to school and is ready to engage and learn from day one.

We will ensure young people develop and maintain a healthy lifestyle by providing access to regular extracurricular activities. We want all children do their best in school will make sure they are supported to meet any additional social, emotional and mental health need. We will work towards every child feeling safe at home and in the community, without fear of violent crime. We will build good foundations in their early and formative years to promote a healthy and successful adulthood.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Review neurodevelopmental pathways (with a focus on ADHD) to identify improvements in diagnosis and support for children with autism and attention deficit hyperactivity disorder.
- Development of EMIS database to improve coordination of care between health visiting and primary care
- Launch of the new Greenwich Community Directory including improved Family Information Service and Local Offer
- Development of new Greenwich Special Educational Needs and Disabilities (SEND) Strategy and governance in partnership with children and families
- Development of a new Children and Young People's Plan in partnership with children and families

Actions for 25/26

- Implementation of the new Transitional Learning Centre (TLC) for young people up to 25 with SEND
- Identification of improvements in the sharing of health and care data for children and young people including the development of the CP-IS function to support the join up of information with unscheduled care.
- Review of Virtual Ward/Hospital at Home provision for children and young people and identification of opportunities for improvement.

Intended outcomes in 5 years' time

The key outcome is for children and young people to reach their full potential, which will be measured by the following:

- Increase in children and young people growing up in a safe and healthy environment with strong supportive networks around them.
- Increased confidence and skills in parenting and infant feeding through enhanced peer support
- Increased engagement with children and young people in positive activities supporting improvements in social skills and healthy lifestyles.
- Young people are better prepared to move into adulthood with increased independence.
- Improved Greenwich Community Directory (including Family Information Service and Local Offer) enabling easier to access advice and information on what support is available for children and families.
- Improved co-ordinated care for people with learning disabilities and autism with a reduction in the escalation of need.
- Reduction in the waiting times for a diagnosis of autism and attention deficit hyperactivity disorder
- Increase in breastfeeding initiation rates.
- Increased engagement and improved outcomes from seldom heard groups as part of the Start for Life offer.

Greenwich priority action – Be Well (1)

Everyone is more active

Address people's health holistically through creating the conditions for people to be more active across Greenwich. This priority will focus on creating environments, activities and opportunities for people to be active in their everyday lives, maintain a healthy weight and enjoy access to affordable healthy food. Supporting active lives through travel, leisure, sport and daily living as part of a Whole-Systems Approach and improving the weight management services for children and adults. There will be greater focus on getting people who are least active into some activity. Primary and Secondary care services will routinely recommend and refer people to physical activity. Pathways to be accessible for people with all disabilities and for carers.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Increase the number of Play Streets, Play Estates and School Streets as part of a wider programme to increase journeys foot and cycle and to reduce car journeys
- Design and implement adult physical activity pathway, which includes families - targeting behaviour change support and activity programmes at those who face the biggest barriers to getting more active
- Review, update and implement Royal Greenwich Get Active Physical Activity & Sports Strategy

Other actions:

- *Deliver cycle training and promote active travel plans.*
- *Develop streetscape design and initiate insight about car dependency.*
- *Further develop the use of Healthy Schools and Healthy Early Years frameworks to support children to have a healthy diet, be physically active and to thrive physically and mentally.*
- *Uplift to Active Lives data set*
- *Increased focus on physical activity in primary care*

Actions for 25/26

- Implement the Local Implementation Plan (LIP).
- Develop the Healthy Weight Care Pathway and take up of related training.
- Develop and implement the Good Work Standard.

Intended outcomes in 5 years' time

All people across Greenwich are more active as measured by level of physical activity data. Key outcomes include:

Increased proportion of journeys that are made on foot or by bicycle.

- Measures: Number of bikeability sessions delivered. Number of schools with TfL stars accreditation. Development of robust local data on people's attitudes toward car usage.

Improved physical environment to enable people to achieve and maintain a healthy weight.

- Measures: air quality and modal shift indicators. Parks Usage. Numbers of Play Streets/Play Estates, School Streets, Healthy Catering Commitment outlets.

Support in schools, public and community settings to promote healthy choices and support people to achieve and maintain a healthy weight.

- Measures: Schools with TfL Stars, Schools taking part in The Daily Mile.

Increased engagement and commitment to tackle child obesity among partners and residents

- Measures: comms activity and resident activation

Support and enable people to be more active and less sedentary in their everyday lives

- Measures: Reducing inactivity levels. Activity levels measured as part of the Active Lives, School Sports and Royal Greenwich School Health Education Unit (SHEU) surveys

Increased engagement and commitment to tackle child obesity among partners and residents.

Health outcomes and inequalities starting to be impacted include

- physical (CVD, respiratory, diabetes, healthy weight), and
- mental health (concentration & achievement, self-esteem, reduced common mental health disorders such as anxiety and depression)

Greenwich priority action – Be Well (2)

Everyone can access nutritious food

Address people's health holistically through creating the conditions for people to enjoy a healthy and balanced diet across the life-course and maintain a healthy weight in Greenwich. This priority area will further focus on tackling food poverty, developing cooking skills and confidence. We will work with workplaces, shops, the hospitality industry, schools, health services and others.

Actions for 24-26

How we will secure delivery

Priority partnership actions:

- Ensure that food and nutrition is included as part of all diet-related disease care pathways such as hypertension, CVD, diabetes, and excess weight
- Refresh the food poverty action plan to align with 'Our Greenwich' and emerging regional and national policy
- Improve the food environment at a neighbourhood, high street and organisational level , harnessing the contributions of all HGP partner organisations, working with planning levers, e.g. Thamesmead Superzone and through integrated commissioning for neighbourhoods
- Improved access to specialist services for those where food and nutrition is a challenge e.g. Dietetics and Speech and Language Therapy (Dysphagia)

Other actions:

•Review & update the Greenwich Healthy Weight action plan, identifying cross departmental and cross agency opportunities to improve the obesogenic environment, reduce weight stigma and support residents to access good food

• Develop a SEL infant nutrition strategy, mobilise a breastfeeding peer support and sustainable tongue tie service through the family hub. Children's centres, health visiting and maternity to achieve and maintain UNICEF Baby Friendly Initiative (BFI) accreditation

• Increase the use of the curriculum and extra-curricular activities to develop children's skills and knowledge around healthy eating, physical activity, and health and wellbeing

• Deliver the food skills programme, including cookery and food growing

• Deliver the Good Food in Greenwich (GFiG) action plan including work to mirror the TfL advertising ban of foods that are high in fat, sugar and salt. Develop Good Food in Greenwich healthy retail strategy

• Ensure all new food outlets engage with the Healthier Catering Commitment and increase engagement with existing outlets

• Develop a sustainable plan for Holiday Hunger/ enrichment programmes

• Deliver the National Child Measurement Programme (NCMP)

• Develop healthy weight care pathways which encourages stakeholders to raise the issue of weight and refer to specialist commissioned weight management programmes

• Further develop and expand of Neighbourhood Food Action Alliances (NFAA) where VCS food organisations are coming together to share food, intelligence and work together

• Link work into supported living services and support planning around independent living skills

Intended outcomes in 5 years' time

The key outcome for Greenwich is access to nutritious food, enabling residents to access a healthy diet and to maintain a healthy weight. Other key outcomes include:

- Increased breastfeeding rates and supporting parents and carers to establish a healthy diet for their children from a very early age
- Increased range and accessibility of healthier meals, snacks and drinks that are available to buy locally
- Increased engagement of schools, public and community settings to promote healthy choices and support people to access good food
- Increased awareness of all services on the healthy weight care pathways
- Increased awareness of nutritious food on diet related care pathways e.g. CVD and hypertension

The outcomes will be measured by a range of measures which include:

- Breastfeeding initiation and breastfeeding prevalence at 6-8 weeks
- BFI accreditation / BFI Gold status achieved by 2025
- Increase in percentage uptake of Healthy Start beneficiaries
- Number of residents attending cookery clubs
- Number of HCC accredited settings
- Number of settings achieving the Good Food in Greenwich Charter
- Number of schools engaged in the Healthy Schools programme
- Percentage participation in National Child Measurement Programme (NCMP)
- Number of residents engaged in weight management services
- Decreased numbers of foodbank users
- Number of VCS food aid organisations involved in surplus food distribution

Greenwich priority action – Feel Well (1)

There are fewer people who experience poor health as a result of addiction or dependency

To address issues of addiction and dependency, people need to be supported as a whole person, not as isolated conditions or symptoms to be treated. This requires an understanding of the challenges, desires, strengths, resources and support networks of each individual. Providing flexible services that meet an individual's circumstances is key to giving people greater control over managing their health and wellbeing.

How we will secure delivery

Actions for 24/25

Priority partnership actions (Tobacco):

- Embed evidence-based Tobacco Treatment through the consistent roll-out of Very Brief Advice (VBA), and at point of care within LGT, Oxleas (mental health and community services) and wider NHS pathways, to include offer of vapes and incentives for pregnant people as part of core treatment.
- Complete the Lung Health Check programme pilot, highlighting early-stage cancer for treatment and Very Brief Advice point of care referral to stimulate Tobacco Treatment

Priority partnership actions (Drugs and alcohol):

- Implement new funding for drug and alcohol treatment through our local partnership arrangements, ensuring increased access to high quality treatment.

Actions for 25/26

Tobacco, drugs and alcohol: Ongoing further implementation of our tobacco, drug and alcohol treatment and prevention programmes. This will include full implementation of the Targeted Lung Health Check programme, identifying lung cancers at an early stage & improve outcomes

Gambling: development of improved support for gamblers experiencing financial, social and health difficulties resulting from gambling addiction; through NHS, local authority and wider partnership activities

Intended outcomes in 5 years' time

The key outcome is fewer people in the area experience poor health as a result of addiction or dependency. To do this we need to create the conditions for people to be more active, eat well and manage their mental wellbeing. As a result, we predict that numbers of those suffering with addiction/ dependency will decrease.

Key measures will include:

- Allocate additional DHSC funding regarding Tobacco Control & Treatment Service aligning with existing contract's demand of the borough, within awaited guidance
- Increased tobacco treatment services across community and NHS settings
- Increased smoking cessation numbers
- Increase uptake of Vapes as smoking cessation aid
- Reduction in substance misuse or crisis admissions
- Increased number of residents accessing drug and alcohol treatment
- Increased healthy life expectancy measures.
- Impact on priority health outcomes: cancers, cardiovascular diseases, respiratory diseases, inequalities, mental health and wellbeing
- Optimised personalised care for adults prescribed correct medicines to manage dependence and/or withdrawal
- More people will access effective, evidence-based drug and alcohol treatment services, reducing the harms to individuals, families and communities

Greenwich priority action – Feel Well (2)

Fewer adults are affected by poor mental health

The Royal Borough of Greenwich is adopting the Thrive LDN approach to improving mental health and wellbeing, working across these key areas: individuals and communities taking the lead; tackling mental health stigma and discrimination; a happy, healthy and productive workforce; mental health services available when and where needed; and working towards zero suicide. Performance measures are being developed for specific recommendations within the Social Mobility Delivery Plan.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Develop diverse/personalised interventions for people experiencing mental health problems within community settings, considering psychological, physical, and social needs – including development of the MH Alliance and Community MH and Wellbeing Hub
- Work with people with lived experience to develop effective communications and engagement to help tackle stigma and provide a sense of belonging
- Continue to develop services in community/hospitals, including talking therapies and mental health liaison teams, to provide the right level of care for people with common or severe mental illnesses
- Ensure commissioned services meet responsibilities for the LDA programme – LeDeR, mental health hospital discharges and Annual Health Checks, through strong partnership working with specialist learning disability clinical services
- Increased engagement in community resources and activities including via self-directed support (PHB, ISF) options

Other actions:

- *Develop a refreshed needs assessment for MH in Greenwich, followed by co-produced solutions to reduce inequalities*
- *Develop/promote a social model of disability and mental health services approach. This means that we have focused on the socially constructed barriers which impact the lives of people with mental health and or learning disability needs, and how those could be removed*
- *Support higher risk and vulnerable populations, with a focus on training, and*
- *Reduce the level and impact of social isolation and loneliness.*
- *Identify and implement effective approaches to engaging local employers around tackling mental health stigma and discrimination. Work with employers to provide workplaces that support good mental health, and with people who are self-employed*
- *Improve information and intelligence to tackle suicide, including communication, engagement and support*

Actions for 25/26

- Develop an understanding of local opportunities for more informal peer support so that people can engage in their communities and increase their connections, leading to supporting others
- Further develop the Greenwich Mental Health Hub, to bridge the gap between Primary and Secondary Care, including a "no wrong door" policy and information sharing, providing a holistic approach to assessing and meeting needs
- Develop the support and accommodation pathway further to support people to recognise and develop independent living skills to integrate back into society after a hospital admission and to prevent crisis
- Address the wider socio-economic factors that affect mental health and wellbeing in our communities, including better support for people to access financial advice services.
- Work with planners, developers and residents to create mentally healthy public and domestic spaces.
- Work to ensure people are in the least restrictive settings, are supported in Greenwich where possible and pathways work as well as they can. This includes working with Housing colleagues

Intended outcomes in 5 years' time

The key outcome is **fewer adults are affected by poor mental health**, which will be measured by the following:

- Staff and local people have a better understanding of what services are available and where
- People are more able to support themselves (self-care) and more resilient
- Reduction in stigma - people able to talk about their mental health in same way as physical health
- Fewer black men entering the mental health system through sections
- Reduced mental health service referral rates
- Reduced waiting times to access support
- Reduced average length of engagement as people are supported to quickly move through the service having received the input they need
- Sufficient, joined up, skilled and knowledgeable workforce to meet local needs
- Increased engagement in community resources and activities including via self-directed support (PHB) options
- Reduced escalation of mental health problems as a result of unaddressed issues such as debt, housing, unemployment and social isolation
- Increased self-management skills for people with mental health problems.
- Reduced health inequalities, in particular for people from our black and minority ethnic communities
- Reduction in number of mental health crisis cases
- Lower rate of local deaths by suicide
- Increased numbers of frontline staff undergo suicide prevention training
- Successful establishment of the Alliance.
- More informed and responsive Primary Care.
- Improvements to new and established Accommodation Pathway.
- Increase in number of Time to Change Champions engaged and working around mental health and wellbeing.
- Residents have good access to green space. Improvement in quality of Health Impact Assessments are included as part of planning applications. Better, more effective and inclusive consultation and engagement happens between developers and local communities.

Greenwich priority action – Feel Well (3)

Fewer children and young people are affected by poor mental health

Our aim is for all children, young people and families in Greenwich to have the support needed to be mentally healthy. This includes being empowered to know how we can help ourselves. Where more help is needed, children, young people and families will have a choice of support, provided by someone families can trust, which is welcoming, safe, without discrimination and easy to access.

We will develop and nurture mentally healthy environments that tackle discrimination and health inequalities. We will empower our children, young people, parents and carers to look after their own mental health and wellbeing. We will give them confidence to access help when they need it, ensuring the best experience and outcomes for a positive difference now and in their future. Our services will be easy to access, with support and treatment as close to home as possible. In line with iThrive, this priority is focused on the holistic needs of children and young people and their mental health and wellbeing. In order to meet our vision, as set out above, children's mental health must be viewed as a system priority that can only be addressed by all partners working together.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Development of a model for a Single Point of Access for children's emotional health and wellbeing needs
- Review the mental health in schools offer including Greenwich's Mental Health in Schools Teams and identify opportunities for improvement and the development of an equitable offer across the Place
- Establishment of a home treatment team for children's mental health
- Mobilisation and review of the new Integrated Clinical Team within RBG Children's Services
- Mobilisation and review of the new clinical support into the Adolescent Assessment Residential and Resource Centre
- Continue to work to embed a Thrive and system approach to Mental Health and Wellbeing in Greenwich

Actions for 25/26

- Implementation and Review of the Single Point of Access for children's emotional health and wellbeing needs
- Development and implementation of opportunities identified through the Mental Health and Schools work
- Development of a new model for providing mental health support to children aged 16-25 as part of the transition to adulthood; including care leavers (noting that care leavers are a protective characteristic in Greenwich)

Intended outcomes in 5 years' time

The key outcome is fewer children and young people are affected by poor mental health, which will be measured by the following:

- Reduction in waiting times from referral to treatment to receive specialist CAMHS support.
- Improved knowledge and skills on mental health and wellbeing for those working with children and young people in Greenwich
- More timely identification, interventions and support for mental health and wellbeing needs in children and young people to reduce and prevent need escalating.
- Improvements in representation of those accessing and engaging with specialist mental health provision
- Improved knowledge and skills on perinatal mental health needs for those providing support to parents in the early years.
- More timely identification, interventions and support for perinatal mental health to reduce and prevent need escalating.
- Improvements in children and young people's wellbeing as evidenced through the School Health Education Unit survey and Young Greenwich feedback.
- Improved awareness of the range of provision on offer to support children and young people with their mental health and wellbeing.
- Decrease in preventable hospital admissions of children and young people in crisis
- Improved response to children and young people experiencing a mental health crisis

Greenwich priority action - Stay Well (1)

Everyone can access the services they need on an equitable footing

The Healthier Greenwich Partnership agreed that to enable high quality health and care outcomes in the local area, citizens' experience of health and care services should include timely care with fewer hand-offs and referrals, improved access to clinical and social support including peer support, integrated care, only having to tell their story once and without stigma, and with better and more equitable access to services.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Continue to improve Primary Care Access by implementing Access Recovery Plan – conversations with all practices continuing, including:
  - review of transition milestones to Modern General Practice to access national funding
  - Practice Improvement Programmes support offer
  - Offer of Greenwich development support programme
- Continue with actions to address acute care waiting times for elective care, both inpatient and outpatients, with a focus on inequalities
- Reduce waiting time for services in Mental Health and Community Care
- UTC – ensure benefits of integrated urgent care model are delivered with appropriate links to same day emergency care, urgent care and MH crisis response and pharmacy first.
- 111 – preparation for procurement process and its resulting impact
- Full roll-out of Population Health Management (HealtheIntent)
- Reducing waiting times for autism diagnosis

Actions for 25/26

- Realisation of integrated data sets that underpin our work – highlighting health inequalities, providing insight into the likely needs of residents as they age and ensuring that the Greenwich pound is invested in the right places to secure better outcomes
- Improve data flows including by (i) solving the problem of data sharing liability; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.

Intended outcomes in 5 years' time

Prevention and Health Inequalities:

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Engage communities:

- Empowered and enabled communities for their health and care outcomes. Co-produced and evaluated, will include using surveys to obtain feedback and compare them to baseline results.

Community Health Services:

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
- Ensure access to urgent care treatment at home, including the ability to receive IV therapy at home following assessment by JET, provide multi-disciplinary community frailty assessments

Primary Care:

- Ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Increased referral to community pharmacy consultation service for same or next day appointment for self-limiting conditions or minor ailments, e.g. blood pressure, contraceptives

Mental Health:

- Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional people (from 2019) aged 0-25 accessing NHS funded services
- Increase the number of adults and older adults accessing IAPT treatment.
- Recover the dementia diagnosis rate to 66.7%
- Improve access to perinatal mental health services.

Acute Care:

- Reduction in waiting times for elective care, both inpatient and outpatients

Greenwich priority action – Stay Well (2)

Effective Integrated community teams based in neighbourhoods, provide the right support when and where it is needed

This priority brings together prevention, primary care, community support, acute, mental health, social care, care providers and VCSE and wider partners. We will build on the Live Well community hub to establish effective and sustainable neighbourhood models of working. A neighbourhood is where communities that live together interact and support one another to live the best lives they can, with community services that meet the needs of local residents.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Build partnerships with local communities and improve the way local communities and organisations work together with the NHS and the Council to improve services closer to where people live that are joined up.
- Develop the way we commission collaborative public health prevention services at a more local level using transformative processes including outcome-based, co-design, collaborative development and integrated approaches based on what matters most to residents. These will link to all local services.
- Agree a shared vision for neighbourhood development in Greenwich, e.g. community-led versus system-led, with agreed metrics to report on impact and answer challenges from national, regional and SEL leadership
- Develop an understanding of what environment / culture is needed to enable and sustain effective system integration, and particularly agreeing the need to develop a learning culture & a systematic approach to learning that ensures we are properly able to connect what we learn from operational delivery with strategic decision-making and prioritisation.
- Agree and develop the necessary governance to enable sustainable system connectivity and delivery through shared learning focused on empowering communities of residents, patients, assets, providers, etc and removing barriers, connecting resources (human, financial and physical space).

Other actions:

• Support primary care and partners to evolve into neighbourhoods, identifying where primary care wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers.

• Develop our community approaches that connect individuals to sources of support that address the wider determinants of health. Build on our community development approaches and expand personalised care support including social prescribing.

Actions for 25/26

- Embed agreed metrics for a neighbourhood development dashboard to report on impact / outcomes and enable continuous learning
- Continue to support and connect GP through a tailored programme of development support, focused on bringing together existing good practice around neighbourhood development from across Greenwich
- Embed agreed governance structures supported by an extended social research function that enable visible connectivity between operational delivery and strategic prioritisation

Intended outcomes in 5 years' time

- Collaboration between residents, patients, carers, community assets and providers to work seamlessly to meet the needs of local populations / communities.
- Joined up, accessible support for those people who need it the most
- Use data and insight, (including from residents / patients) to understand local needs and wants and inform service improvements and new ways of working
- Strive for collaborative quality improvements focussed on prevention and shared outcomes
- Align clinical and operational teams of community health providers with established communities over time working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams wherever necessary and practicable.
- Increase collaboration between previously siloed teams and professionals, (including Secondary care, Primary care, Community, MH, VSCE and local providers) doing things differently and improving patient care, working with and for whole populations / communities.
- At place, identify opportunities to serve local needs more effectively / efficiently e.g. bringing together teams on complex / continuous care (e.g. LTC), admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams.
- Use population health management as a means of identifying, targeting and addressing the needs of particularly vulnerable patient groups, e.g. Core20PLUS5 populations
- Work with communities to further develop, or plug gaps with their own assets and resources, including supporting a "compassionate communities" approach.
- Embedded governance structures that use a systematic approach to learning to inform and drive strategic decision making and prioritisation for Greenwich, whilst remaining responsive to national, regional and SEL imperatives

Greenwich priority action – Stay Well (3)

Unfair and avoidable differences in health and wellbeing are reduced

The factors that determine health outcomes for individuals and communities are complex, and include social, economic, cultural, environmental and commercial drivers. To address these issues, people need to be supported as a whole person, not as isolated conditions or symptoms to be treated. This requires a strong understanding of and response to the complex determinants of inequalities, including both direct and indirect racism and other forms of discrimination including those related to age, gender, sexuality, disability and gender identity. This will require a proactive and systematic approach including working in new, genuine and sustainable partnerships with communities and places, tackling isolation and loneliness, and tackling poverty.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Embed new SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures.
- Develop targeted cancer screening improvements, focusing on Lung, Cervical, Prostate, Bowel and Breast in particular, key focus on influencing uptake, and then lifestyle changes to reduce risk (see other priorities)
- Build on the learning from the two 100-day challenges to reduce cardiovascular inequalities and the Connecting Thamesmead programme to reduce social isolation
- Coordinate an anti-racism community of practice (COP) to support stakeholders adopting processes within their work such as cultural humility principles to address structural racism and ethnic health inequalities.

Other actions:

- *Develop new, systematic and ongoing methods of gaining insights from our diverse communities into the factors that affect their mental and physical health; better understand what matters most to our residents and supporting the co-design of interventions.*
- *Ensure a particular focus on unwarranted variation in access, experience and outcomes; proactively challenging racism, discrimination and striving for equitable access to services in all we do*
- *Establishing a population health system to drive targeted improvement to tackle inequalities with a focus on Core20plus5*
- *Work with people with lived experience to develop universal and targeted communications to help tackle stigma and discrimination in the Royal Borough of Greenwich.*
- *Reduce the level and impact of social isolation and loneliness*

Actions for 25/26

- Change the way we engage with grassroots community organisations, including those working with our diverse populations, so they are effectively supported in their work with local communities. This will include funding community-led action to harness the energy, creativity and deep understanding of our residents held within these grassroots groups and organisations
- Work with planners, developers and residents to create mentally healthy spaces.
- Support the implementation of the 'Our Greenwich' Plan to address the wider socio-economic factors that affect mental health and wellbeing in our communities, including by better supporting people to access financial advice services

Intended outcomes in 5 years' time

The outcome is for Greenwich's residents to feel it is a welcoming and inclusive place, and to reduce inequalities in life chances for people with protected characteristics and health inclusion groups. Achieving this outcome will include the following measures in:

Engagement:

- the number and type communication and engagement activities with people from our diverse communities including those with lived experience of stigma and discrimination.
- The number and types of co-design; positive feedback from residents about their inclusion
- Number and type of grant programmes/grant funded community projects that improve outcomes and are sustainable

Spaces:

- Number of play streets, school streets and superzones delivered
- Effective activation of green and blue spaces in the Borough, with more residents accessing
- Improvement in quality of Health Impact Assessments included as part of planning apps
- Better, more effective and inclusive consultation and engagement between developers and local communities.

Isolation:

- Number of residents are supported to be less socially isolated by engaging in their communities, volunteering or through support from VCSE

Cultural humility

Improved awareness of the impact of ethnic health inequalities and improved practice to address them.

Poverty:

- No resident in financial crisis is left unsupported, with those experiencing acute financial pressure provided with financial support & advice to prevent their situation becoming worse

Health outcomes:

- Better: Cardiovascular health, Cancer, diabetes, mental health, Vital 5, and vaccination uptake
- Reduced mortality through proactive health checks for those with Learning Disability, autism, or Serious Mental Illness
- Reduction in overprescribing in frail people improves patient experience and reduces waste

Greenwich priority action – Age Well

Health and care services support people to live fulfilling and independent lives and carers are supported

We will work with individuals and carers to develop an offer that supports people to live long, healthy, active and independent lives. This includes developing services in line with our Home First approach wherever possible to ensure care and effective treatment for both sudden and unexpected, and longer-term health problems or disabilities, through an integrated urgent care system and stronger community-based care. The Age Well priority also focuses on ensuring individual have access to safe and high-quality home, residential and nursing care when needed. Help people to die well, in their usual place of residency, in line with their wishes.

How we will secure delivery

Actions for 24/25

Priority partnership actions:

- Delivering actions which improve market sustainability, quality and workforce recruitment and retention initiatives across community based, residential and nursing settings, including a refresh of Market Sustainability Plans and targeted use of government funding.
- Co-design, development and delivery of community-based support models for those with care and support needs and their carers. This will include delivery of the new Homecare model, development of community enterprises and new models of care.
- Optimise and develop our Home First approaches by expanding virtual wards to provide assessment, treatment and care to all patients in the place that they call home (including care homes), and to ensure that patients cared for at home have direct access to diagnostics.

Other actions include:

- *Launch of integrated Assistive Technology Enabled Care service*
- *Work with partners to further develop Falls and Frailty offers across the Borough and with residents to co-produce areas of priority*
- *Improve the join up of data and insight regarding demand and supply of community-based services*
- *Define our strategy and delivery plan for accommodation with support services across needs and ages*
- *Further develop and promote the Framework for Enhanced Health in Care Homes*
- *Work in partnership to design and test an approach to embedding digital and care technology into local offers*
- *Delivery of joint Carers strategy*
- *Work with all our partners to ensure that the learning from Safeguarding Adults Reviews informs our practice*
- *Develop community-based offers to support those living with Dementia*
- *Shape the approach for a Community MSK service in line with best practice and aligned to the outputs of the SEL MSK programme*
- *Increase use of Urgent Care Plans (advanced care plans) across Greenwich Practices*

Actions for 25/26

- Focus on supporting providers around sustainability and quality via the delivery of the MSP
- Continue work to embed assistive digital technology into local offers that can improve the lives of residents with specific needs, both in prevention, short and longer-term support

Intended outcomes in 5 years' time

For our local residents to receive consistent high quality care in the most independent environment across the continuum of care and wherever possible in their own home.

- To provide care and treatment at home for people experiencing a wide range of chronic conditions and acute episodes of ill health. This includes services which can assess, treat and provide ongoing management of COPD, dementia and delirium, frailty and falls, palliative and end of life care and dehydration and infection.
- An increase of deaths in Usual Place of residence by 2% by 2027. 0.5% of patients on primary care registers have an advance care plan

People with the potential to live more independently are moved to less intensive care and support services build on what is already in place promote prevention, self-care and social prescribing:

- Greenwich have a range of good quality community-based options including access to local clubs and meaningful activities and employment, Home First Service, neighbourhood-based home care and accommodation with support, with outcomes quantified by measuring satisfaction levels, healthy life expectancy measures, health and wellbeing indicators. People are able to self-direct their care and support

A modernised offer with strength based and joined up practices are in place across our local offers which enable people to access local assets and support within neighbourhoods. Good access to safe and high-quality home, residential and nursing care when needed;

- Local people, practitioners and partners will have a good understanding of the local options, including self-funders, and will assume quality of care and a skilled and compassionate workforce.
- We continue to work alongside local people in co production
- Digital and technology solutions are embedded in local offers, people and staff are confident in its benefits
- Data and insight is joined-up so we are aware of the quality of provision, people access good and outstanding settings, demand and supply is known and informs service developments and continuous improvement

Carers are: respected as expert care partners, have access to personalised services they need to support them with unmet needs, are more able to have a life of their own outside their caring role, are supported to mitigate (where possible) the financial impact of the caring role, are supported to stay mentally and physically well and will be treated with dignity

South East London Integrated Care System

NHS South East London

Royal Borough of Greenwich - local delivery

Greenwich borough delivery of SEL pathway and population group priorities

The Healthier Greenwich Partnership is committed to partnering well within our local population, our neighbouring boroughs and the South-east London ICS. As such we are committed to working with our neighbouring boroughs, and recognise that a number of our partners are providers to more than one borough, and that our population's health & care needs are served by providers in wider SEL. The development of common pathways, support for core offers, and proactive engagement, support and championing of key SEL programmes will help deliver at scale benefits, whilst recognising that local engagement will also be critical to deliver the impact.

Urgent & Emergency Care

- Greenwich is continuing work to support the on-going success of Urgent Care and Same Day Emergency Care, particularly the UTC at QEH, with colleagues at SEL level. Focus on supporting QEH to achieve 76% ED target
- Greenwich's virtual wards will continue to expand, providing patients with acute care in their own home where possible. Key developments focus on linking these pathways to London Ambulance Service, preventing conveyance to hospital when this is not necessary and ensuring patients being cared for in the community have access to the diagnostics they need in a timely manner.
- System partners will continue to support the development of same day emergency care for patients requiring specialist support which can be accessed directly and managed in an ambulatory or ward environment without the need to attend ED.
- Continue to expand navigation roles, both into the community and voluntary sector, to ensure the holistic needs of residents can be met outside of the hospital environment. This includes active case-finding support within QEH, with social prescribers (Live Well) in ED and supporting discharge.
- With the 111 contract ending in 2025, there is the opportunity to design a model that integrates 111 with local services and new models of care, which we hope to pilot during 24/25.

Population Health & Prevention

Greenwich has undertaken a huge amount of work during 23/24 to ensure that relevant IG agreements are in place to support the roll-out of HealtheIntent. This system is hosted by LGT and has been rolled-out across Lewisham practices, secondary care and part of mental health. The ground-work undertaken in respect of Lewisham is helping with roll-out for Greenwich and we are benefiting from previous lessons learnt (this work includes our targeted CVD prevention programme). Once GP practices are signed-up, there are plans to extend the roll-out to community and mental health (Oxleas), Public Health colleagues and other data held by the local council (RBG). We are actively participating in wider networks and sharing progress and lessons learnt with colleagues across SEL ICB.
We are strengthening our community infrastructure, working with GHIVE, neighbourhood development, all building on the learning from Covid support, and deep engagement.

Learning Disability and Autism

Greenwich is committed to the aims of the SEL LDA programme, and our autism strategy will be aligned to the helpful comprehensive SEL framework and priorities across CYP and adults. We are supportive of the programmes focus on helping people to thrive, with a focus on care and support offers working across SEL, to developing the market, working with providers of inpatient secure, non-secure and community options, accommodation and housing. We also see the significant benefits of workforce development, improving the knowledge of skills of health & care staff, enabling reasonable adjustments, for better personalised outcomes.
Greenwich has a significant 'forward thinking' transformation programme for our LD services, which transforms the way we work with and support our residents to help them live the life they want to lead, and which aligns well with the SEL aims.
We will be publishing our commissioning intentions in 24/25 and we have the Autism Strategy, both of which will influence the market.

Other examples of local delivery

- Greenwich is in the process of re-commissioning its MSK community service, with a lot of work undertaken since Sep 23 to collect feedback from people across the borough, as well as from referrers to the service. An event has been held in Feb 24 to look at how we can improve the pathway/model, based on the feedback and input from a wider range of people. This will eventually form the specification of the service that we will commission so that the new service is mobilised and can commence from Apr 25.
- Breast screening – successful application to SEL Cancer Alliance to run a campaign to increase uptake. "Breast screening – it's what we do" campaign (launching Mar 23) will use behavioural science to better understand the diverse audiences, analyse behavioural barriers, refine decision-making journeys and create persuasive, creative communications so residents can easily move from intent to accessing breast screening

Greenwich Enabler requirements

Workforce

What is needed to ensure success?

- Public Health service transformation
- Improved skills in securing outcomes through service design, procurement, transformation, system leadership and change capability
- A different, sustainable workforce model rooted in our communities with opportunities for volunteering and flexible career opportunities, through the Health Ambassador Programme
- New ways of working in effective partnerships with our diverse communities & organisations
- Values-based recruitment and more integrated posts, collaborative workforce planning
- Working environments that support best practice and innovation, e.g. removal of bureaucratic boundaries to enable shared resources, less risk averse.
- Staff retention schemes, so they feel valued and supported by a health and wellbeing package
- Different ways of working and greater clarity for staff about how they fit into the big picture
- Expanded training places, fellowship opportunities, peer support groups and structured learning and development environments for staff to thrive
- ARRS roles fully recruited, retained with clear career pathways, supported by wider system
- A clinical model of care which transcends the traditional boundaries of primary and secondary care to allow more patients to be cared for at home by appropriately skilled clinicians.

Digital

What is needed to ensure success?

- Continued development of our online offer
- Investment in understanding and tackling ongoing digital divides in our communities and between different organisations
- Ability to securely share information and data and match services to needs
- Good data underpinning Population Health Management approaches across the system using tools such as Cerner – HealtheIntent, EMIS and other national and local datasets
- Use technology to further increase access to health and care support (e.g. remote monitoring and virtual wards). We will work with NHSE colleagues and suppliers to shape and enable systems that 'speak to each other' in different organisations.
- Build on the work already underway to tackle digital exclusion e.g., Digital Inclusion Officer
- Develop a single record for all citizens, to enable integrated multi-disciplinary and multi-organisational care, across health & care system, including non-NHS
- Improved use of technology to support innovation or new ways of doing things, including consultations, social media, websites, telephony, record access, and bookings
- Use of social media for optimising the way we engage.

Estates

What is needed to ensure success?

- Utilisation of the 'One Public Estate' and other opportunities, especially within areas of growth, to ensure residents have access to appropriate facilities across the Borough identifying "anchor estates" in neighbourhood.
- Strategic priority planning and decision making to improve the utilisation of primary care estate space.
- Contribute to the development of the refreshed infrastructure delivery plan and local plan
- Maximise the potential of key sites, working closely with PCNs, including Kidbrooke Health & Wellbeing Hub, Eltham Community Hospital (including Community Diagnostic Centre and wards), existing practices, Gallion's Reach, Woolwich, Plumstead Health Centre, Charlton Riverside

Finance

What is needed to ensure success?

- Funding for initiatives
    - RBG public health funds and funding to develop community resilience
    - Inequalities funding
    - NHS Greenwich Charitable Funds
- Shared system view on shifting resources to prevention and community
- Collective approach to risk/gain share
- Continue to work closely with system partners to enhance financial transparency and resilience in order to jointly plan and deliver local offers
- Securing best value and working within available resources – leveraging investment where possible

Lambeth Borough Overview

Our population

Lambeth is an inner London borough with 322,000 residents and a registered GP population of 442,286. Over the last two years, there has been a 4% growth of registered patients. The population is set to grow by 2.4% by 2032. Our population is becoming older with 50% growth expected in the over 50s in the next 10 years. The number births is reducing and has fallen by 26% in the last 10 years. The population remains highly mobile with 20% of individuals moving in or out of Lambeth each year. Population density is already twice that experienced in London and nearly 32 times higher than the average for England. The population is highly diverse with 63% of residents describing their ethnicity as other than White British and with 43% of Lambeth residents identifying as Black, Asian or Multi-Ethnic. We have a sizeable Portuguese speaking community. It is estimated that 10% of the borough's population identifies as Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+), the highest in London. 70% of the Lambeth population lives in the 40% most deprived areas in England and 16% of our households are in fuel poverty.

Health outcomes for our population

Strengths

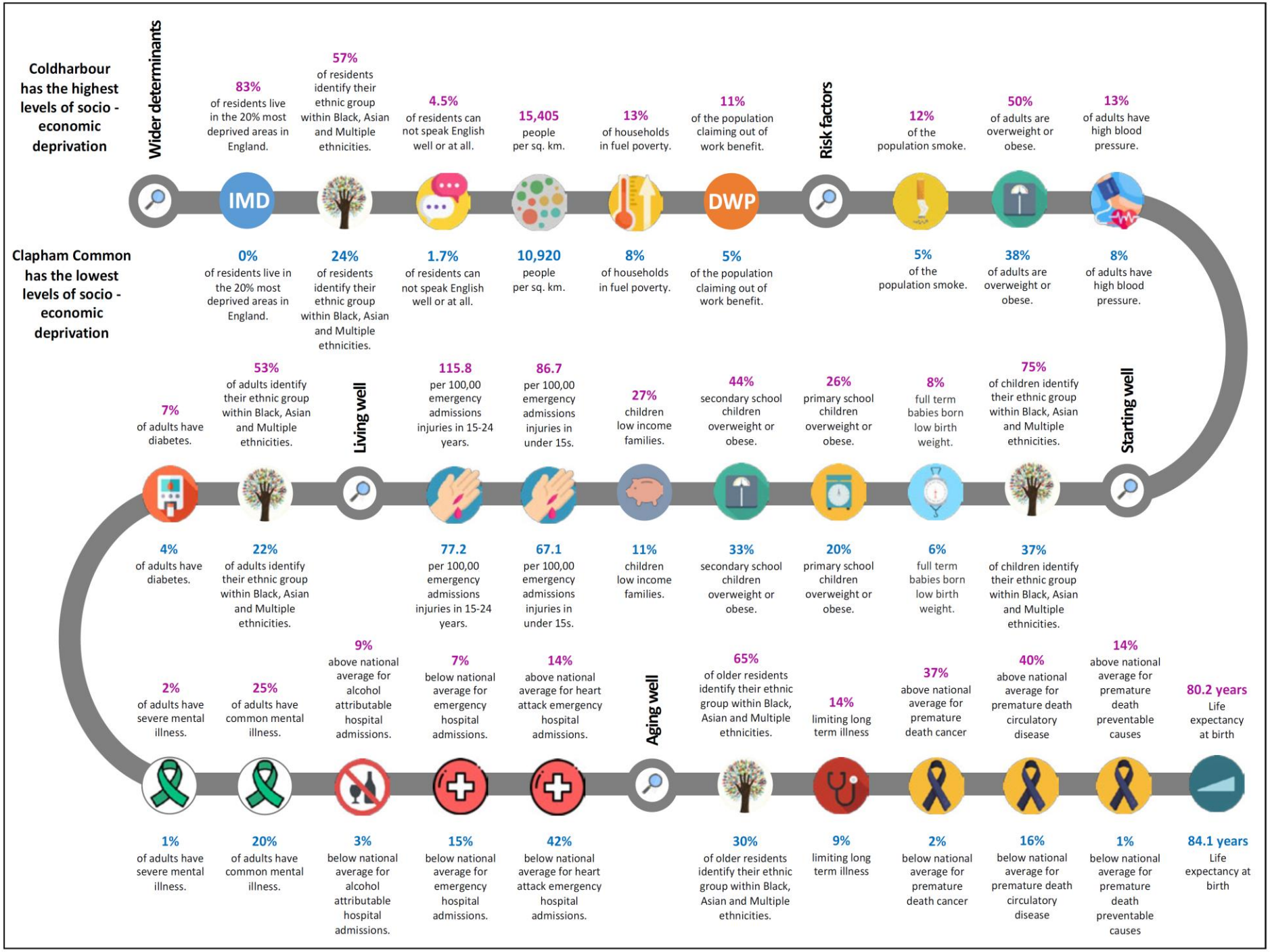
- Life expectancy has generally improved since 2010 for both males and females in Lambeth but at a slower rate than the previous decade
- The life expectancy of women in Lambeth is higher than the London and national average
- Lambeth has the highest detection rate for sexually transmitted infections
- Tuberculous incidence rate has fallen in Lambeth and is lower than the London average.

Challenges

- 1 in 3 residents are classed as high-risk alcohol users
- Hospital admissions linked to smoking and alcohol use significantly higher in Lambeth than the London average
- 1 in 3 Lambeth residents are overweight and 1 in 4 Lambeth residents are obese
- 1 in 4 residents experience high levels of anxiety
- Years spent in poor health has increased in Lambeth
- Serious Mental illness more likely to affect health inclusion groups
- 17% of registered patients are experiencing chronic pain.

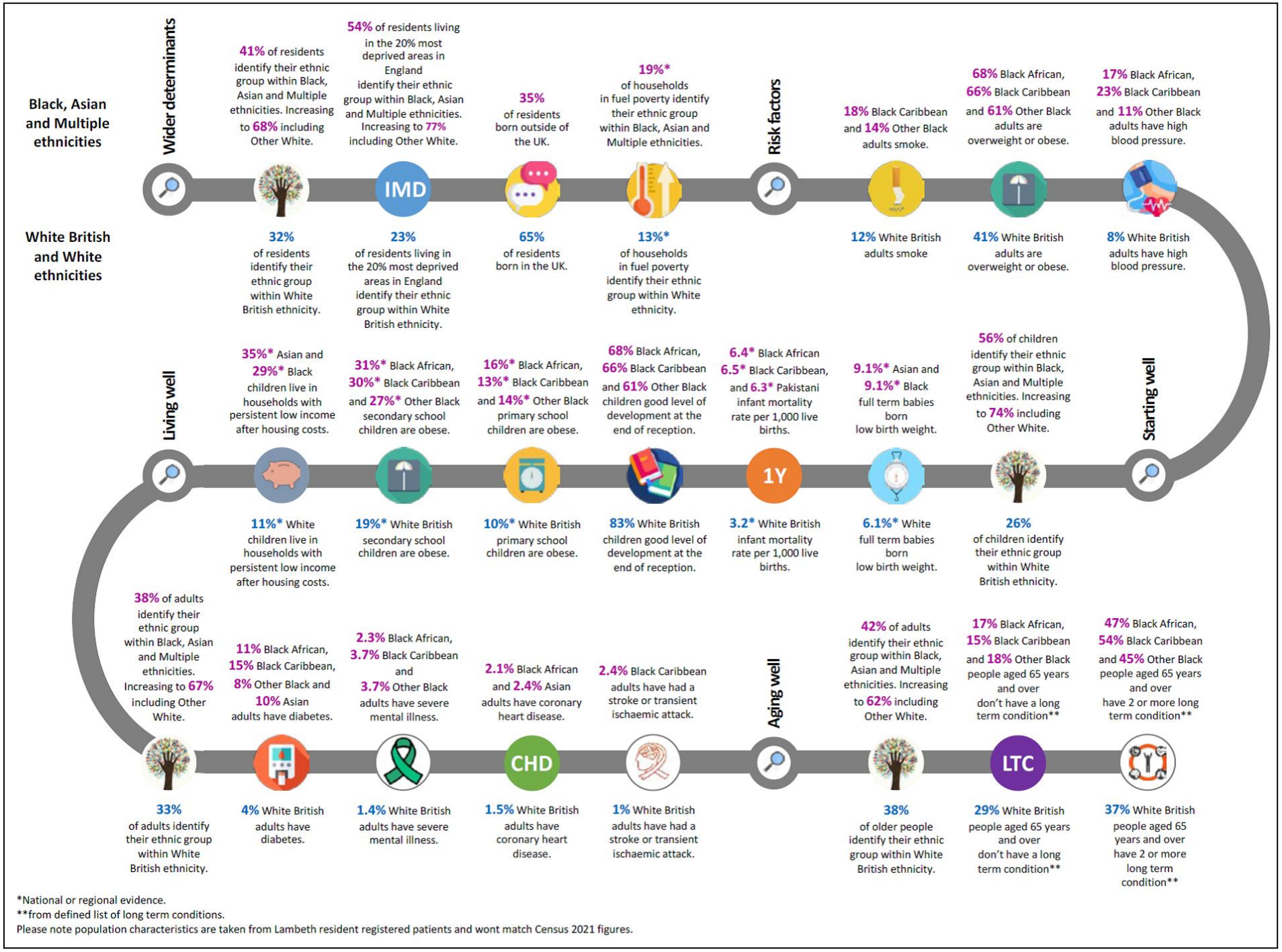
Inequalities within our borough

- The poorest communities have the worst outcomes across a wide range of measures including healthy life expectancy and the gap is widening between Lambeth and England
- Within Lambeth, the gap is also widening between those with the lowest levels of socioeconomic deprivation (Coldharbour) and those with the highest levels of socio-economic deprivation (Clapham Common).
- Residents from Black backgrounds are more likely to live in areas of social deprivation, develop long-term conditions, have poorer mental health and experience discrimination and racism when accessing services.
- 77% of Lambeth residents living in the 20% most deprived areas in England are from Black, Asian, Multiple ethnicities and Other White.
- Rates of obesity and high blood pressure are considerably higher in Black African, Black Caribbean and Other Black ethnicities in Lambeth
- Smoking rates are over 20% *lower* in White British and Other White ethnicities.



NHS
South East London

Within Lambeth we see significant geographic inequalities across a range of health and wellbeing measures....



*National or regional evidence.
**from defined list of long term conditions.
Please note population characteristics are taken from Lambeth resident registered patients and wont match Census 2021 figures.

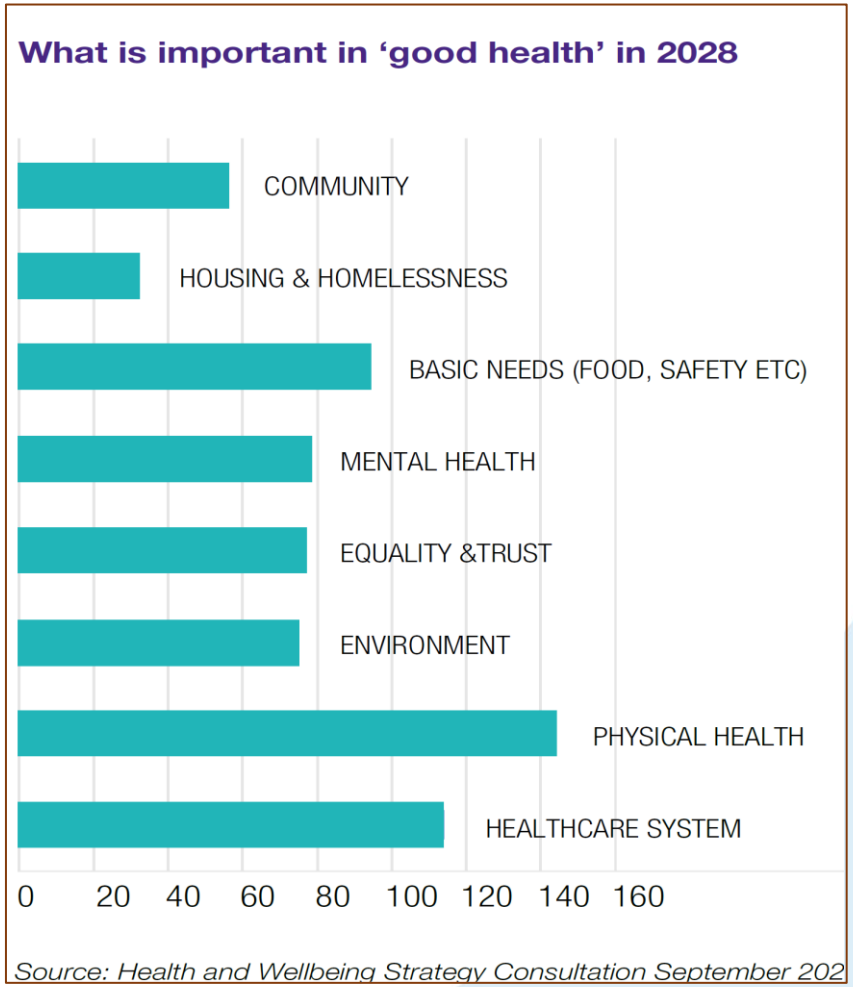
NHS
South East London

Within Lambeth we see significant population inequalities across a range of health and wellbeing measures....

Lambeth Borough

What we've heard from the public

In developing our Health and Wellbeing Strategy, we consulted with the public, Voluntary, Community, Faith and Social Enterprise organisations, on what is important in Lambeth in regards to their health and wellbeing. At least 650 people and 80 organisations took part, with many more contributing to informal engagement at events like the Lambeth Country Show. Where there were gaps in our knowledge, we spoke directly to those communities, for example through a specific focus group for the Latin American Spanish and Portuguese speaking communities or with organisations or representatives of the communities' including faith leaders and LGBTQi groups to ensure their perspectives were captured. Over 85% of public respondents supported our objectives and when asked about what is important in 'good health', the public clearly articulated physical health, the healthcare system and basic needs as their top three priorities.



Lambeth - Our objectives

Our key objectives - what we want to achieve over the course of the plan

The key priorities that we aim to achieve over the next five years are outlined in our *Health and Wellbeing Strategy (HWBS) 2023-28*; **ensuring the best start in life, supporting people to lead healthy lives and have good physical and mental wellbeing** and **supporting communities to flourish and build their resilience**. Lambeth Together has committed to contribute to delivering on these strategic goals and our *Lambeth Together Strategic Health and Care Plan* and the *Joint Forward View* is Lambeth health and care system's (ie Lambeth Together's response). Our 16 key objectives, expressed as outcomes, within this Plan, are set out below:

People lead healthy lives and have good physical and emotional health and wellbeing for as long as possible

1. People maintain positive behaviours that keep them healthy
2. People are connected to communities which enable them to maintain good health
3. People are immunised against vaccine preventable diseases
4. People have healthy mental and emotional wellbeing
5. People have healthy and fulfilling sexual relationships and good reproductive health

Physical and mental health conditions are detected early and people are well supported and empowered to manage these conditions and avoid complications

1. People receive early diagnosis and support for physical health conditions
2. People who have developed long term health conditions have help to manage their condition and prevent complications
3. When emotional and mental health issues are identified; the right help,-support and diagnosis is offered early and in a timely way

People have access to and positive experiences of health and care services that they trust and meet their needs

1. People have access to joined-up and holistic health and care delivered in their neighbourhoods
2. People know where to go to get the right help, and are treated at the right time, in the right place, for their needs
3. Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age welll
4. Women have positive experiences of maternal healthcare and there are no disproportionate **maternal** mortality rates among women
5. People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services
6. People using mental health support services can recover and stay well, with the right support, and can participate on equal terms in daily life
7. People who are homeless or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Lambeth - Our priorities

Our priorities

To achieve the objectives set out above, our Alliances and Programmes will lead on a shared set of outcomes and deliver priority actions against them. All our work will focus on those groups and communities that have the poorest health outcomes. Alliances and programmes will work together to achieve particular actions, which whilst organised around programmes/Alliances, are collectively owned across our partnership.

Neighbourhood & Wellbeing Delivery Alliance

People are connected to communities which enable them to maintain good health

People receive early diagnosis and support for physical health conditions

People who have developed long term health conditions have help to manage their condition and prevent complications

People have access to joined-up and holistic health and care delivered in their neighbourhoods

People know where to go to get the right help, and are treated at the right time, in the right place, for their needs

Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well Older adults are provided

Children and Young People's Alliance (CYPA)

People are connected to communities which enable them to maintain good health

People are immunised against vaccine preventable diseases

People have healthy mental and emotional wellbeing

When emotional and mental health issues are identified; the right help, support and diagnosis is offered early and in a timely way

Women have positive experiences of maternal healthcare and there are no disproportionate **maternal** mortality rates among women disproportionate

Homeless Health Programme

People who are homeless or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Sexual Health Programme

People have healthy and fulfilling sexual relationships and good reproductive health

Living Well Network Alliance (LWNA)

People have healthy mental and emotional wellbeing

When emotional and mental health issues are identified; the right help, support and diagnosis is offered early and in a timely way

People using mental health support services can recover and stay welll, with the right support, and can participate on equal terms in daily life

Substance Misuse Programme

People maintain positive behaviours that keep them healthy

People know where to go to get the right help, and are treated at the right time, in the right place, for their needs

People who are homeless or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Learning Disabilities and Autism Programme

People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services

Staying Healthy Programme

People maintain positive behaviours that keep them healthy

People are connected to communities which enable them to maintain good health

People are immunised against vaccine preventable diseases

Lambeth – Our progress to date

Key Successes in Delivery in 2023/2024

- The Living Well Alliance **funded the Culturally Appropriate Peer Support and Advocacy Project (CAPSA**), with **Black Thrive, which won a Health Service Journal (HSJ) Award for 'Best Not for Profit Working in Partnership with the NHS' for their work**
- Addressing Health Inequalities through Social Prescribing Link Workers (SPLW's) - The Neighbourhood & Wellbeing Alliance actively **engaged with our community via our SPLW's running a set of events engaging with 100's of residents** to emphasise and build community understanding of wellbeing and services available.
- Lambeth Pharmacy First Plus Pilot launched 2023 **enabled Community Pharmacy to support people with minor conditions directly by providing advice and treatment to enable more self-care.**
- The introduction of **General practice incentivisation schemes** including to a scheme to encourage General practice to undertake structured medication reviews for those over 75 taking 10 or more medicines.
- The 'Choose Well Campaign', **supporting people to consider alternatives to A+E** was rolled out in 2023 with a broad communications and engagement, including door stop leaflets, letters and supporting information for those attending the Emergency Department.
- Cost of Living programme; Has **provided over 66,000 units of support to over 26,000 households in the borough**
- Utilising insights from the LEAP's Enhanced Caseload Midwifery programme to **inform enhancement of personalised and safe maternity care.**
- Expanded capacity in 'Home First' - a new reablement initiative **supporting people to return home after discharg**e
- **Recruitment** of 7 Mental Health Practitioners to provide early identification, assessment and **intervention to people with a range of emotional, phycological and mental health conditions in primary care.**
- Development of the Individual Placement Support Service (IPS) which **enables more people with SMI to achieve their goal of sustainable paid work with a fair wage**.
- Support provided to the school-age immunisations service to **promote the flu vaccine to school age children**, including sourcing venues for pop-up clinics, providing comms support and working directly with low uptake schools to support delivery
- Working with local communities to ensure residents have access to advice and support in community settings to stay welll, which is tailored and culturally appropriate through initiatives such as; Thriving Communities, Health and Well Being Hubs, the Beacon Project and Combatting Drugs Partnership.
- A new **HIV care and & peer support network** is in place with a new care and support service being mobiliser.
- Project ADDER established across Lambeth and Southwark to **support increased referrals to substance misuse services**

Key Challenges to Delivery in 2023/2024

- Acknowledgement of the constrained economy and public sector funding
- The impact of inflation, and industrial action
- ICB requirement to reduce running costs by 2025/26
- Implementing and embedding new processes for EPIC, the new electronic patient administration system impacting on resources
- The challenges associated with rising cost of living and engaging with seldom heard groups to tackle health inequalities
- Difficulty in attracting skilled and experienced clinical workforce

Learning and Implications for Future Delivery Plans

- Optimise ways of working to maximise efficiencies to ensure that we 'make every contact count'.
- Continue to strengthen our health system partnership working with primary and secondary care, VCS and community organisations
- Continued investment in the use of research and intelligence (via Lambeth DataNet and the Joint Strategic Needs assessment to improve health and provide more equitable care within our community

Lambeth priority action – Staying Health Programme

Staying Healthy Programme

Promoting the health of the Lambeth population and supporting communities to maintain good health and wellbeing.

How we will secure delivery

Actions for 24/25

- **Continue work on vital 5 approach** to strengthen the identification/screening and signposting dependent/risky drinkers for support starting with a focus on hypertension and obesity, given links to alcohol consumption.
- **Develop an easy identification tool for high risk drinking** to support referrals to a treatment service
- **Immunisation**: Work with PCNS to improve call / recall and alternatively delivery sites for seasonal vaccination programmes with a focus on over 65s and those with long term conditions
- **Use NHS Health Check** to improve routine identification of smokers and those at greatest risk of obesity, providing brief advice and referral to the stop smoking service and to weight management support
- **Expand smoking cessation support** to a universal offer and the provision of a range of support to target groups. This will include increasing access to e-cigarettes as an option to support quitting tobacco.
- **Continue to develop the weight management service** with better links into communities that have the highest need and are likely to benefit most
- **Promoting uptake of the community pharmacy** stop smoking and blood pressure check service, and the health and wellbeing champion in pharmacy service.

Actions for 25/26

- **Evaluate and review new programmes of delivery**
- **Embed population health management approaches using better data linkage**

Intended outcomes in 5 years time

- People maintain positive behaviours that keep them healthy
- People are connected to communities which enable them to maintain good health
- People are immunised against vaccine preventable diseases

Lambeth priority action – Children and Young People's Alliance

Children and Young People's Alliance

Supporting children and young people in Lambeth to grow up healthy and happy.

How we will secure delivery

Actions for 24/25

- Develop plans to design and **deliver a multi-agency Single Point of Access (SPA) to mental health support**, drawing together a range of services seeking to support children and young people and their families.
- Continue focused discussions with LEAP to pull together terms for an advisory group to **develop of comprehensive dataset for Lambeth women using maternity services to counter significant inequalities in experience**.
- **Evaluate learnings from mortality case reviews at a system level** and incorporate this information with insights gained via other maternity measures to feedback into community/health visitor providers
- Work with Primary Care Networks to **improve call/recall arrangements and consider alternative delivery sites to improve access for childhood immunisations and seasonal vaccination programmes**
- Offer **varied emotional wellbeing provision for children and young people that is a cohesive and joined-up offer**, that is welll-communicated and enables improved access - **develop a standardised approach to measuring outcomes**
- Work collectively to **improve experiences and recovery outcomes for black service users** and carers **using culturally appropriate care** and support that meets people's needs
- **Develop specialist eating disorder and complex psychological and behavioural needs pathway** to enable **more people to be supported in the community and reduce unplanned admission due to crisis**
- Delivering a pilot with SLAM and community organisations (The Well Centre, Coram and Place 2 Be) to **better understand how we can join up our response to CYP emotional health and wellbeing need, bringing services, data and statutory provision together.**

Actions for 25/26

- **evaluate the effectiveness of the messaging initiatives in supporting marginalised and underrepresented women and birthing individuals in Lambeth implemented in 2024/25.**

Intended outcomes in 5 years time

- People are connected to communities which enable them to maintain good health
- People are immunised against vaccine preventable diseases
- People have healthy mental and emotional wellbeing
- When emotional and mental health issues are identified; the right help, support and diagnosis is offered early and in a timely way
- Women have positive experiences of maternal healthcare and there are no disproportionate **maternal** mortality rates among women

Lambeth priority action – Neighborhood Wellbeing and Delivery Alliance

Neighbourhood Wellbeing and Delivery Alliance

Improving the health and wellbeing of adults by working together in local neighbourhoods.

How we will secure delivery

Actions for 24/25

- **Utilise Health Inequalities Funding** to determine a clear set of priorities for funding in 2024-25.
- **Develop and deliver an equitable provision of integrated care** across the borough, focusing on Thriving Neighborhoods, and in partnership with PCNs, secondary, social, and community care, and the voluntary sector .
- **Implement action plan to support Carers** to receive wellbeing interventions via practice personalised care teams
- **Develop a Primary Care Network at scale offer to increase uptake of NHS health checks** for those most at risk by focusing on outreach and delivery in community setting.
- **Deliver the Catch 22 Bowel Cancer Screening initiative** to increase the uptake of bowel cancer screening
- **Roll out initiatives to support individuals managing long-term conditions** like chronic pain, diabetes, and hypertension through collaboration with community and voluntary organisations, by fostering trust and confidence in the healthcare system among our diverse communities
- **Develop the Adult Social Care 'front door' future model of delivery**, ensuring an inclusive and equitable service, with an interface with community health and primary care

Actions for 25/26

- **Develop a local same day urgent and emergency care model** between Lambeth and Southwark, offering comprehensive clinical assessment and signposting services, aiming to transition several current 111 activities to local borough management by winter 2025.

Intended outcomes in 5 years time

- People are connected to communities which enable them to maintain good health
- People receive early diagnosis and support for physical health conditions
- People who have developed long term health conditions have help to manage their condition and prevent complications
- People have access to joined-up and holistic health and care delivered in their neighbourhoods
- People know where to go to get the right help, and are treated at the right time, in the right place, for their needs
- Older adults are provided with the right health and care support at the right time, live healthy and active later lives and are supported to age well

Lambeth priority action – Living Well Network Alliance

Living Well Network Alliance

Supporting adults in Lambeth who are experiencing mental illness or distress.

How we will secure delivery

Actions for 24/25

- **Continue to develop and expand the Alliance's Culturally Appropriate Peer Support and Advocacy (CAPSA) service** which employs people from Lambeth's Black communities with lived experience of mental health issues to work with and advocate (speak up) for those we support.
- **Continue the development of the 'Dialog' tool to ensure a robust** and consistent process to capture treatment satisfaction and feedback.
- **Continue to develop the Primary Care Alliance Network (PCAN) to upskill GPs and Primary Care colleagues**, building confidence to support people in the community
- **Deliver on the reprovision of the Lambeth Hospital** together with SLaM, including the mobilisation of a redesigned inpatient care model to provide better quality and more culturally appropriate clinical service
- **Develop specialist eating disorder and complex psychological and behavioural needs pathways** to enable more people to be supported in the community and reduce unplanned admission due to crisis
- **Offer varied emotional wellbeing provision for children and young people** that is a cohesive and joined-up offer, that is well-communicated and enables improved access
- **Deliver a multi-agency Single Point of Access (SPA) to mental health support**, drawing together a range of services seeking to support children and young people and their families
- **Consider recommendations from the Joint Strategic Needs Assessment Health Profile** of Mental Health in Lambeth and identify any potential new initiatives.

Actions for 25/26

- **Continue to develop our services – IPS (Individual Placement and Support), CAPSA (Culturally Appropriate Peer Support and Advocacy) and Staying Well** – to maximise their impact and effectiveness across the whole of Lambeth

Intended outcomes in 5 years time

- People have healthy mental and emotional wellbeing
- When emotional and mental health issues are identified; the right help, support and diagnosis is offered early and in a timely way
- People using mental health support services can recover and stay well, with the right support, and can participate on equal terms in daily life

Lambeth priority action – Sexual Health Programme

Sexual Health Programme

Improving people's sexual and reproductive health and enabling people with HIV to live and age well, across Lambeth, Southwark and Lewisham.

How we will secure delivery

Actions for 24/25

- Through the South London HIV network meetings the **Programme is preparing for the delegation of NHSE specialised commissioning (HIV treatment)** to ICBs by investigating pathways, capacity, discharge processes and opportunities for collaboration.
- Work continues with the Digital Team to further **develop online booking across providers to support access and gain 'live' system oversight of capacity of all service access.** The 'Find Sexual Health' webpages will improve service user experience, appointment booking and provide relevant information on SRH/HIV with a view to continued expansion to cover SEL in due course.
- **Work underway for new Outreach + YP service across Lambeth, Southwark and Lewisham. A new contract to be procured and in place for 1 October 2024.** Current engagement with stakeholders, communities groups and providers.
- **Increase accuracy of partner notification and reporting across all services that perform STI testing**
- **Redesign Long-Acting Reversible Contraception (LARC) training and delivery** across primary and secondary Care

Actions for 25/26

- Maximise opportunities to co-create improved HIV pathways
- **Increase and improve outreach and education to underserved groups on all aspects of sexual and reproductive health.**
- Work with the NHS and independent providers to **refresh the abortion service offer** across SEL and London

Intended outcomes in 5 years time

- People have healthy and fulfilling sexual relationships and good reproductive health

Lambeth priority action – Learning Disabilities and Autism Programme

Learning Disabilities and Autism Programme

Improving outcomes and support for people who are autistic or have a learning disability.

How we will secure delivery

Actions for 24/25

- Progress partnership negotiations on **Enhanced Intervention Service (EIS) to provide crisis intervention/admission prevention services, improving our borough offer.**
- Continue work to improve opportunities for **people with learning disabilities to be in employment improving current service offers.**
- **Review crisis intervention/admission prevention services** to agree an improved borough offer
- **Developing new supported employment and internship opportunities** through our health and care partners.
- **Develop the Lambeth All-Age Autism Strategy** with users, carers and partners
- **Contribute to the South East London Integrated Care Board Learning Disability and Autism Programme** and support the development of integrated, workforce plans for the learning disability and autism workforce
- **Continue the roll out of Oliver McGowan Mandatory Training (OMMT) for all Health and Care workers.**

Actions for 25/26

- **Ensure accommodation-based placements maximise lifelong independence underpinned by clear systematic contractual framework** to ensure best value Adult Learning Disability Placement strategy. A new commissioning exercise will take place in Quarter 1 2025-26.

Intended outcomes in 5 years time

- People with learning disabilities and/or autism achieve equal life chances, live as independently as possible and have the right support from health and care services

Lambeth priority action – Substance Misuse Programme

Substance Misuse programme

Reducing the harms caused by substance misuse and supporting those using substances to access the right help to meet their needs.

How we will secure delivery

Actions for 24/25

- The support offer through Lorraine Hewitt House is currently under review and the service is due to commence with a new service spec on 1 April 2024.
- **Young Persons Substance Misuse Service recommissioned**. The programme will focus on more prevention to work with schools to identify children most likely to get into fall into substance misuse.
- The **Onstreet Engagement Team has been commissioned focusing on substance misuse, working with community safety, rough sleeping and homelessness team.**
- **Implement the Combating Drugs Partnership delivery plan** providing a multi agency approach designed to generate a collaborative approach to tackling harms caused by drug and alcohol misuse.
- **Use a combination of 'Vital 5' and NHS Health Check approach** to improve routine identification of smokers and those at greatest risk of obesity, providing brief advice and referral to the stop smoking service and to weight management support
- **Deliver stop smoking services and support including specialist services** and community pharmacy provision making best used of additional government funding for 24-25 and Swap to Stop scheme provision.

Actions for 25/26

- **Develop our outreach and early prevention initiatives** such as our Assertive Outreach Team in partnership with Police and Community Safety and access to early and brief interventions on alcohol and drugs use

Intended outcomes in 5 years time

- People maintain positive behaviours that keep them healthy
- People know where to go to get the right help, and are treated at the right time, in the right place, for their needs
- People who are homeless or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Lambeth priority action – homeless health programme

Homeless health programme

Programme to improve health outcomes for people who are homeless or at risk of becoming homeless (including rough sleepers and refugees).

How we will secure delivery

Actions for 24/25

- **Model to be developed to support people passing through supported accommodation** and enables them to be registered with a GP and start work with service providers on health and care needs.
- **Development of a model to allow cross referencing GP registration for those in supported housing,** with engagement with GP.
- **Develop intelligence to review how long rough sleepers brought into accommodation, have sustained tenancy**.
- Working with Lambeth Housing to **improve the quality of temporary accommodation** through contract monitoring and improved technology.
- The Lambeth Rough Sleeping Outreach Team will continue to target all rough sleepers found in Lambeth to **ensure everyone is offered a route off the streets**. Long term entrenched rough sleepers will continue being case worked by specialist roles within the team such as a Living On The Streets worker, and embedded roles such as a Public Protection Officer and an Approved Mental Health Professional.

Actions for 25/26

- **Expansion of treatment provision for substance misuse** and alcohol dependence.
- **Increase referrals to substance misuse services** from the police (custody), probation and criminal justice system.
- **Increase number of people accessing and completing treatment for substance misuse.**

Intended outcomes in 5 years time

- People who are homeless or at risk of becoming homeless, (including rough sleepers and refugees) have improved health

Lambeth - local delivery of SEL priorities

Borough delivery of SEL pathway and population group priorities

As the Lambeth Together Care Partnership, we recognise the role we play as a key delivery partner in all SEL programmes, and we have aligned our delivery plans to the key priorities. It sets out how health and care services in Lambeth will work together to improve health and wellbeing outcomes for people of all ages and from all our communities, over the next five years. Examples of how we are contributing at a local level to the overall aims of South East London are shown below.

Children and Adults Mental Health

- **Continue to develop and expand the Alliance's Culturally Appropriate Peer Support and Advocacy (CAPSA) service** which employs people from Lambeth's Black communities with lived experience of mental health issues to work with and advocate (speak up) for those we support.
- **Continue the development of the 'Dialog' tool to ensure a robust** and consistent process to capture treatment satisfaction and feedback.
- **Continue to develop the Primary Care Alliance Network (PCAN) to upskill GPs and Primary Care colleagues**, building confidence to support people in the community
- **Deliver on the reprovision of the Lambeth Hospita**l: the mobilisation of a redesigned inpatient care model to provide better quality &Z more culturally appropriate clinical service
- **Develop specialist eating disorder and complex psychological & behavioural needs pathways** to enable more people to be supported in the community and reduce crisis admissions du
- **Offer varied emotional wellbeing provision for children and young people** that is a cohesive and joined-up offer, that is welll-communicated and enables improved access
- **Deliver a multi-agency Single Point of Access (SPA) to mental health support**, drawing together a range of services seeking to support children and young people and their families Delivering a pilot with SLAM and community organisations (The Well Centre, Coram and Place 2 Be) to **better understand how we can join up our response to CYP emotional health and wellbeing need, bringing services, data and statutory provision together.**

Other examples of local delivery

- **Deliver the Catch 22 Bowel Cancer Screening initiative** to increase the uptake of bowel cancer screening
- **Contribute to the South East London Integrated Care Board Learning Disability and Autism Programme** and support the development of integrated, workforce plans for the learning disability and autism workforce
- Local delivery of the **Recovery Plan for Primary Care Access** as well as SDF – (Strengthening General Practice/ Integration at Place/ GP Resilience) programmes

Population Health and Prevention

- **Continue work on vital 5 approach** to strengthen the identification/screening and signposting dependent/risky drinkers for support starting with a focus on hypertension and obesity, given links to alcohol consumption.
- **Develop an easy identification tool for high risk drinking** to support treatment
- **Immunisation**: Work with PCNS to improve immuisation uptake
- **Use NHS Health Check** to improve - identification of smokers and those at greatest risk of obesity, providing brief advice offers of support services
- **Continue to develop the weight management service** with better links into communities that have the highest need

Lambeth Enabler requirements

Enablers

Our principles

The way we work will be:

- supported by a positive and action orientated approach to equity for all protected characteristics including taking an anti-racist approach, seeking to build trust and confidence with our communities
- an asset-based approach, building and amplifying what is already in the community, starting with the assumption of strengths and trust in Lambeth's communities
- shaped by a more determined and dynamic approach to integration, which understands that no one organisation has the answers to these complex issues we are attempting to tackle, and that collaboration is essential
- an approach which enables and supports the concept of 'Health and Wellbeing in all Policies', building on what has been achieved since 2016
- underpinned by open and participative research, where research, data and evidence building involves local people and informs our decision making.

Our ways of working

- Measure and understand the experience of people accessing our services and use this information to reduce inequalities.
- Commit to and embed equality, diversity and inclusion across all levels of our system with a focus on reducing health inequalities throughout all our work.
- Work together as an effective, well-governed, and transparent Local Care Partnership within an Integrated Care System and in collaboration with other Local Care Partnerships.
- Deliver through our Delivery Alliances and Programmes, with strategic oversight, effective assurance and risk management functions.
- Work to the **quadruple aim framework** to maintain a whole-system approach to providing health and care by focusing on improved patient experience, better population health outcomes, improved experience of providing care and delivered at best value.

Workforce

- Support our workforce and their wellbeing, including developing and retaining our staff, and supporting fair pay for care staff as part of Lambeth's Ethical Care Charter.
- Have a workforce that, at all levels, can relate to people's lived experience, is representative of and supports our diverse and intersectional communities.
- Have a workforce that has capacity, is trusted and supported so communities receive a consistent and reliable service.
- Enable our workforce to work together, across organisational boundaries, in an integrated way, including through our Clinical and Care Professional Network.

Our communities

- Communicate and engage with our patients and residents using a range of methods ensuring information is accessible and easy to understand, and listen to patients, residents and community voices, ensuring those voices actively influence improvement.
- Work collaboratively to reduce health inequalities and support healthy neighbourhoods, recognising and supporting our assets in the community including residents, carers, grassroots organisations, volunteers, voluntary and community sector (VCS) organisations and community groups.
- Have 'anchor institutions' that serve the wellbeing of our population by strategically and intentionally managing their resources to help address local social, economic, and environmental priorities to reduce health inequalities.

Intelligence

- Develop a culture and infrastructure that prioritises data-driven decision making and approaches to understanding the unique needs of Lambeth residents, especially those who are facing health inequalities. Our goal is to make a positive impact in specific populations within our community, such as those from different ethnic backgrounds, sexual orientations, and those living in deprived areas.
- Identify opportunities to improve services, provide proactive care, and understand the impact of what we do on our populations. This will involve improving how we collect and analyse information and learn from best practice, research, and quality reviews to continuously improve our efforts.

Finance

- Provide a stable financial environment that supports continued improvement in health and care services and outcomes for people, to ensure a robust and effective delivery of core responsibilities, by using approaches that improve productivity, efficiency and value through making the best possible use of the money we have.

Estates

- Encourage all health and care partners to work together in the same buildings to transform service delivery and improve access to care, delivered from high-quality premises.

Digital

- Make sure residents have access to digitally enabled care across health and care settings that are easily accessed, consistent and ensures the right service for their needs.
- Make sure those residents who do not wish to use digital tools and/or are digitally excluded, can still access health and care services at the same level and standard.
- Work with partners across SEL ICS and beyond to enable sharing of information to support planning and care delivery.

South East London Integrated Care System

Lewisham Borough Overview

NHS South East London

Our population

Lewisham currently has a population of 300,600. It is the 14th largest borough in London by population size and the 6th largest in Inner London. In the next five years our population is likely to rise to over 310,000 and to over 320,000 by 2032. 52.5% of the population are female; 23.5% are 0-19 years of age; 9.5% are aged 65 or over; 67% are 20-64 years of age. The population of very young children aged 0 – 4 is larger in Lewisham than in England.

We have a significantly younger population compared with national averages, with more people aged between 25 and 44. There is a smaller population of those aged 65+. However, it is thought our population growth won't be evenly spread across the ages and we will see an increase in the older population and a slight decrease in the younger population and working age population. Almost half (48.3%) of our population are from an ethnic minority community. Between 2011 and 2031 it has been projected that the size of the population of children and young people 0-19 in ethnic minorities will grow much faster than the rate of children from white ethnic groups.

Health outcomes for our population

For female residents, Lewisham life expectancy (83.2 years) now exceeds the national average (83.1). However for male residents, life expectancy is significantly lower (78.8) than the national average (79.4).

The main cause of death in Lewisham is cancer (28%), followed by circulatory disease and respiratory problems.

Lewisham has lower average mental health scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is higher than in London (7.1%). According to the 2020/2021 ONS Annual Population Survey, 29% of Lewisham residents age 16+ reported high anxiety levels, compared to the London average of 24%, and 24% across England.

We are seeing an increase in the complexity of need and those needing care and the number of people living with multiple health conditions is increasing.

Inequalities within our borough

Lewisham is the 63rd most deprived Local Authority in England and within the 20% most deprived Local Authorities in the country. Bellingham, Downham, Rushey Green and New Cross are the most deprived local wards in the borough.
Lewisham's Black and Minority Ethnic communities are at greater risk from health conditions such as diabetes, hypertension and stroke. In addition, Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, including psychotic disorder and Post-Traumatic Stress Disorder (PTSD), and experience inequalities in access to services. In borough we also see late presentations of lung and colorectal cancers.

Those in poorer health were disproportionately impacted by Covid. For some services, including the uptake of preventative healthcare such as health checks, immunisations and certain cancer screening, Lewisham is still to return to pre-pandemic levels. This is concerning in Lewisham, which even prior to COVID-19 was already seeing lower uptake and long-standing health inequalities such as notable differences in life expectancy depending on the area of the borough a resident lived.

Lewisham Borough

What we've heard from the public

Lewisham Health and Care Partners have engaged with stakeholders on the development of this local care plan. Through this engagement, the following common themes emerged.

1. The need to develop a truly integrated way of working across the local system and within neighbourhoods.
2. The need to provide timely and relevant care to children and families at their time of need that is truly person-centred and helps reduce inequalities in access.
3. The need to take a broad lens to access and inequality to better understand what the drivers are and how to address them
4. The need to ensure services are delivered by a happy, healthy workforce and recruitment and retention prioritised.

To support the delivery of this plan, Lewisham has committed to a new, co-designed model of engagement. The model will :

- Support local people to exercise power and contribute as equal partners.
- Build trust by acting on feedback and developing deeper relationships with local people.
- Reduce barriers to engagement (for example language barriers, resource barriers and cultural barriers).
- Work together to achieve more with what we have (recognising funding/time/capacity limitations).

Our People's Partnership will sit alongside and feed into the broader structures of the Lewisham Health and Care Partnership (LHCP) bringing patient and citizen voices and lived experience into supporting the strategy and delivery work of the LCP

Lewisham Borough

Our partnership aims

We are committed to achieving a sustainable and accessible health and care system to better support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Our plan supports the aims of Lewisham's current Health and Wellbeing strategy which are:

1. **To improve health** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
2. **To improve care** – by ensuring that services and support are of high quality and accessible to all those who need them, so that they can regain their best health and wellbeing and maintain their independence for as long as possible.
3. **To improve efficiency** – by improving the way services are delivered; streamlining pathways; integrating services, ensuring that services provide good quality and value for money.

Our plan also aligns with our commitment to make Community Based Care:

Proactive and Preventative – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively;
Accessible – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.
Co-ordinated – so that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

South East London Integrated Care System

Lewisham's priority objectives

NHS South East London

1. To strengthen the integration of primary and community based care	2. To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	3. To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes	4. To maximise our roles as Anchor Organisations, be compassionate employers and build a happier, healthier workforce	5. To achieve financial sustainability across the system
We will work together in collaboration and with the communities we serve. We want to design, plan and deliver our services with service users, patients and residents. We want teams to work as close to the patient as possible and for services to be delivered through integrated multi-disciplinary approaches with organisational barriers no longer getting in the way.	*We will work together to join up services and to ensure all parents and carers can access support they need when they need it.* *We want to support and empower parents and carers in caring for and nurturing their children and enable all children and young people to thrive.*	*We will contribute fully to the delivery of the Lewisham's Health Inequalities and Health Equity Programme's objectives which includes improving system leadership and accountability for health equity; empowering communities; identifying and scaling up what works; and prioritising and implementing specific opportunities for action from the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)*	*We will work together to create a range of employment opportunities for local people and create an environment that fosters wellbeing in our staff. We want to create more entry level roles and contribute to wider local economic development. We want to deploy resources more effectively and creatively to help address employment gaps.* *We want to improve the health and wellbeing of everyone who works for us.*	*The ongoing financial constraints are an impetus for change and we will work together to overcome the financial hurdles ahead.* *By working more closely and smartly we want to alleviate the pressure on services across the system – enabling our budgets to be stretched in ways that support effective service delivery.*

Lewisham - our priority actions

As partners we will take the following priority actions in support of our objectives. More detail on these actions are set out in the following pages and in LHCP's programme and delivery plans.

Strengthening the integration of primary and community based care	Our priority action is to establish the model, infrastructure and approach required to enable effective integrated working at a neighbourhood level. Through this approach we will establish local models of care for at least two long term conditions and to support older people. We will also expand the provision of early intervention and community support for mental health.
Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services	Our priority action is to establish the integrated model for family hubs across Lewisham and to identify the integrated pathways that can be delivered through family hubs.
Addressing inequalities throughout Lewisham health and care system	Our priority action is to build and implement an agreed infrastructure through which initiatives to address health inequalities and achieve health equity in the borough can be delivered.
Maximising our roles as Anchor Organisations, being compassionate employers and building a happier, healthier workforce	Our priority action is to identify opportunities for joint apprenticeship programmes. We will also implement joint initiatives to promote health and care careers and develop tools and approaches to inform workforce planning and address workforce.
Achieving financial sustainability	In partnership we will work to optimise the use of resources, align our financial planning and maximise financial resilience to system pressures.

Lewisham - Our Programmes

Our programmes

We aim to deliver a substantial improvement in health and care outcomes within our priorities. These new priority areas sit alongside other established programmes of work, including all age mental health, planned care and long-term condition management, urgent and emergency care and children's community health.

Delivery of our plan is managed by the partnership's programme boards and associated delivery plans. These include the Family Hubs and Start for Life Programme, the Older People and Frailty Programme, the Mental Health Alliance and the Integrated Neighbourhood Network Alliance. Other programmes of work, including those on planned and unplanned care, workforce and estates also contribute to the achievement of our strategic aims and priorities.
The success of our partnership working and the progress we make against our agreed programme and delivery plans will be overseen by our partnership boards and health and care alliances.

We are also establishing a joint programme management approach to provide Lewisham Health and Care Partners with the assurance that our partnership programmes are being delivered effectively and to time and budget.

Lewisham – Our progress to date

Key Successes in Delivery in 2023/24

- **Older Adults Transformation Programme** - Implemented and continue to develop the 'Capturing the Voice of the Older Adult group' who developed a series of 'I' statements for the programme. Business case for pro-active care prepared with partners for implementation in 2024/25
- **NHS@Home(virtual ward) -** successfully implemented hospital discharge pathways in addition to its' admission avoidance patient cohort.
- **Hospital Discharge**: The number of patients with a **length of stay of over 100 days** has reduced from 14 to an average of 6
- **Embedded the Health Inequalities** Programme and associated partnership workstreams
- **6 Health Equity Fellows** in post and to complete 2 year role in October 2024
- **All 6 Fellows have been matched** with a community organisation that has been commissioned to recruit and manage a pool of community champions
- **Aligned the Lewisham Community Champions** initiative to the PCN Health Equity Teams
- **Developed & delivered 4-6 week programme** for two cohorts to introduce 16 – 17 year olds to potential careers in health and care
- **CYP mental health:** Working with Black Thrive and as part of the national connectors programme, the ICB has engaged with two schools across Lewisham as part of wider SEL ICB work to co-produce a set of tailored interventions to support CYP mental health, particularly children and young people with Black heritage.
- **Access to Black Therapists Pilot –** A pilot has been put in place and the provider Wellbeing For Us will offer access to black therapists for talking therapies. The offer will also include non-Eurocentric therapeutic group work.
- **Conducted review of practice based Multi-Disciplinary Meetings**. Areas for action include adopting a more proactive approach to case finding and referrals, placing greater focus on patient outcomes measuring impact.
- **Population Health Team developed a neighbourhood data profile** to focus activity to support local health priorities in the N3/ Sevenfields PCN Project.
- **Successful implementation of Joy Social Prescribing Platform** across Primary Care, now provides social prescribing activity data across Lewisham system.
- **Family Hubs :** there will be three fully operational family hubs from Aril 2024 comprised of additional staff that offer a wider range of service provision for families
- **Expansion of the Children's Community Nursing Service** to include an allergy nurse and Continence and Constipation Service to reduce children's outpatient appointments and improve outcomes for families.
- **GP-Led Youth Clinic implemented** at The Mulberry Hub, evaluation completed and second year funding sourced to develop model in south Lewisham.

Key Challenges in Delivery in 2023/24

- **Older Adults Transformation Programme** - Systems and processes to have a shared understanding across the system of the population that the Proactive model of care is seeking to support and the mechanism for identifying them
- **UEC Programme** - High levels of attendances at ED leading to significant pressures on hospital
- **UEC Programme -** Attendant pressures in community due to increasing levels of homelessness and complex social/MH issues leading to difficulties in discharging from hospital.
- Difficulties in identifying suitable care home placements in a timely way
- **Implementing year 3 of CMHS** –Limited development and progression against agreed priorities for 2023/24 as majority of MHIS and SDF Funding had to be used within the acute MH care rather than community.
- **Understanding the impact of community mental health transformation**: It has been difficult to quantify the impact of the investment into community mental health teams, although an Expert Reference Group led by SLaM Quality Centre has been established to quantify this for Lewisham Adults.
- **Acute and crisis pathway** – continued number of high presentations to emergency departments with long waits for inpatient beds. Limited movement in the number of patients clinically ready for discharge resulting in longer lengths of stay.
- **Neurodiversity** – Demand continues to outstrip the current available capacity across children's and adults, particularly for ADHD and ASD diagnosis. Staffing challenges also impacting the ability to reduce the back-log and waiting times for autism assessments for children and young people .
- **EHCP Assessment** - Increasing demand for health assessments for EHCPs leading to increasing numbers of assessments completed later than statutory timescale.
- **CYP Mental health** – SLaM financial position and the impact on delivering the CYP EWB&MH Transformation priorities, particularly eliminating 52+ week waits
- **Partners reported challenges in capacity to support and deliver -** in each workstream and a lack of ability to engage effectively during the design stage. As a result, we reduced the number of workstreams and focussed on one Neighbourhood at a time, the objective being to test new ways of working and scale.
- **Working within a neighbourhood footprint -** that is not coterminous with PCNs can present challenges, there is a need to flex across these boundaries. Also, recognition that within the 'neighbourhood' there are also hyper local communities.
- **Pilot workforce toolbox -** which articulates minimum standard of training for frontline staff

Learning and Implications for Future Delivery Plans

Older Adults Transformation Programme - Developing a collaborative learning and supportive culture to enable system working
UEC programme - focus on improving discharges with the Home First programme. In 2024/25 we will continue to address the key issues causing discharge delays, through piloting a Hospital Care Homes liaison post to improve links between care homes and the hospital teams, and focus on improving joint working and patient outcomes with enablement and therapies teams.
Ensuring effective acute flow to enable investment and focus on other areas: Pressures on the mental health urgent and emergency care pathway have dominated the focus in 2023/24. It's important the system ensures the appropriate capacity and flow is in place for 2024/25 to then enable the system to focus on the wider pathway.
Streamlining the deliverables for each financial year: Recognition that plans for 2023/24 were perhaps ambitious across all the key priorities and therefore moving into 2024/25, there will be a streamlined approach to service delivery.
Focus on data and outcome recording and improving the quality of this data: Common datasets across the six boroughs will be a key focus in 2024/25 to ensure the system can appropriately and effectively understand the impact of the investment and transformation for our local residents. There will be a concerted effort across both mental health trusts to improve the data quality within the mental health services dataset (MHSDS).
For successful neighbourhoods working building relationships and trust in the community is critical, this takes time and must be incorporated into planning approach.
Important to align our work and learn from what works well in other settings for example working with Health Equity Fellows and aligning work with opportunities for action outlined in BLACHIR. Report.
Agreed and shared approach to tracking the impact of initiatives across the Lewisham system and early agreement on how to mainstream successful initiatives.

Lewisham priority action 1: integration of primary and community based care (1)

Integrated Neighbourhood Networks

Through our Integrated Neighbourhood Network Programme, we will build on existing work across the partnership to improve the delivery and integration of community-based care at a neighbourhood level and will establish the model, infrastructure and framework required to deliver integrated neighbourhood working .

How we will secure delivery

Actions for 24/25

- Review impact of 23/24 actions
- Update PCN and neighbourhood data profiles
- Update neighbourhood plans to address priorities identified from data profiles
- Progress multi-disciplinary working areas for action including approach to anticipatory case finding and suggest any additional GP contract changes
- Finalise framework for neighbourhood working with a view to scale up to other neighbourhoods
- Deliver and evaluate neighbourhood community training
- Implementation of new South Lewisham mental health youth hub
- Deliver phase II of the Social Prescribing Personal Health Budget Scheme
- Development of cross borough working arrangements with Greenwich and Bromley focussed on the Horn Park Pilot

Actions for 25/26

- Design and delivery of training package to support integrated neighbourhood working
- Embed framework for integrated neighbourhood working
- Improving access to Personalised creative wellbeing activities, working in partnership with ICS SEL Creative Health Lead
- Scale up of successful approaches to improve MDM working and implement new contract changes
- Undertake evaluation of Waldron ground floor refurbishment and use by community
- Review and evaluation of the Social Prescribing Platform

Intended outcomes in 5 years time

- Strong Neighbourhood Alliance(s) in place
- Integrated and coordinated neighbourhood teams in place
- Personalised health and care services coordinated around population needs
- Improved local awareness of services available
- Established social prescribing networks that support the needs of the Lewisham population
- Improved and timely referrals between services
- Effective multidisciplinary working/teams in place following best practice

Lewisham priority action 1: integration of primary and community based care (2)

Older People's programme

The Older people's programme is an LCP priority that through formulation of a preventative and proactive approach aims to shift activity from unplanned to planned whilst keeping those over 65 living independently in their home for as long as possible. Through the Older People Transformation Board, we will shift over 65 Emergency Department attendance and Unplanned Admission activity to the community thorough the implementation of the Proactive Model of Care outlined in our Business Case (2024). For the purpose of this update, the focus is on the Proactive Care model.

How we will secure delivery

Actions for 24/25

- Invest £200,000 to launch and implement the Proactive Model of Care in collaboration with LGT colleagues
- LGT finance team to build a 'record and report' system which will produce the analysis required to monitor impact of the Proactive Model of Care
- 'Capturing the Voice of the Older Adult' group will monitor impact of the Proactive Model of Care on achieving the 'I' statements and produce an annual report
- Support colleagues at LSE to evaluate (i) the circumstances of older people with moderate care needs and their Unpaid Carers, (ii) the support they receive (iii) the consequences for their wellbeing of different support and (iv) the implications of different care arrangements for costs and value for money of the care system.
- Continue to nurture the professional relationships with LGT senior colleagues building on the collaborative approach adopted to draft the Business Case
- Ongoing engagement with professionals through the Professionals Group

Actions for 25/26

- Invest £300,000 embed the Proactive Model of Care in collaboration with LGT colleagues
- LGT finance team to continue to monitor impact of the Proactive Model of Care through the 'record and report' system. This information will be used by LGT colleagues to mainstream the Proactive Model of Care from 01 April 2026.
- 'Capturing the Voice of the Older Adult' group will continue to monitor impact of the Proactive Model of Care on achieving the 'I' statements and produce an annual report
- Use the findings from the LSE study to support commissioning intentions for community services

Intended outcomes in 5 years time

- Sustained 4% reduction in ED attendances for over 65s
- Sustained 4% reduction in Unplanned Admissions for over 65s
- An annual sustained increased proportion of Older Adults remaining at home.

Lewisham priority action 1: integration of primary and community based care (3)

Long Term Condition management

Working across the Lewisham Local Care Partnership, we will establish models of care for the proactive detection, management and reduction of Long Term Conditions, including for those with complex multi-morbidities, wider wellbeing challenges and where inequalities exist in how different patient cohorts experience LTCs.

How we will secure delivery

Actions for 24/25

1. Improve how we use Lewisham and SEL datasets to robustly understand population health dynamics, proactively shape our priorities and target finite resources.
2. Review Community Dermatology Services and agree long-term provision.
3. Improve the low rates of hypertension control in Lewisham, including primary care quality improvement, patient activation and VCSE development.
4. Redevelopment of MSK services in line with national and SEL guidelines. Scoping the cost-value benefits of the 'getUbetter' app used in Lambeth and Southwark to date.
5. Review and improve access to community respiratory services, including adult and paediatric spirometry and supporting management within primary care.
6. Scale and spread of learning from the Chronic Kidney Disease Multimorbidity Model of Care pilot, to develop intensive, holistic multidisciplinary management of people with CKD, multiple LTCs and social wellbeing concerns.
7. Referral optimisation between primary and secondary care, including the Emis Referral Optimisation Protocol and promoting Consultant Connect, Advice & Guidance and PLTs.

Actions for 25/26

- Utilise the integrated neighbourhoods model to establish a sustainable MDT approach for people with LTCs, including proactive identification, community-led risk assessment and voluntary sector capacity building.
- Support a holistic review of all community services within the LGT block contract with a view to re-designing or re-configuring provision to secure best practice, reduce waiting times and improve Value for Money.

Intended outcomes in 5 years time

- Reduction in the number of people living undiagnosed with LTCs.
- Delivery of services and management of care for people with long-term conditions that are proactive, holistic, preventive and patient-centred.
- Patients have an active role with collaborative personalised care planning at the centre of everything we do.
- Clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress.
- Care planning for local populations makes best use of local authority services (including social care and public health) and community resources, alongside more traditional health services.
- Increased motivation and ability of patients to self-manage and support, ensuring they access the most appropriate services in a timely and safe manner.
- Improved patient experience through early and accurate diagnosis of disease with effective treatment closer to home.

Lewisham priority action 1: integration of primary and community based care (4)

Early Intervention and Community Support

In partnership we will expand the provision of early intervention and community support for all-age mental health services.

How we will secure delivery

Actions for 24/25

- Development of an integrated single point of access for all CYP services.
- Ongoing delivery of the adult community mental health transformation programme, maximising the investment made available and learning from the stocktakes and evaluations of programme delivery from 2023/24.
- Development and design of a new community model of care building on the models from Scandinavia and Trieste(Italy).
- In partnership with South London Listens Programme, and in collaboration with residents and Voluntary, community and social enterprise sector (VCSE), continue to develop, build and test alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population.

Actions for 25/26

- Continue to embed delivery of community and primary care mental health and wellbeing services.
- Through Local Care Partnerships, and in collaboration with residents and VCSEs, to continue to develop and build alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population.
- Flexible approach to delivering MHSTs in schools and rolling out Wave 12

Intended outcomes in 5 years time

- For CYP, have implemented the i-Thrive Framework including joined-up approaches to deliver an integrated single point of access in place for mental health and emotional wellbeing support.
- 100% coverage mental health support in schools.
- Each PCN to have a fully established adult integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of our local population.
- Increases in the number of people accessing employment support.
- Increased access to Talking Therapies (including for people with long term conditions) and equitable recovery outcomes for all population groups.
- Increased investment in VCSE providers with noted improvements in the diversity of the VCSE provider landscape for adults.
- Upskilling of at least 40 community leaders and volunteers as Be Well Champions, and establishing hubs providing regular wellbeing activities/spaces and signposting

South East London Integrated Care System

Lewisham priority action 1: integration of primary and community based care (5)

NHS South East London

Urgent and Emergency Care

Through our local programme we will support colleagues across SEL and Lewisham to reduce the need for ED attendances and acute admissions where these could have been prevented by earlier intervention. We will work closely with all system partners to ensure that appropriate attendances are quickly managed, and inappropriate attendances are minimised through referral away to suitable alternatives. We will seek to fully embed the Home First approach and ethos in Lewisham, resulting in a high proportion of patients discharged home, with excellent follow up support where needed.

How we will secure delivery

Actions for 24/25

- Same Day Urgent Care mapped and interfaces improved
- Increase referrals to SDEC
- Improve use of Consultant Connect
- Pilot in place to trial referrals away from ED
- Data reliability achieved with ward/patient level dashboard
- Intermediate Care Strategy Developed to support improved hospital discharge pathway
- Care Homes liaison post pilot in place
- Improve Weekend discharges
- Consolidate successes of the Virtual Ward by expanding capacity to 75 beds (adults) and 5 beds (paeds), including seamless step down pathways for respiratory, frailty and Heart Failure as a minimum and a step up offer to primary care

Actions for 25/26

- Review of performance against agreed actions for 24/25
- Further use of population health data to assess activity
- Agree new partnership actions

Intended outcomes in 5 years time

- Same Day Urgent Care model is well understood and provides access to same day urgent care for Lewisham residents
- Integrated model of NHS@home including UCR in place
- Reduction in patients discharged to care homes to best benchmarked peer borough
- Increase in proportion of patients not needing further care/support following enablement
- Attendances at UHL ED are more appropriate
- Increase in number of discharges before 5pm
- Increase in weekend discharges

Lewisham priority action 2: integrated, high-quality, whole-family support services (1)

Family Hubs and Start for Life Programme

In partnership, we will establish five Family Hubs in Lewisham to provide accessible, physical and virtual points of contact for families, children and young people aged 0-19 (or aged up to 25 for young people with special needs) and to deliver integrated pathways. As of April 2024, Lewisham will have three new Family Hubs fully operational with additional staff based on site and additional services for parents, including a new Family Navigator role to support families to access services across the system.

How we will secure delivery

Actions for 24/25

- Integrate Children and Family Centres into Family Hubs by March 2025 to create a sustainable model when the Start for Life funding ceases in March 2025
- Spring 2024 Expand the offer of community health services through Family Hubs e.g Immunisations and healthy weight
- Summer 2024 - Evaluate impact of year 1 of Family Hubs on outcomes for families, children and young people, including on key health indicators evidencing access to and outcomes from services.
- Summer 2024 - Review provision across Family Hubs and Early Years to ensure equal access to services, and make changes as needed
- Autumn 2024 - Open 2nd FH in area 1 (Honor Oak Youth Centre)

Actions for 25/26

- Spring 2025 – Sustainable offer in place following cessation of DfE funding
- Spring 2025 – Digital Family Hub offer in place, including web, apps, automation of processes
- Summer 2025 – Open FH in area 2 (location tbc). Likely to include a hub model for SEND and autism.
- Autumn 2025 – Evaluation of Family Hub and Early Years offer and review of health outcomes achieved

Intended outcomes in 5 years time

By joining up and enhancing services through our Family Hubs, including integrating Children and Family Centres, parents and carers in Lewisham will be able to access the support they need when they need it. The Family Hubs will be supported by a network of other services and families will be able to access information on services virtually or via outreach work. Parents and carers will feel supported and empowered to care for and nurture their babies and children, ensuring they receive the best start in life – Connect, Grow, Thrive.

This in turn will improve health and education outcomes for babies, children and young people and enable them to thrive. The planned outcomes for Family Hubs include:

- An increase in the number of parents accessing support for perinatal mental health
- An increase in the number of women from target groups accessing infant feeding support services
- An increase in the number of parents receiving structured support with parent-infant relationships
- An increase in uptake and completion of vaccinations
- A reduction in the number of children with excess weight at Reception and Year 6
- A reduction in waits for CAMHS referrals

Lewisham priority action 2: integrated, high-quality, whole-family support services (2)

Local Child Health Teams

Alongside our priority to establish Family Hubs, we will deliver an enhanced children's health offer in the community working alongside primary care that increases access to support closer to home. This will help develops our primary care workforce to deliver more efficient care to children and young people.
Integrated working will consider will help address inequalities by providing appropriate and accessible services for the communities in Lewisham. It aims to provide better support communities who at risk of adverse life outcomes and limited positive health outcomes due to health inequalities and adverse childhood experiences (ACE).

How we will secure delivery

Actions for 24/25

- Engage and consult with children and young people, primary care and acute services to develop an Integrated Community Model for Lewisham
- Work with SEL leads to develop a Lewisham model of integrated community based care, using established teams to help leverage improved outcomes. This will adapt best practice from areas already providing effective integrated models in SEL.
- Identify a PCN to co-design the neighbourhood model for integrated working.
- Engage with wider primary care to identify options to work with pharmacies.

Actions for 25/26

- Review the impact of the community model and integrated working with PCNs.
- Extend the Community Model to more PCNs by March 2026.
- Identify opportunities to develop services for LTC linked to the implementation of core offers for CYP Core20Plus5.

Intended outcomes in 5 years time

- Improve child health outcomes – a reduction in CYP follow up primary care appointments and admissions to hospital (ED and non-elective)
- Overall reduction in paediatric appointments as health needs addressed and managed efficiently in primary care
- Improvement in overall quality of care CYP receives
- Reduce inequalities in access to care – reach the local CYP population
- Strengthen the health system

Lewisham priority action 2: integrated, high-quality, whole-family support services (3)

Consistent and Sustainable Children's Community Services

To improve access, reduce variation and improve capacity in community care for children, young people and their families.
To implement the SEL Core Offers for Community Services based on the Core20Plus5 for CYP.
To improve access to asthma services within the community, to consider its links with air quality and the impact this has on vulnerable communities living in areas of deprivation.

How we will secure delivery

Actions for 24/25

- Continue to monitor core community services to identify areas of pressure across Therapies, Community Nursing and Community Paediatrics.
- Continue to monitor the demand for Education Health and Care Needs assessments and timely completion of health assessments for EHCPs.
- Monitor the recovery plans from LGT to reduce the waiting times for ASD assessments and implementation of the ASD Core Offer.
- Implement the core offers for Asthma, Respiratory Hubs, Epilepsy and H@H in Community Services.
- Implementation of the All Age Autism Wellbeing Service offering pre & post diagnostic support offer for CYP and families; and adults in Lewisham.

Actions for 25/26

- Ongoing development of Continuing Care policies, procedures and practice across SEL/London reduce variation in care and assessments.
- Review the impact of the All Age Autism Wellbeing Service on ASD waiting times.
- Ongoing review of waiting times for EHCNA and ASD assessments.
- Review alignment of Community health services with Family Hub model, and identify services which would be appropriate to co-locate.
- Review impact of core offers on health outcomes for CYP.

Intended outcomes in 5 years time

- 90% of EHCNA health reports completed within the statutory timescale. Waiting times outside of the statutory timescales reduced.
- Reduction in waiting times for ASD assessments to within 3-5 months target.
- Improved access to community nursing for health needs and enteral feeding support in specialist schools.
- Reduction in referrals to Urology and Constipation out patient clinics from Primary Care.
- 80% of community services have a core offer attached specifying CYP outcomes to be delivered at place.
- 70% of core offers are implemented at place.
- Reduction of inequality in health outcomes.
- Planned winter response and reduction in emergency attendance for CYP between December and February (annually).
- System capacity increased to meet the needs of approximately 300 additional places in specialist school over the next three years (impact capacity of Nursing and Therapy support services).

Lewisham priority action 3: Addressing inequalities

Addressing inequalities

In partnership we will build and implement an agreed infrastructure through which initiatives to address health inequalities and achieve health equity in the borough can be delivered. The implementation of specific opportunities for action and recommendations from Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) will have a fundamental thread throughout the Programme and each workstream will oversee the implementation of the BLACHIR themes and delivery of specific opportunities for action.

How we will secure delivery

Actions for 24/25

- Implement a Lewisham-wide **targeted hypertension project**
- **Improve awareness** of Black, Asian and Minority Ethnic communities groups of symptoms of cancer and screening programmes through the Lewisham Cancer Awareness Network., linking with Community Champions, Faith and Community Groups
- **Support Practices and PCN** to deliver cancer components of the PCN DES , working with the SEL Cancer Alliance
- **Deliver community projects/initiatives** through the PCN Health Equity Teams
- Have an established **preventative community-based outreach initiative** in place for Lewisham
- **Evaluate** the PCN Health Equity Fellows and Teams.
- **CYP mental health:** Working with Black Thrive and as part of the national connectors programme, the ICB has engaged with two schools across Lewisham as part of wider SEL ICB work to co-produce a set of tailored interventions to support CYP mental health, particularly children and young people with Black heritage.
- **Asylum & Refugee Lewisham Partnership Meeting:** a multi-agency approach addressing inequality of provision of accommodation and wrap around support for highly complex vulnerable families of asylum with management of associated risk factors managing interventions.

Actions for 25/26

- Align the work of the Lewisham Cancer Awareness Network with the PCN Health Equity Teams
- Refine and finalise the Lewisham Health Inequalities workforce toolbox for use across frontline health and care services in Lewisham
- Evaluate the targeted Tier 2 weight management service for Black African and Black Caribbean residents
- Implement learning from the Black Thrive programme within schools.

Intended outcomes in 5 years time

- Established and sustainable PCN Health Equity Teams in the 6 Lewisham PCNs with active Community Champions supporting community preventative initiatives
- Improved population coverage of Rapid Diagnostic Service
- An increase in uptake for all three main cancer screening programmes to reach the regional (London) average uptake - breast, bowel and cervical
- An increase in all childhood immunisation programmes to reach the regional (London) average uptake
- Improved uptake of NHS Health Checks in Lewisham above the regional average

Lewisham priority action 4: Maximising our roles as Anchor organisations

Workforce and Employment

Working together we will establish joint initiatives to attract and retain staff; provide opportunities for shared career pathways; promote health and care careers; establish staff health and wellbeing programmes and address workforce inequalities

How we will secure delivery

Actions for 24/25

- Complete programme to support health and social care staff wellbeing
- Design Health and Care Jobs Fair to raise awareness of local employment opportunities in entry level and support roles
- Develop an entry level apprenticeship scheme for therapy support workers
- Pilot workforce planning tool

Actions for 25/26

- Deliver further careers insight and employment opportunities programmes
- Extend the apprenticeship programme
- Develop partnership Black, Asian and Minority Ethnic communities leadership development programme
- Implement outcomes of workforce planning tool analysis

Intended outcomes in 5 years time

Vacancy rates will be reduced by at least 50%
75% of posts will be filled after first advert
An increase in Black, Asian and Minority Ethnic communities representation at senior management level.

Lewisham priority action 5: Achieving financial sustainability

Achieving financial sustainability

In partnership we will work to optimise the use of resources, align financial planning and maximise financial resilience to system pressures across the local Health and Care System

How we will secure delivery

Actions for 24/25

- During 2023/24 we will work collaboratively across the LCP to better understand how improvements in outcomes and experience in defined population groups can support sustainability of services, individual organisations and the system as a whole. We will link this in the first instance to our work being undertaken within our Older People and Frailty Programme.

Actions for 25/26

- Building on the work of 2023/24 described above, the LCP will aim to have agreed service improvement and associated service changes to achieve improvements in outcomes and experience and shared financial planning.
- Any contractual or financial arrangements that need to change will be agreed with local health and care partners and with SEL ICB.

Intended outcomes in 5 years time

The LHCP aims to have implemented plans for delivery of patient care which optimise the use of financial resources and ensure delivery of services which meet the needs of the local population and are sustainable in the long term.

The LHCP aims to have maximised financial resilience to system pressures through sharing of information to underpin activity and financial planning, and to better inform timely decision making around deployment of resources.

Lewisham enablers (1)

Workforce

Our workforce is our strongest asset but locally we continue to face recruitment challenges and staff shortages across the health and care system. Therefore, a programme of activity around workforce and employment is a key priority for Lewisham. We want to enable further collaboration and integration of workforce plans and aim to improve succession planning, increase the use of joint appointments, adopt joint recruitment approaches and have the flexibility to rotate roles across the local and SEL system.

We believe that there are opportunities to create more entry level roles into health and care and use the assets and resources we have as local organisations to benefit the communities around us.

As a partnership we are also committed to working together to improve the health and wellbeing of everyone who works within the partner organisations and to be a compassionate employer.

Digital

Across the partnership we will seek to use technology to best effect, improving communication between health and care professionals, supporting integrated record sharing and providing co-ordinated care to residents, patients and service users more effectively. We will work with the ICS Digital Programme to:

1. Improve interoperability between health and care data systems maximising the use of our population health and care data management system
2. Embed a consistent approach to data sharing across ICS and across local organisations, particularly when involving third party providers (Voluntary, community and social enterprise sector)
3. Increase the use of authorised health technology to promote self-care and to help manage long term conditions
4. Increase the use of technology and flexible approaches to consulting to enable same day urgent care access for those who can/will use technology and to free up traditional capacity for those who cannot
5. Explore digital platforms which can accommodate video conference capabilities to provide direct consultations to patients/service users
6. Work across the system to reduce digital exclusion

Lewisham enablers (2)

Finance

The ongoing financial constraints across Lewisham are an impetus for change and we are working together to overcome the present and future financial challenges.

By working more closely and transparently, we aim to better understand how improvements in outcomes and experience in defined population groups can support the sustainability of services, of individual organisations and of the system as a whole. We are linking this through our system intentions to work being undertaken within our Older People Programme and treatment of hypertension.

Achieving financial stability is a key local care and health partnership priority.

Estates

As partners we want our estate to support service transformation and collaboration and integration across the health and care system. Our buildings should enable us to work smarter and more effectively in delivering community based care and contribute to the improvement of patient experience and satisfaction.

We will ensure that our estates plans align with the South East London Estates Strategy and the PCN estates reviews. This work will be supported by the Local Health and Care Partnership's estates forum which brings together partners across the system. We will work with our clinical colleagues to ensure alignment of estates plans with clinical strategies.

Our programme leads will identify the estates requirements within programme and to ensure successful achievement of delivery plans.

Lewisham borough: Examples of local delivery of SEL priorities

Lewisham borough delivery of SEL pathway and population group priorities

Lewisham's Local Care Plan sets out our direction of travel as a partnership and outlines the priority areas on which we will focus over the next 1 – 5 years in support of the programmes, pathways and priority target groups identified in SEL ICB's Joint Forward View. Examples of how we are contributing at a local level to the overall aims of South East London are shown below.

Mental Health

The 'Should I Really Be Here' (SIRBH) initiative aims to identify and test community-based approaches that people say will help support early help-seeking & support for males, ages 16-25 who identify with African-Caribbean/dual or multiple heritage background. The initiative will improve ways of accessing this target group, ways of engaging and ways of supporting to make positive contribution to wellbeing. the project is currently in the scoping phase with partners and is intended to go live in 2024/25.

Access to Black Therapists Pilot – A pilot has been put in place where Wellbeing For Us will offer access to black therapists for talking therapies. The offer will also include group work for non-Eurocentric therapeutic interventions.

South London Listens and Goldsmith's University project - partnership currently being mobilised to increase the number of adults being able to access counselling and CBT, where access to counselling will be available through student placements and work closely with Be Well Hubs and Champions.

Population Health Management

Through Lewisham's integrated Population Health Management System, we use data from various health and care systems to improve the health of Lewisham's population, by understanding general trends and needs, and identifying those individuals to target for improved care.

By interrogating the data we can better support individuals by identifying those who we believe are at risk of a particular illness or condition and improve the way in which we plan services.

We are currently managing around 20 active projects, some examples being:

- Looking at overlapping patients across AF, HT, CKD and Diabetes to understand where we can approach patients collectively rather than for singly for one condition and to establish where patients may not have yet been tested for the other conditions
- Proactively managing older adults.
- Case finding those at risk of HT in the next 5 years time
- Waiting list dashboard management by picking out those we can optimise for surgery

Lewisham borough: Examples of local delivery of SEL priorities

Maternity – Mindful Mums

The ICS and local authority jointly commission Bromley, Lewisham and Greenwich Mind to deliver the Mindful Mums and Being Dads programmes, which are peer–led programmes of support with mental wellbeing and resilience for expectant and new parents.

The programmes have been successful in improving wellbeing, increasing resilience and reducing isolation amongst parents with emotional wellbeing needs in Lewisham.

Based on this success, the provider is currently piloting new programmes aimed at meeting the specific needs of new parents from ethnic minority backgrounds, young parents, and parents that identify as Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+).

Additionally, Lewisham Maternity Voices Partnership, the ICS and Lewisham and Greenwich NHS Trust have recently been shortlisted for an award from the Royal College of Midwives for their partnership work on Cultural Humility in Maternity Care. They developed a Quality Standard which sets out six principles for good and safe maternity care from the perspectives of Lewisham women and birthing people of diverse cultural backgrounds, and aims to increase the involvement of Black, Asian and minority ethnic service users in quality assuring services. A short film was created which can be viewed here: Quality Standard for Cultural Humility in Maternity Care - YouTube

Urgent and Emergency Care - Home First

Since May 2022, participants from across health, social care and the voluntary sector in Lewisham have co-designed and started implementing a blueprint for change that will enable the Lewisham system to sustainably support people being discharged home.

By working together, the Home First programme has been broken down into 90 day sprints. Every 90 days the group come together to review the achievements of the previous 90 days, decode the collective learning, and plan for the next 90 day sprint.

By working in this way and developing joint actions and initiatives we have implemented systems to identify patients with complex discharges earlier, reduced intermediate bedded care LOS and improved intermediate bedded care patient outcomes. Following intervention and establishment of a LLOS group, the number of patients with an extremely long length of hospital stay has reduced significantly.

In the forthcoming period our priorities are:

- Improvement in issues causing delayed discharges under pathways 1 & 3
- Develop a “one team” approach across our teams who support people being discharged home in Lewisham
- Better alignment of capacity to demand in post-discharge enablement & therapies

Partnership Southwark Overview

Our population

We have 307,000 residents. Our population is comparatively young, with the average age (32.4 years) almost two years younger than London, and almost seven years younger than England. 39% of residents are aged 20-39, compared to 26% in England. We have a large Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+) population – over 8% of our adults compared to 4% in London and 3% nationally. Latest estimates indicate that 51% of people living in Southwark have a white ethnic background compared to 81% nationally. Our diversity is greater among our children and young people, with roughly equal proportions of young people from white and black ethnic backgrounds. The latest population projections suggest that the population will continue to grow, with over 17,000 additional people living in the borough by 2030. Population growth is set to take place across almost all parts of the borough, but the largest increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle.

Health outcomes for our population

Strengths

- Residents are living longer and healthier lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by half since 2001, narrowing the gap with England.

Challenges

- 1 in 4 children in reception are overweight
- 15,000 emergency attendances by children under 5 per year
- Second highest level of STIs and HIV in Eng.
- Around 2,400 admissions for ambulatory care sensitive conditions per year
- 55% of cancers diagnosed at stage 1 or 2
- Around 55,000 adults have a common mental health condition
- ASC provides support to 1500 unpaid carers
- Amongst the highest rate of emergency admissions for falls in London
- Highest rate of emergency admissions for dementia in London

Inequalities within our borough

- Approximately 21% of Southwark's population live in communities ranked within the most deprived nationally. This increases to 23% among those aged under 18.
- Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark particularly communities in Faraday and Peckham wards.
- Residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services
- Southwark has the fourth highest LGBTQ+ population in the country, and we know that this group can suffer discrimination for access to services, as well as poorer health outcomes
- Southwark has the highest number of asylum seekers in accommodation centres in SEL. The population may have experienced conflict, violence, multiple losses, torture, sexual assaults, and/or risk of exploitation, as well as experiencing issues accessing health and care services.

Partnership Southwark

What we've heard from the public

- Engagement has been undertaken through:
  - Southwark Stands Together
  - South London Listens
  - Southwark 2030
  - Partnership Southwark workshops around the partnership's engagement approach to priority workstreams
  - Partnership Southwark outreach work
  - Centric and Social Finance work with both Partnership Southwark and public health

- The high level feedback has been as follows:
  - Discrimination and structural racism are impacting access and experience of services
  - Vulnerable people are falling through gaps in support
  - Mental health and wellbeing for children, young people and adults is a priority
  - Services need to be culturally appropriate and accessible for all
  - Concern regarding rising cost of living, food poverty and affordable housing
  - Local communities and community autonomy is high valued
  - Power sharing between communities and services is needed when considering, designing and testing plans and services

Southwark - Our objectives

Our key objectives - what we want to achieve over the next five years

The top things that we want to achieve over the next five years are outlined in our Joint Health and Wellbeing Strategy, 2022-2027. These have been committed to by all Partnership Southwark members:

A whole family approach to give children the best start in life	Healthy employment and good health for working age adults	Early identification and support to stay well	Strong and connected communities	Integration of health and social care
We want to ensure all families in Southwark receive access to good-quality maternity care, reducing differential outcomes between population groups. We want to build resilient families through holistic care in pregnancy and early years, improve mental health for the whole family and keep children safe through early identification and support for families at risk of adverse childhood experiences.	Across the health and wellbeing economy, we want to increase access to good quality jobs, promote health through employment support, enable people to lead healthy lifestyles, building on the already strong work on the Vital 5, and promote and maximise access to leisure and physical activity.	We want to ensure services prevent ill-health through early detection. We want to help people stay well through falls prevention, support for recovery from hospital admission, and wellbeing support for carers and families. We will have an enhanced focus on communities and neighbourhoods with poorer health to ensure better uptake of prevention and services to manage long-term conditions	We want to ensure local people shape their local areas and services. We want to ensure that services are accessible to the most excluded groups and reduce social isolation and loneliness. We will develop strong collaborations between statutory services and the voluntary and community sector, undertake targeted work to remove barriers to services and focus work on addressing loneliness.	The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work. By bringing NHS, council and voluntary and community organisations together, we can define the shared outcomes we want for our population and ensure the right leadership, accountability and oversight to support our work.

Southwark - Our priority actions

Our priority actions

The following priority actions demonstrate how we will deliver our objectives, and is also be detailed in our local Health and Care Plan.

Strategic collaboration

Southwark – Our progress to date

Key Successes in Delivery in 2023/2024

Increased maturity of Partnership Southwark as an effective driver of integration including:

- agreement of the Southwark Health and Care Plan and the strengthening of associated programme arrangements for Start, Live, Age and Care Well
- concrete progress in priority areas including delivery of mental health teams in schools, 1001 days and vital 5, hypertension and cancer screening
- lower limb wound care model developed reflecting world class best practice
- development of collaborative neighbourhood working in mental health
- deepening integration of health and social care as reflected by new structure with joint place executive lead
- significant investment in health inequalities fund targeting improved outcomes for marginalised communities
- focus on prevention through a series of successful community health and wellbeing events in schools and community centres promoting uptake of vaccinations and healthy behaviours in our most deprived neighbourhoods
- progress on the Community Southwark 'State of the sector report' recommendations relating to funding, estates and engagement
- transfers of care patient experience project using innovative ethnographic research approach provided valuable insights for discharge improvement

Key Challenges in Delivery in 2023/2024

System-wide demand pressures and financial constraints impact on our capacity to develop and deliver change programmes and invest sufficiently in prevention. Specific challenges included:

- adult mental health placement pressures leading to significant overspend across health and social care
- Children and young people's mental health 52 week waits reduction target impacted by growing demand
- supporting patient flow by ensuring sufficient community capacity to enable discharge from hospital
- financial constraints impact on potential for funding new models of care and programme resources
- data limitations arising from EPIC implementation and lack of analytics capacity impacted on development of comprehensive outcomes frameworks and population health approaches including Core20plus

Learning and Implications for Future Delivery Plans

- we need to further deepen our integration at place level to drive joined up solutions that help reduce demand on our health and care services through integrated neighbourhood models providing proactive multi-disciplinary care need further development
- we will build on the learning from our 2023/24 Health Inequalities Fund programme to improve impact and ensure robust monitoring and evaluation arrangements
- continued need to focus our joint investments supporting discharge from hospital and avoiding admissions to support the urgent and emergency care system
- we have established an approach to working together on our organisational Green Plans which we want to incorporate further into our decision making
- the management cost reduction process has created uncertainty about support for ongoing programme plans which requires careful planning
- we are working to develop a plan to put in place from April 2024 shadow delegation of the health aspects of our joint management of mental health complex care placements within a framework agreed across partners, provided by South London Partnership, our local mental health provider collaborative

Southwark priority 1: Strategic Collaboration

Strategic collaboration – Mental Health

In Partnership Southwark, we are committed to reaching a place of true integration across the system. We recognise that this will not happen instantly, and will require significant work from all our partners in order to achieve our goals. We want to embed ourselves in communities, working at a neighbourhood level to support residents, identified populations and tackle inequalities. Residents are telling us that the system is too fragmented, with conflicting priorities and inequalities in terms of access and experience. As the demand for services increases, a lack of integration between services is going to exacerbate these concerns and mean that we are not giving the right focus on the outcomes for residents. We are already in a collaborative space for Children & Young People and Adults (particularly CMHT) due to the work which is being delivered by partners. We want to make the most of this momentum to explore how a strategic collaborative could work, including through examination of aligned funding models delivered through integrated provider arrangements focussed on delivering agreed population outcomes.

How we will secure delivery

Actions for 24/25

- Undertake engagement workshops with key system partners. The aim of this work is to map what is already taking place, consider what we could do differently and think about a more formalised strategic form that could overset this, leading to better performance and outcomes across the system. This will help to set our level of ambition for the strategic collaborative and create a delivery structure for getting there (e.g. an overarching steering group with a number of strands underneath this which feed in, such as MH Placements and substance misuse).
- Investment of health inequalities funding in grassroots organisations to support those with mental health issues

Actions for 25/26

- To be determined based on outcome of 2024/25 discussion with partners.

Intended outcomes by 2028

- To reduce numbers of people reaching crisis point and give prompt and appropriate support for people in crisis
- To increase the number of people able to live independently
- To increase numbers of people living in stable and appropriate accommodation
- To improve mental health outcomes for people from black communities in Southwark
- To improve physical health for people with mental health issues
- To increase numbers of people in education, training, volunteering or employment

Southwark priority action 2: Start Well 1001 Days Programme

1001 Days Programme

Within the overall Start Well workstream covering residents aged 0-25 years old, a specific programme focused on the first 1001 days of life (conception to 2 years old) has been identified as a priority within Southwark. The programme is specifically targeted at families in the Camberwell Green area and is utilising a neighbourhood approach to allow for tailored and creative approaches to meeting need. Camberwell Green has been selected as the initial area of focus as it is an area of high deprivation (most of the area is in the second most deprived quintile nationally) and:

- evidence shows that socioeconomic deprivation increases the risk of maternal perinatal mental illnesses,
- 16% of mothers living in Camberwell Green did not breast milk feed at all, 31% partially breast fed compared with 11% and 24% respectively for mothers in the second least deprived quintile (maternal population in the least deprived quintile is very small),
- Camberwell Green has the highest prevalence of obesity in Reception aged children in the borough.

Camberwell is also a community asset rich area with strong, well embedded, and trusted community groups and leaders making this an ideal area to trial the resident led, neighbourhood targeted programme approach. Proposed focuses for the programme are perinatal, parental and infant mental health; looking at local workforce development; and breast feeding and infant nutrition.

How we will secure delivery

Actions for 24/25

- Agree the core essentials of the 1001 Days Approach and steps to setting up within other neighbourhoods to enable spread and scale the programme.
- Select next neighbourhood(s) to launch the programme within.
- Map and initiate relationship building with key partners in selected neighbourhoods.
- Launch streamlined listening phase, and agile approach to development of interventions plan in chosen neighbourhoods.
- Share key learning from neighbourhood working & resident led approach with system and wider partners.
- Continue to build and maintain relationships with residents and community groups in focus neighbourhoods and across system partners.
- Explore needs and opportunities for data sharing between system partners.
- Link with existing planning around workforce development to align plans.
- Integrate the 1001 Days approach and learning with relevant system programmes to ensure sustainability.

25/26

- By 25/26 we expect to be ready to have the 1001 Days Approach actively working in all neighbourhoods of the borough and fully integrated into existing programmes of work such as the Family Hubs programme.

Intended outcomes by 2028

Through the areas of focus that have been proposed, our aim is that:

- By 2027, all women and their partners who live in Southwark will feel equipped and empowered to provide the best start in the first 1001 days of their children's lives through the provision and access of family-centred, integrated support and services that meet their specific needs.

Southwark priority action 2: Start Well Children and Young People Mental Health

Children and Young People Mental Health

The Southwark Partnership is known to serve children and young people at an elevated risk of mental health issues. Southwark young people are at a higher risk than the national rate of being first time entrants to the Youth Justice system, of homelessness and of attendance at Accident and Emergency. There are high rates of prevalence of being at risk of the 'toxic trio' (adult mental health, domestic abuse, alcohol / substance misuse) being amongst the highest rates in the country where all three risk factors are present.

How we will secure delivery

Actions for 24/25

- Active management of waiting lists and reduction in waiting times for service users
- Improving equality of access
- Supporting 16-25 year olds to access the right support
- Improving parental mental health to keep families strong linked to 1001 programme
- Support for Southwark schools – universal and targeted offer for pupils, staff and parents
- Supporting children responding to trauma and distress and crisis stepdown
- Supporting the emotional and mental wellbeing of young offenders (including prevention)
- Develop a seamless pathway for children and young people with eating disorders
- Ensure that the mental health needs of those attending Accident and Emergency are better met
- Improving the responsiveness of perinatal mental health support with link to 1001 programme

25/26

- On going delivery of 2024/25 programmes

Intended outcomes by 2028

- Young People are able to access holistic services which are structured around need rather than age
- Southwark system can demonstrate seamless, system wide collaboration in a joined-up vision and clear, sustainable investment through transparent decision making and collective accountability
- Families are able to access support for their mental health and wellbeing in a way that supports improved family outcomes
- Resilient and representative groups able to improve service users experience
- Improved connectivity and pathways between SEL commissioned services and local services to increase uptake
- Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access emotional wellbeing or mental health services
- Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences

Southwark priority action 3: Live Well
Community Mental Health Transformation

Community mental health transformation

Working collaboratively with residents, Voluntary, community and social enterprise sector (VCSE) and local authorities, expand the provision of early intervention and community-based mental health support offers for adults through both statutory and non-statutory organisations, and across health and care services.

How we will secure delivery

Actions for 24/25

- Embed service user and carer involvement into service design and review across the system e.g. through the launch of a Service Users Network.
- Neighbourhood team structures designed, tested and implemented, incorporating multi-disciplinary teams and capitalising on the combined resource of MH professionals across primary care, secondary care and local VCSE professionals.
- Review of referral processes between CMH services and secondary care with a view to streamline and reduce rates of unsuccessful referrals. Work with service users and residents with lived experience to ensure simple points of access across the system for self-referrals and referrals from other professionals.
- Develop improved relationships and systems for SMI health checks to take place with the most appropriate health care team.
- Finalise a proposal to measure outcomes across the system using the national outcomes framework metrics and existing system measures.
- Link with children and young people's Emotional, Wellbeing & Mental Health Steering and Delivery Groups to join up work around young people's transition from CAMHS to adult services

Actions for 25/26

- The 3-year implementation period of the CMH Transformation programme formally concludes on the 31st of March 2024 with service models incorporated into business as usual from 2024/25 onwards.
- Based on programme feedback explore preventative community based early support (health inequality fund investment) via grassroot organisations to reduce the number of residents experiencing mental health issues & requiring mental health crisis services.

Intended outcomes by 2028

- Each neighbourhood in Southwark to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population.
- Reduction in the inequality of service users' access, experience and outcomes around CMH services. In particular, Southwark's Black, Asian and Minority Ethnic communities and other groups that have previously been underserved.
- Care is continuous: service users have an 'easy in, easy out' experience when stepped up/down between primary and secondary care and vice versa.
- Mental health care is largely preventative and reduces the number of residents experiencing a mental health crisis.
- Links with the VCSE are improved, service-users are able to get support with wider issues such as housing.
- Improved mental and physical health and reduction in mortality, particularly among residents with SMI.

Southwark priority action 3: Live Well Vital 5

Vital 5 – exploring a whole family approach

The Southwark Vital 5 programme aims to increase prevention and early detection in these five areas, as we know that identifying, recording, and sharing the Vital 5 data between all relevant partners and our patients, and acting on the results would make the biggest difference to people's health and wellbeing and to the sustainability of health and social care. The Vital 5 programme will enable residents to know their Vital 5 status through accessible screening, having access to pathways of care and intervention that proactively meets their needs, reducing variation and inequity.

How we will secure delivery

Actions for 24/25

- Lead the aims and objectives of the vital 5 programme within the Live Well workstream and strengthen alignment at borough level with SEL Vital 5 programme
- Increase uptake of NHS health checks by those with greater risks along with risk reduction interventions
- Work with colleagues across South East London and in Southwark to understand and share good practice and develop recommendations for piloting locally.
- Complete evaluation of digital health kiosks in the community.
- Embed agreed service delivery model incorporating the awareness and screening of the Vital 5 in the public health promotion outreach programme.
- Work jointly with primary care and data leads to facilitate a viable solution to enable safe data transfer of Vital 5 measurements and conversations into resident's primary care records.

Actions for 25/26

- Building on previous year's work, lessons learnt and round up
- To be agreed in Q3 24/25
- Link health & wellbeing events to the Health Inequality funded grassroots organisations to accelerate focus on prevention through a series of community health and wellbeing events in schools & community centres promoting uptake of vaccinations & healthy behaviours in our most deprived neighbourhoods

Intended outcomes by 2028

Southwark system in collaboration with SEL providing a seamless, system wide joined-up approach to delivery to screening and interventions, risk factor documentation and communication between services.

Local ambition:

- Residents in Southwark to be aware of what the Vital 5 is, and what their own measurements are
- A minimum of 55% of NHS Health Checks are undertaken by residents from Black, Asian and other ethnic minority backgrounds
- Fully embedded "Making Every Contact Count" approach to maximise interactions with patients across health and care system
- To provide culturally sensitive services for residents, offering easily accessible and exciting options for improving individual and family health.
- To have improved BMI monitoring that has enabled targeted action to reduce obesity rates

National ambitions:

- 80% of the expected number of people with high BP are diagnosed by 2029
- 80% of the total number of people diagnosed with high BP are treated to target as per NICE guidelines by 2029

Southwark priority action 3: Live Well Cancer

Cancer

The reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

We also aim to improve quality of care in the community for those living with cancer by promoting community services, social prescribing and the importance of physical activity.

How we will secure delivery

Actions for 24/25

- Utilising the inequalities funding over the next financial year, to ensure a targeted approach to inequalities reduction.
- Working with public health colleagues to align project aims to their JSNA documents.
- Ensure we use a people centred approach, conducting community engagement when necessary for successful project delivery.
- Work with South East London Cancer Alliance colleagues to ensure we are aligning with their forward view and strategic aims to ensure a joined-up approach.
- Working through project actions and forward view in our council and ICB cancer working group.
- Working closely and sharing learning with other boroughs in SEL.

Actions for 25/26

- As above

Intended outcomes by 2028

Our 5 year aim, is to ensure that Southwark is benchmarked similar to SEL, London and national levels of uptake. Furthermore, we hope to be well underway to achieving national targets for cancer screening across the breast, bowel and cervical programmes. Whilst we aim for screening rates to increase, we are keen to ensure an even coverage of uptake across Southwark with a greater reduction of inequalities across the borough.

In addition, we hope for high quality cancer care reviews to be conducted routinely in the community. The promotion of local services, support and the importance of physical activity will be a routine part of cancer care in the community.

Southwark priority action 4: Age & Care Well (1)

Age & Care Well – Programme priorities

With an eye to Prevention, strength-based approaches and self-management, the aim is to help older people to remain active, productive, independent and socially connected for as long as possible and recognising whether it's between hospital and home or from one community services to another, services need to be consistently joined up and responsive to the individual needs of older people. The specific areas of focus will be scaling up the lower limb wound care model for Southwark, improving care and support for people with frailty through the development of an integrated model, and better coordination of services for those living with dementia. We also want to align with the ambitions of the Community Mental Health Transformation model to address mental health of older people, aligned with neighbourhood development initiatives.

How we will secure delivery

Actions for 24/25

- Develop and test an improved integrated frailty pathway and develop recommendations for neighbourhood prototyping to test new service models
- Embedding service user and carer involvement in the design of new models of care
- Developing an outcomes framework which takes the system, workforce and individual service users and carers into account
- Implementing phase 1 & 2 of the lower limb wound care model that was successfully developed by the workstream in 2023/24, embedding new roles to develop a system led, more comprehensive model of practice
- Working with colleagues across SEL and in Southwark to understand good practice Align the Falls implementation and dementia care with the frailty pathway to help ensure a holistic approach
- Ensure the views of carers are fully reflected in the development of new care pathways

Actions for 25/26

- Develop the frailty workstream including technology as an enabler of integrated services to older people incorporating telehealth, telecare, equipment and other digital solutions
- Working with community mental health services to ensure older people's mental health services are optimised in the revised neighbourhood model.

Intended outcomes by 2028

- There is improved access to specialist and comprehensive physical and mental healthcare & wellbeing services and to community activities where required.
- We will have an integrated lower limb wound care pathway which achieves better outcomes, including:
  - Better quality of care
  - Proactive management
  - Higher detection rates
  - Early intervention approach and reduction in crisis management
  - Fewer hospital admissions
- We will have implemented a transformed frailty pathway focusing on prevention and proactive care which covers mild, moderate and severe frailty. The model will be aligned to our improved dementia care pathway.
- We will have fewer avoidable admission to hospital for older people in relation to falls.
- Neighbourhood development approaches ensure good connectivity across the system.
- The Community Mental Health model will include older people, stopping people reaching crisis and ensuring they receive care closer to home.
- We will be able to demonstrate improvements across the range of measures in the outcomes framework that we have developed.

Southwark priority action 4: Age & Care Well (2)

Age & Care Well – Workforce Development

The workforce across the health and care sector is a major priority and challenge for our local system, including individual providers as well as the large institutions. There is a keenness to optimise interprofessional practice and integration opportunities through neighbourhood approaches, also working innovatively to develop new and diverse roles and career pathways, apprenticeships and connecting further with communities and capitalising on the skills and passion of local people in Southwark.

How we will secure delivery

Actions for 24/25

- Progress and test neighbourhood service delivery
- Ensure workforce consideration are central to all workstreams, and reflected in the learning cycle of development, prototyping and evaluation of service improvements, including a focus on workforce equality and diversity objectives
- Maximise local employment opportunities, including through consideration of apprentice roles and VCSE roles
- Maximise opportunities for career development and advancement in integrated service models
- Establishing links with wider workforce planning strategies in Southwark, SEL and nationally and collaborate where it makes sense to do so
- Further developing neighbourhood champions to support healthy living initiatives and develop skills/professional opportunities for the community

Actions for 25/26

- Seek opportunities to fund innovative posts and VCSE roles supporting integrated services
- Ongoing development and delivery of workforce development plans

Intended outcomes by 2028

- We will have implemented our workforce initiatives which include a range of Voluntary and Community Sector partners to create a sustainable local workforce.
- There will be a proactive collaboration and recruitment into local care & health sector with local people (placements, apprenticeships, local training/engagement opportunities, tailored support in deprived neighbours to support into work)
- Establish neighbourhood networks of champions who outreach into their local communities.
- Evidence of interprofessional practice – which moves beyond multi- disciplinary approaches.
- We will have made demonstrable improvement in recruitment and retention rates in Southwark's services for older people

Partnership Southwark: local delivery of SEL priorities

Partnership Southwark delivery of SEL pathway and population group priorities

It is recognised that delivery of our local forward view priorities depends on a combination of place level and system-wide plans. For a number of key pathways, population groups and enablers the benefits of geographical scale are recognised and SEL programmes are in place, and Southwark is committed to ensuring its place-based plans are fully aligned to these. This alignment is particularly important where there are substantial system level and place level workstreams such as in mental health, children and young people and primary care. All of our priorities are partnership focused and resident centred, working across Partnership Southwark to understand the best outcomes for the borough.

Learning Disability & Autism

Southwark has a Learning Disabilities and Autism local lead role that supports the local delivery of the SEL programmes objectives, by, for example:

- supporting cases where mental health has deteriorated and there is a risk of admission to an inpatient unit
- operation of Dynamic Support Registers to identify risks of admission
- discharge planning for people who are inpatients in mental health hospitals back into community living with range of appropriate support
- inputting into SEL operational and strategic LeDeR pathways

Cancer

Our focus is reducing late diagnosis rates through the reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

Urgent and Emergency Care

Southwark has a key role to play in helping maximise system capacity by reducing the number of preventable admissions, and ensuring the prompt discharge of people from hospital who are medically fit for discharge. Southwark's Better Care Fund and the associated Adult Social Care Discharge fund will be expanded in 2024/25 and set out the approach to providing integrated out of hospital health and care services that deliver these objectives. A discharge improvement programme will be part of the approach. Southwark will also seek to ensure we consistently meet or exceed the 70% 2-hour urgent community response standard.

Primary care

Working in neighbourhoods will provide the population access to specialist care from a range of services in an accessible way, both in the local area and within a shorter waiting time. Practices working together in the neighbourhoods will enable a supportive environment for staff, clinical supervision, development pathways and opportunities within the workplace. This in turn will mean that staff retention will increase and bolster the workforce. An example from a patient perspective would be presenting at the practice with a musculoskeletal symptom and being offered a first appointment within 1 week with a physio. Being seen by the right person at the right time would then prevent further decline in symptoms and with an early treatment plan lead to better outcomes for the patient.

Southwark enabler requirements (1)

Workforce

Our Local Care Partnership has a demonstrated record of developing new roles that drive forward integration, for example our mental health support workers that bring together primary and secondary care. The individual members of our partnership are also at the leading edge of educating and training our future workforce.

As a partnership our aim is to continue to develop innovative roles and ways of working that support integration, including multi-disciplinary teams, and make best use of our constrained resources. We also have an ambition to explore areas of staff development that might benefit from doing more together, for example apprenticeships, where each partner has a successful programme.

As workforce is one of our system's most pressing issues and for important practical reasons, many of our partners look beyond our borough-level arrangements for collaboration and joint working on workforce. We would welcome a productive dialogue between the partnership and system wide forums on workforce plans, we would also like to see system collaboration inculcating a supportive environment for the cross organisational ways of working that are at the heart of integration. Issues relating to key worker housing also to be considered.

Estates

The ICS South East London Estates Strategy and SEL PCN Estates Reviews identify our current priorities and baseline for the NHS community and primary care estate in Southwark. As a rapidly growing borough these priorities include development opportunities arising from regeneration and renewal.

The Local Care Partnership has a Local Estates Forum with wide engagement from partners and the SEL Estates team work alongside the Forum to maintain relationships and seek out opportunities for joint working.

The focus for development for Partnership Southwark is to use this work and priorities to:

- support integration and effective use of the Southwark estate. This includes making the best use of the opportunities presented by the growth in the health estate, and to make use of wider opportunities from the innovative use of the collective estate in Southwark.
- Continue to make progress towards the goal of reducing estates related emissions by 80% by 2032 in line with the ICS Green Plan. This will be achieved by optimising the use of our estates and identifying resources to enable our buildings to move towards net zero carbon emissions.

Southwark enabler requirements (2)

Digital

Contribute towards the delivery of the ICS and ICB digital plans and strategies; including roll out of the SEL Digital First programme, stock take of GP practice digital tools, review of social prescribing software, and promoting the use of the NHS App.

Provide proactive support for the development of business intelligence analytics to ensure robust data collection, to ensure the availability of data aligned to the achievement of national and local ambitions, and to feed into planning activities, including local identification of opportunities to tackle health inequalities.

Provide support to GP practices and the Southwark Primary Care Digital Group to inform a view of the digital estate across both Primary Care Networks (PCNs); ensure compliance with information governance across the estate; and replace outdated digital infrastructure so that the workforce can access a person's health and care record, and other information, with ease and from any location.

Deliver workforce training to ensure development and retention of organisational expertise in the use of digital tools, including ongoing work to embed Atamis contracts management and oversight of the procurement pipeline, improved supplier management, and compliance with statutory requirements.

Finance

Contribute towards delivery of the ICS and ICB financial plans as set out in the Medium Term Financial Strategy (MTFS). Ensure Place delivery of a balanced financial plan and efficiencies expected as an ICB.

Partnership Southwark has an ambition to have an integrated financial plan and a strong financial standing that will enable us to deliver our collective priorities. Ensuring a collaborative approach to planning and contracting, as well as delivery, the Partnership recognises the very real challenges the local health and care economy faces and the need to work together to find solutions to jointly manage these issues across the LCP. Working collaboratively as six SEL places to manage financial risks across boroughs.

We are working to ensure Partnership Southwark LCP members (ICB, council and provider partners) plan and deliver services together in transparent ways as close to local people's homes as possible to deliver social value and mitigate our collective and individual financial risks for the benefit of the whole system.

We are working to increase ownership and accountability at a local level to achieve our shared priorities. This will provide opportunities for improvements by working in collaboration to redesign services, including with our local VCSE and residents.

Build on the local provider collaborative model for Mental Health. Implement the new Provider Selection Regime for procurement of NHS contracts.

Southwark enabler requirements (3)

Sustainability

Individual organisations will implement their green plans in line with the Partnership Southwark Environmental Sustainability Policy Statement agreed at the strategic board in January 2023. For the ICB this specifically includes the commitments in the ICS Green Plan and the Primary Care Green Plan.

A Partnership Southwark green champions network will be established for sharing best practice and identifying opportunities for collective working. A commitment to ensuring that sustainability implications are systematically considered in all decision making will be implemented.

Our ambition is to have made clear progress towards the NHSE targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2032 and the council's climate change plan and target for a carbon neutral Southwark by 2030. This will be measured through progress on key domains of the ICS Green Plan including workforce and system leadership, air quality, travel and transport (staff and patients), estates and facilities, sustainable models of care (including prevention and lean service delivery), digital, medicines (20% of NHS carbon footprint), supply chain and procurement, food and nutrition, adaptation, green spaces.

Quality

The role of Partnership Southwark in promoting quality was discussed at a board development session in February 2024. The approach to quality within individual organisations was considered and the best approach to adding value through the partnership was explored.

There was consensus that the initial focus needed to be on quality within the health and care plan priorities, for example within the frailty deep dive and the continued development of the health and care plan outcomes

We will continue to build a community of learning and shared focus on quality that takes full advantage of the experience and skills of our diverse partners to help quality improvement drive our programme of integration and that supports a shared accountability for the wellbeing and experience of the population in their interactions with our services. This work will be aligned to our Health and Care Plan priorities, the needs and experiences of our population and underpinned by collaboration and mutual support between services.

Southwark enabler requirements (4)

Medicines optimisation

Medicines optimisation is a key golden thread that runs through all our workstreams. Medicines prevent, treat and manage many illnesses and conditions and are the most common intervention in healthcare. Successful implementation of medicines optimisation relies on close collaboration and engagement, with shared-decision making between the residents in Southwark and all partners involved in medicines including all of our providers and community pharmacists who can play an important role in optimising adherence and reducing waste. Patient safety is paramount and should not be compromised at the expense of other factors influencing medicines choice. Clear communication is needed between SEL and place regarding delegation of this budget at place level.

Safeguarding

Safeguarding Adults at Risk and Children and Young People should be the golden thread that runs through all activities of the ICB/ICS. The above cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to recognise and promote the importance of a whole-family approach which is built on the principles of 'Reaching out – think family' to help protect all those at risk of harm, abuse or neglect. This approach is being embedded across all of our services, whilst focusing on developing evidence-based approaches to safeguarding practice that balances the rights and choices of an individual whilst also safeguarding children and young people from harm. Safeguarding is complex and challenging and our plans for the 5 years ahead within this Joint Forward Plan year are ambitious, but they are achievable and underpinned by strong partnership working across the health economy and wider system.

Communications and engagement

Public engagement is a key cornerstone of our approach in Southwark. Ensuring we dedicate resource and time to public engagement to work towards a co-production approach will be vital in securing the best services for people and communities in the borough. We will seek to have people and communities within the partnership at every level to support involvement at the Strategic Board and Executive team to ensure we are able to listen to and learn from lived and learned experience as we develop, maintain and monitor services.

We will use the information from this meaningful engagement to inform our work to provide health and care services. We will also apply it to our communications activity to support the development of Partnership Southwark and to make sure that people across the borough are aware of, and understand what support is available to them. Our communications and engagement activity will also strive to support our work to tackle health inequalities in the borough by involving people from a broad range of communities and tailoring our communications to communicate effectively with our key audiences using the channels most suited to their expectations and needs.

South East London Integrated Care System

SEL Care Pathway Programmes

Our SEL wide objectives and priorities for key care pathways and service areas

Prevention, Wellbeing & Health Equity

Overview of our current system

Health equity is the absence of unfair and avoidable or remediable differences in health among population groups; reducing health inequalities is at the heart of this work. Across South East London (SEL), there are known differences in life expectancy across and within our boroughs, linked to deprivation. Furthermore, physical inactivity, obesity and smoking rates are higher than the national average in a number of our boroughs. All these factors can be addressed by effective approaches to prevention. Many prevention services have been in place for several years and have delivered significant positive impacts for our residents including cervical screening, diabetic retinopathy and bowel screening as well as childhood immunisations and vaccination programmes. However, some service arrangements can feel fragmented, complicated and disjointed, resulting in variable uptake and our current service arrangements often miss the opportunity to integrate every conversation on health and wellbeing with a focus on early intervention especially around obesity, smoking and drugs and alcohol.

Strengths / opportunities

- Clearly defined ICB/ICP priority
- Clear evidence base and demonstrable positive outcomes
- Delegation to Local Care Partnerships for out of hospital services - Local Care Partnerships membership includes local partners, links to Health and Wellbeing boards and strategies
- Collaborations and relationships at hyperlocal level, including with Voluntary, community and social enterprise sector (VCSE) Community pharmacy clinical services such as vaccinations, BP checks, stop smoking and contraception services.
- Ways of working and relationships established during pandemic with communities
- PCNs moving to integrated neighbourhood teams
- Developing community pharmacy offer
- Strong partnership with local authorities and potential for much more
- Established Director of Public health network
- The delegation of dental, optometry and pharmacy to the ICB from NHS England

Challenges

- National agreed contracts which brings inflexibility
- Some commissioned services are income generating for some providers, for example flu vaccination, and therefore business models are predicated on receiving this income
- Changing behaviours, ways of working that have been in place for a considerable amount of time
- Reducing complexity
- Demand can often outstrip capacity resulting in increased waiting times
- System has moved to be reactive to manage demand especially with some of the national and regional vaccination programmes
- Aligning commissioning function as historically has positioned in different parts of the system
- Lack of trust with statutory services for some of our communities
- Securing the bandwidth, operationally and financially, to support a clear and systematic focus on prevention programmes

What we've heard from the public

Local people have repeatedly told us in engagement work across the system that they want a more holistic approach to their health and care, an increased focus on the 'whole person' and 'whole family', and that wider determinants of health need to be addressed. We heard this again during our engagement work to develop the SEL integrated care strategy and the SEL working with people and communities strategy 2022. We have heard that we must address access issues to prevention services, which are not just due to a lack of capacity but also due to a lack of suitable services for people, and that people want us to design and develop solutions in partnership with them. We have also heard we must work in partnership with the Voluntary, community and social enterprise sector.

Some of our prevention services

Most women go to their GP practice for their cervical screening while others attend a local sexual health clinic

Diabetic eye screening services are provided by a single provider in South East London in a variety of settings

Women aged 50-71 will often attend breast screening services at various community and hospital settings

Bowel screening home testing kits are sent out automatically

Annual health checks for people with severe mental health conditions will take place at either GP practices or community mental health services

Adults and young people aged 14 or over with a learning disability will attend their GP practice for their annual health check

NHS Health checks are available to those aged 40-74 at their GP or local pharmacy or at another community location

Most adults attend their community pharmacy or GP Practice for their winter vaccinations, such as flu, covid, pneumococcal and shingles

Children may attend their GP Practice for their childhood vaccinations and immunisations. School aged children often receive their vaccinations at school.

Our vision and objectives

Our vision

For all our residents to have the same opportunity to lead a healthy life, no matter where they live or who they are, through equitable, convenient and effective access to prevention and wellbeing services and support.

This vision is underpinned by a commitment to: 1. build trust and confidence with the communities we serve. 2. enable both NHS and non-NHS evidence-based interventions and services to be provided. 3. parity between mental and physical health. 4. take an 'all ages' life course approach. 5. focus on individual, family and communities. 6. span primary, secondary and tertiary prevention. 7. reduce health inequalities.

Our key objectives – what we want to achieve over the next five years in SEL

★ ICS Strategic Priority

Over the next five years, we want to:

1. **Establish a systematic prevention programme,** focussed on early detection and intervention and associated with the key population risk factors in SEL for both adults and children and young people (CYP), embedding targeted population health approaches.

2. **Establish a systematic prevention programme targeting patients with and at risk of developing long term conditions** to prevent the development of multiple or more severe long-term conditions.

3. **Define, develop and embed a population health management approach** to underpin the design and delivery of our health and care services across SEL, that targets and tailors interventions on a population basis

4. **Improve the way in which we partner with residents and community groups** to ensure we understand barriers and issues, resulting in the development and implementation of co-produced solutions which meet the needs of our diverse population and build trust and confidence.

Our principles

★ ICS Strategic Priority

Ways of working: Embedding Sustainability and Leveraging Opportunities

Ensure prevention is an integral part of every conversation on health and wellbeing with a focus on early intervention and not a standalone agenda for our residents and their families.

Working to one goal with one voice: a multi-system approach working with partners across organisational boundaries and in collaboration as we all need to work together to improve health and wellbeing in our communities.

Permission for and encouragement for innovation and creativity: to explore new ways of working and thinking more holistically about prevention for whole communities.

Freedom and funding to explore different approaches: at an ICB, LCP and hyperlocal level and to develop a plurality of approach and a responsive offer to population need.

Amplifying impact through an evidence approach: a commitment to continue to collect, evaluate and share outputs to ensure and to be able to evidence equitable access, value for money and the best use of resources.

Spotlight on whole life course

A focus on a whole life course: enable consideration of the critical stages, transitions, and settings where large differences can be made in promoting or restoring health and wellbeing.

Population Health Approach

Placing people at the centre of delivery: improving access for all to prevention services taking a holistic approach.

Core 20 plus 5 plus: targeting our approach and actions for this group of adults and children.

Systematic risk identification and intervention approach to tackling inequalities in health outcomes for populations.

Committing to community first and community driven approaches: enabling communities to take a driving role in the co-design and co-development of services.

Diversity, Equity and inclusion

Focus on equity at all stages: and therefore reducing the unfair, avoidable or remediable inequalities among our residents in SEL and focusing on root causes rather than effects.

Anti-racism and cultural humility: a commitment to tackling racism within our system and embedding cultural humility into our system.

Building strength through diversity: and therefore fostering innovation and problem-solving by pushing everyone to look at things from different perspectives.

Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1. **Prevention and Health Equity Principles:** Put our prevention, wellbeing and health equity principles into action by i) co-designing a SEL wide systematic approach to prevention focused on early detection and intervention and delivering inequalities priorities ii) establishing a multi-year VCSE partnership to build trust and confidence and support effective prevention and wellbeing services iii) embedding this approach across SEL including aligning operational planning to make prevention 'business as usual'.

2. **Actionable Insights:** Through the various networks and collaborations deliver and support the delivery of meaningful local engagement with communities, local groups and their representatives to enable them to co-develop and design future services and approaches. Ensuring that they are at the core of the programme especially those marginalised groups who's voices are not always heard.

3. **Increase the uptake of all prevention services**: Pilot innovative ways to engage local communities in accessing joined-up services including dedicated health and wellbeing centres, mobile units, outreach and community pharmacy. Providing opportunities for partners to deliver holistic services in creative and sensitive ways.

4. **Reducing confusion and complexity**: Produce a generic advocacy guide that can be adapted locally to inform and guide residents on what is available to them and when they become eligible for NHS Services, what is available in their local area through health and care, and other partners. Cascading this through our trusted partners in the community to ensure that this is accessible and relevant to our communities

5. **Vaccination and Immunisation Strategy:** Co-develop with Local Care Partnerships, Local Authority partners, NHS England and UKHSA an agreed South East London immunisation strategy which supports and provides resources required for each place to deliver their vision, defines roles and responsibilities of all system partners, and considers alternative settings for vaccination delivery such as community pharmacy and schools.

Our progress to date

Key Successes in Delivery in 2023/2024

- During the 2 covid vaccination campaigns in 23/24 a significant number of community pharmacies engaged with the programme which resulted in the majority of the population choosing to attend their local pharmacy for their vaccination.
- A polio catch up campaign was run to ensure that parents were able to access a polio booster or course for their child.
- Development of a co-designed advocacy guide
- Development and deployment of the SEL Vaccination and Immunisation Strategy
- Launch of the SEL Vital 5 programme with £4m of targeted investment in delivery of SEL-wide interventions to support five key risk factors for burden of disease which disproportionately affect minoritised and lower social-economic groups
- Roll-out of vital 5 check in a number of care settings across SEL with over 7,000 residents accessing a free preventative health and wellbeing check underpinned by resident listening exercises and co-production.

Key Challenges to Delivery in 2023/2024

- Fragmentation of planning across organisations within the system
- Impact of industrial action on system partners
- Clinical and operational capacity
- Reduction in public health budgets and resourcing
- Fragmented commissioning arrangements for vaccinations and immunisations
- Competing priorities
- Evaluation of interventions and pilots
- Outbreaks and incidents which have required an intense management and operational response
- Timing of guidance on national campaigns with local implications

Learning and Implications for Future Delivery Plans

- More focused efforts on few priorities where the need and likely impact is highest
- Moving to a more joined up approach to prevention tailored to the needs of the diverse SEL population
- Ensuring we underpin our approach with continuous learning, evaluation and impact monitoring approach

South East London Integrated Care System

Our key prevention deliverables for 24/25

- with further development through our integrated care strategy

NHS South East London

★ ICS Strategic Priority

Reduction in preventable vaccine disease		Screening		Health Checks		Vital 5	
Area	**Objective**	**Area**	**Objective**	**Area**	**Objective**	**Area**	**Objective**
Childhood immunisation	SEL increase in overall take up of 5%, with at least a 7% increase for the Core20 population Launch joined-up Childhood Immunisations and adult vaccination campaigns; specific community-informed comms	Bowel Screening	Increase of 4% in the uptake of bowel screening in the eligible population Increased awareness of the change in eligibility to include 50+	SMI Physical health checks	Across SEL, 13,500 health checks completed by end of Quarter 4	Vital 5 Check	Promote and increase the uptake of the Vital 5 Check pilot in the Core20Plus5 population through delivery in a range of different NHS and non-NHS settings.
						Hypertension	Test the uptake and effectiveness of a structured self-management programme for people with hypertension to enable scaling of this service in the future; Increase awareness, opportunity and coverage of community blood pressure testing (standalone and as part of Vital 5 or other health checks) promoting the community pharmacy hypertension service.
Adult winter immunisation	5 % increase for flu and covid for eligible population and 7% increase for core 20 population Launch joined-up, audience-centred campaign covering all immunisations including outbreaks + surges	Cervical Screening	Increase uptake by borough to 80% of eligible population Improving quality and therefore reducing rejected samples	LD Annual health checks	Over 75% of annual health checks completed for all individuals on the LD register	Healthy Weight	Promote healthy weight in health and social care settings; Focus on prevention through addressing maternal and preconception obesity, including promoting breastfeeding in maternity pathways; Supporting CYP Tier 3 Weight Management Service; Reduce inequalities in the provision of Tier 2 weight management services through more tailored offers to specific population groups; co-design and embed pathway improvements across Tier 2 to Tier 4 weight management services with focus on health equity and addressing demand and capacity gaps.
						Healthy Mind and LTCs	Improve the uptake and delivery of depression and anxiety screening and pathways for people with long term conditions (LTCs) across different settings; Improve workforce competency in providing mental health support for people with LTCs.
		Breast Screening	Increase uptake to 80% of the eligible population (50-70 year olds)	NHS Health Checks	to target health inequalities such as Black, Asian and Minority Ethnic communities and groups with high risk of T2 diabetes and onward referral to the National Diabetes Prevention Programme.	Tobacco Dependence	Equitable access to stop smoking services, including vapes and behavioural support across SEL; Sustainable rollout of NHS Long Term Plan Smoking Cessation Services at all Trusts; SEL-wide approach to communication of services and engagement with hardly reached communities to encourage engagement with stop smoking services.
						Alcohol Harms	Reduce the access to high strength alcohol through roll out of high impact initiatives and sharing of licensing best practice; increase the recording of alcohol status and delivery of brief advice; increase awareness of benefits of reduced consumption, and alcohol harms.

Women's and Girls' Health

Overview of our current system

Women's and girls' health needs are complex and vary across the life-course. Currently women's and girls' health needs are met by a patchwork of providers and professionals across SEL; including primary care, gynaecology, maternity, community sexual health services and genitourinary medicine. There is also fragmentated commissioning between the NHS and Local Authority partners. The complex landscape means that provision is often not well integrated, there are challenges in access linked to training and workforce issues, and inequalities in access, experience and outcomes for our diverse SEL population.

Strengths / opportunities

- Life course approach
- Alignment with national Women's Health Strategy which has strong evidence-base and high levels of engagement/insight
- Learning and translating good practice from others who have already progressed the development of Women's and Girls' Health Hubs
- Ability to connect and network inter-disciplinary expertise in the system
- Pockets of excellence and innovation that can be harnessed and scaled
- Links to existing expertise and work across the system (e.g. SEL APC gynaecological network, Maternity and LMNS Network)
- Opportunities to realise population-level benefits through co-commissioning with local authority partners

Challenges

- Currently no women's health hub providing a range of dedicated services
- Fragmented commissioning and provider landscape
- Variation in availability and quality of services, and in the needs of women and girls across the life-course
- Long waiting lists exacerbated by Covid (e.g. gynaecology, menopause)
- Significant inequalities with some populations and young people disproportionately impacted
- Lack of robust population-level needs assessment to understand the current and future health and wellbeing needs of women and girls in boroughs and across SEL and to identify future priorities
- Investment nationally in the development of Women's and Girls' Health Hubs is non-recurrent and designed to enable establishment of at least one 'hub' in every ICS, requiring the ICS to prioritise, focus efforts where we will deliver best outcomes and facilitate co-commissioning arrangements to support scaling and sustainability of provision

Our vision and objectives

Our vision

Improve access to health care for women and girls' across the life-course, enhancing experience, empowerment, and improving health equity and outcomes – with a focus on increasing services and support available where women and girls' live, work and are educated in the community.

Our key objectives – what we want to achieve over the next five years

- Improvements in access, experience and health outcomes (particularly relating to sexual and gynaecological health), and reduced disparities between different groups of women and girls.
- To co-commission a more effective and joined-up 'hub and spoke' model of women and girls' health across SEL that includes high quality information provision and signposting tailored to local need; prevention and early intervention services and support; and intermediate care.
- Improved workforce satisfaction and retention across the system and increased use of multi-disciplinary team working.
- Improved efficiency in the system, reducing the number of appointments needed (e.g. through a 'one stop shop' model); increasing quality of, reducing variation in secondary care referrals.

Our working principles

Our principles

- Women's and Girls' Health hubs are in the community and are working at the interface between primary and secondary care and/or the voluntary community sector
- Women's and Girls' Health hubs offer more than a single service (including both physical and mental health), including both gynaecological and contraceptive services as a minimum
- The hub model should result in more women being seen in the right setting, by the right professional, at the right time – it is not the consolidation of services and workforce in one centralised estate – rather it should build on and better integrate existing women's health services and address any gaps to address inequalities
- We will ensure our model for women's and girls' health hubs is co-produced and informed by the voice of service users/residents and our workforce
- More than one organisation will be involved in the design, commissioning and/or delivery of care, beyond simply referring in
- They will be co-commissioned or jointly commissioned and have integrated governance and leadership
- We will take an 'all ages' life course approach and be individual, family and community focused – ensuring the needs of our diverse population are first and foremost
- The location of services will reflect clinical guidelines on where specialist care is recommended, as well as harness opportunities to integrate or co-locate services closer to the community

Our priority actions

Our priority actions – what we will do		Intended outcomes in 5 years time
Actions for 24/25	Continue to share learning and good practice through SEL women's and girls' health network – to inform our approach locally.	• Improved access to healthcare services for women and girls, and reduced disparities in access to healthcare, quality of care and health outcomes • Increased cervical cancer screening uptake • Reducing unplanned pregnancies • Reducing pressure on secondary care (e.g. reducing multiple referrals, variation in referrals and improving primary and secondary care interface) • Improved staff training, morale and workforce retention
	Complete needs assessment and pathway review, led by public health, focused on long-acting reversable contraception (LARC) for both gynaecological or contraceptive reasons; heavy menstrual bleeding; menopause and pre- conception. This will include incorporate analysis and synthesis of existing data and clinical guidelines, stakeholder engagement (service providers and service users/residents), service and pathway mapping, and a review of provider and service usage data.	
	Based on the outputs of the above needs assessment, we will identify specific populations we need to target, define the core offer and a consistent set of outcomes across SEL tailored to population needs. Alongside this, we will work with commissioner, provider, VCSE and service users/residents to co-produce the service model for Women's and Girls' Health Hubs; consider options for delivery and commissioning; and take final recommendations through relevant ICB/ICS and Local Authority governance.	
	We will test the delivery of a Women's and Girls' Health hub model via a proof of concept approach (either consolidating this in 1-2 boroughs or through a number smaller initiatives across SEL) during 2024/25, underpinned by learning and evaluation to inform future delivery and the investment model required to scale and sustain the model across SEL.	
Actions for 25/26	We will review and evaluate the Women's and Girls' Health hub proof of concept, translating recommendations into a business case for longer-term collaborative commissioning of the model across SEL.	

Enabler requirements

Workforce

- Supporting upskilling of PCN and wider community workforce..
- Training and education to underpin effective multi-disciplinary working.
- Supporting ability to measure impact of women's and girls' health hub on workforce retention and morale.

Digital

- As part of the hub offer, we may want to explore digital tools (e.g. supporting sharing of knowledge and self-management/signposting information; or enabling group consultations) and may require support with this.

Estates

- Ensuring estates are fit for purpose to deliver model of women's and girls' health hubs, recognising that this is about building on and enhancing existing services rather than consolidating services into one hub. Estates expertise will be required in any business case development once the service model is further developed.

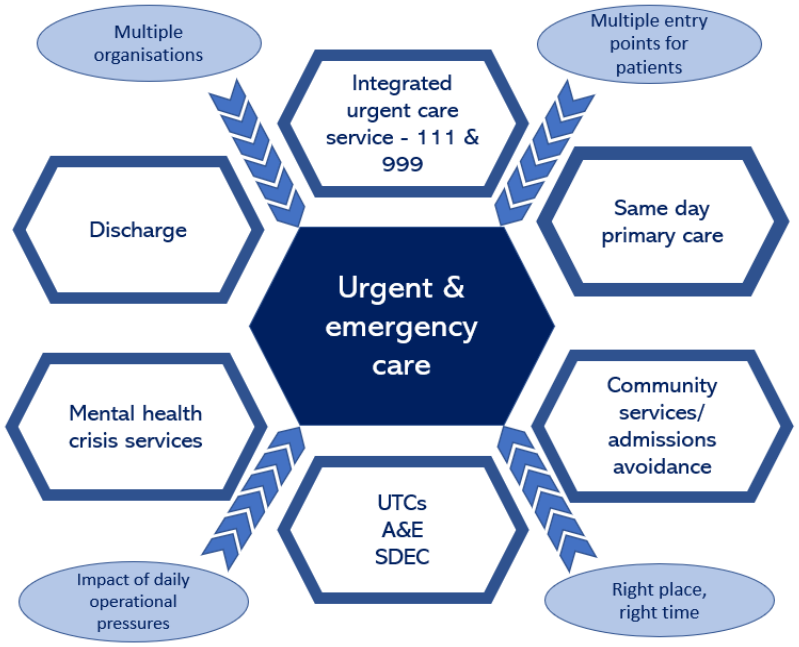
Data

- Good IT/EMIS interoperability will be central to the success of the SEL Women's and Girls' Health Hub service. We will require support from the SEL Data and Digital team to explore options to facilitate this as part of service model development so this infrastructure is in place for any proof of concept delivery.

Urgent and Emergency Care (1)

Overview of our current system

Overview of UEC system

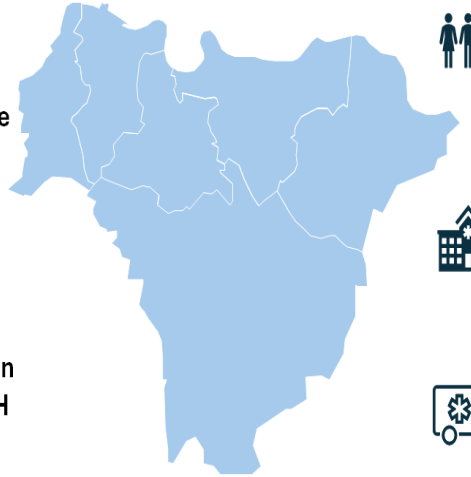


Health inequalities:

- We have inequalities in our current pattern of utilisation of hospital based urgent and emergency care services and think inks too to corresponding inequalities in access to other services:
  - Analysis shows that Black people and those living in the most deprived areas of south east London when compared to White people and those living in less deprived areas (even once adjusted for differences in average age) are over-represented in activity and spend in hospitals' A&E and non-elective hospital activity.
  - Better, earlier prevention and management of ill-health would lead to less use of emergency hospital care demand and lower re-admission rates.
  - Achieving significantly better improvements in quality of life for residents of south east London would further, in the long term, reduce the resource required to deliver emergency care which has limited ability to impact people's long-term health outcomes.

Urgent and emergency care snapshot – 2022/23

17% of ED attendances across SEL are for over 65s



633,782 ED attendances

3.1% ED attendances in SEL are for MH complaints

257,909 Emergency admissions

104,623 Ambulance conveyances

24.7% increase in total number of patients waiting 4-12 hours to be admitted.

What we've heard from the public

Access to urgent care and long waits is a key issue for local people. Local people have previously reported that difficulty accessing primary care appointments led to them seeking help and care at Emergency Department (ED) and other urgent services, and whilst many people were aware of and had used urgent care alternatives to A&E (such as urgent care centres) there is a need for increased publicity, information and signposting on different urgent care and out of hours services and where to access them (Our Healthier South East London engagement on the NHS Long Term Plan, September 2019). Inclusive and accessible environments in EDs including good triage and clear signposting has been raised. Including clear signposting and triage. Our Friends and Family Test Results for SEL Emergency Departments in October showed feedback that was a Positive 70% Negative 20% (National comparison Positive 74% Negative 17%).

Urgent and Emergency Care (2)

Strengths / opportunities

Collaboration
SEL has a well-established and effective system approach to operational pressures providing real-time mutual aid across the system (e.g. daily surge calls). The system-wide Acute Flow Improvement Group and the Discharge Solutions Improvement Group enable engagement of local system leaders in the longer-term and most systematic and consistent improvement of UEC pathways.

Community and integrated urgent care
As early adopters of Urgent Community Response (UCR) provision, we have developed an effective UCR service across all of SEL. SEL is also the lead commissioner for NHS 111 for London and plays a pivotal role in developing integrated urgent care.

Governance
Established Place-based UEC Boards are in place to support local development and delivery working alongside the SEL Board to secure agreed common standards and approaches delivered locally. Board include representation from the wide range of stakeholders involved in planning and delivering UEC.

Communication & Engagement
There is strong engagement and communication in Boroughs with the opportunity of achieving more consistency by way of a SEL UEC communication strategy that aligns with the recommendations in the Fuller Report. Whilst there is some good local engagement, for example in local UTC procurement, more work is required to engage with our residents on UEC service design and in communicating what services are on offer.

Service Redesign
There is a wealth of service improvement expertise across the system and a huge opportunity to funnel this expertise into spreading existing pockets of good practice and fulfilling national requirements. Using UEC/health/111 data sets together will help us to understand the way the population uses UEC services, the changes in acuity seen across the UEC pathway and highlight areas for opportunity. We will maximise the opportunity of innovative digital solutions as well as improving consistency and alignment across the system where this is beneficial for the population.

Challenges

Collaboration
Emerging collaborations and partnership are in their infancy with individual partners often having to concentrate on their own pressures and constraints, resulting in variation across systems. There is also scope to better join up work across UEC and other key programmes (primary care, pharmacy, community services, CYP, etc.).

Demand, capacity and flow
We need to better understand and address demand, capacity and flow constraints including considering how we better tackle challenges related to demand and capacity together and improve transfers of care across the UEC care pathway.

Balancing operational pressure and long term improvement
System solutions for UEC often require behaviour and culture change which can take a long time and a sustained effort; this can be challenging when immediate operational pressures often take focus away from more medium-term sustainable change.

Service design
We need to be better at evaluating improvement initiatives and stopping initiatives that cannot evidence positive outcomes. As a system we also need to agree an approach to resourcing initiatives that have shown positive outcomes where these often have short-term/pilot funding arrangements in place.

Communication & Engagement
We need to improve our meaningful patient and front-line staff engagement in UEC service transformation. Again, the short-term interactions with patients and operational pressures on front line teams make this challenging to overcome.

Inequalities
We know that there are a number of factors driving behaviours that increase pressure on UEC services, such as increasing patient expectation of immediacy of care, damaged trust between the public and health care provision, and other factors such as the cost of living crisis. Social factors such as deprivation rates may also indicate more complex home and care needs which impact on discharge requirements and flow through our acute hospital sites. We need to prioritise patients with the greatest need to better influence health outcomes and ensure we are shifting the curve for those population groups that are over reliant on urgent and emergency care services for their care.

UEC - Our vision and objectives

Our vision

To deliver an integrated safe and responsive Urgent and Emergency Care model that meets population needs and enables people to access the care they need, in the least intensive setting, when they need it and minimising the time spent in hospital through a resilient and sustainable service offer.

Our key objectives – what we want to achieve over the next five years

The top things that we want to achieve over the next five years

1. To **reduce the inequalities** gap and current over representation of our CORE20 (most deprived) population in our UEC system
2. To ensure the delivery of **high quality, safe care** including improving the **timeliness of UEC responses** and the sustainable delivery of UEC related performance standards
3. To ensure nobody spends one more day in hospital than is necessary with supportive and effective **transfers of care** and the sustainable delivery of **discharge** standards
4. To secure an accessible, responsive, timely and **joined up same day urgent care** offer secured through our integrated neighbourhood teams.
5. To demonstrably **harness opportunities** to optimise our UEC care pathways to ensure they are **innovative, effective, efficient and productive** and meet best practice guidance
6. Teams that are providing front-line care **feel supported to deliver safe and effective care** as demonstrated in recruitment and retention rates and staff survey results.

UEC - Our priority actions

Our priority actions – what we will do

1. **Develop and deliver an effective population health approach** to improve outcomes and reduce health inequalities, by improving engagement with our population and partner agencies to drive improved communication, service design, understanding of patient expectation and behaviour.

2. **Implement a system approach to quality and safety** with risk based management and action that will support whole system ownership of risk, safety and quality across all UEC services (e.g. Integrated urgent care (111/999), ambulance handover, acute, MH etc), including for front line teams so that staff, patients and services remain safe.

3. **Further enhance our integrated out of hospital offer** which delivers a consistent model of care including population health management, community MDT care, 111 IUC, enhanced rapid response, high frequency user service and care home support along with integrated UEC services for children and young people and those with urgent mental health needs.

4. **Stream people to the most appropriate place to receive urgent and emergency care** (including mental health and children and young people*) from point of contact (e.g. 111, primary care, ED) and appropriately align resources to deliver capacity to meet demand to ease pressure on services and secure better and safer patient experience.

5. **Prioritise a number of focused initiatives to strengthen in hospital flow & discharge for both physical and mental health, all ages* -** minimising time in hospital through embedding the SAFER flow bundle (senior review of patients, all patients with expected discharge date and clinical discharge criteria, flow from assessment to admission to discharge, early discharge (before midday and over weekends) and regular review (multi-disciplinary team reviews with therapy and social work teams), plus the provision of enhanced out of hospital service to support discharge, with particular attention on vulnerable populations and complex cases.

6. **Cultivate a future-focused approach** by facilitating the SEL UEC System Leadership [Board] to focus on longer term aspirations and outcomes to support action 1-5, alongside operational performance and pressures.

* Priority UEC actions are also included within the SEL Babies, Children & Young People and Mental Health Programmes and therefore detailed UEC actions are not included in this section.

Our progress to date

Key Successes in Delivery in 2023/2024

- Invested in discharge improvement, providing system funding to our Transfer of Care (TOC) hubs
- Continued focus on increasing weekend discharges at a local level with some incremental improvements
- Violence and Aggression reduction network continued, linking into the ICS Quality Group, providing a system-wide forum for sharing information and supporting risk management
- Started the procurement process for a new 111 IUC service, working with system partners to develop local integrated neighbourhood care teams, including surveying patients on their experiences
- Launched Mental Health 111 #2 offer for residents of SEL
- Developed a SEL front door streaming and redirection strategy and completed initial baseline audits
- Completed good practice review of delirium pathways with a view to implementing a pilot in 24/25
- Supported sites in working towards national requirements for SDEC
- Convened a productive system-wide winter workshop that enabled identification and prioritisation of interventions well ahead of the winter period
- SEL Surge team are now a System Coordination Centre (SCC) and meet the specification published in 2023 to become accredited by the national IUEC team.
- SEL SCC launched twice daily Mental Health flow meetings bringing together providers to move patients to appropriate locations for ongoing care.
- Procuring a smart system (RAIDR) to gather operational data from system partners in a single system.
- Established UEC clinical leadership network to increase collaboration across professional boundaries (e.g. medical/surgical, GP)
- Investment in increasing G&A bed capacity across our acute providers to improve bed occupancy rates thereby improving flow and enabling improved waiting times in ED

Key Challenges Delivery in 2023/2024

- Significant operational pressure, including impact of industrial action, impacted on our ability to achieve improved performance and create space for longer term improvement goals. Competing priorities for recovery (e.g. cancer, elective etc.) also impacted on UEC delivery.
- System working as an ICS is still in its infancy and understanding different roles presents challenges to working across place and system. Collaborative working is also more challenging during times of both operational and financial pressure across health and social care with limited capacity to focus on longer term system improvements
- Prioritising the important over the urgent (e.g. population health)
- Large scale transformation in line with the Fuller recommendations has been challenging in joining up different system teams/partners to delivery plans for integrated UEC.

Learning and Implications for Future Delivery Plans

Significant operational pressure including resulting from IA is likely to continue and impacts on our ability to focus on longer term improvement. We will need to find a way of balancing these two requirements and enable space to focus on longer term planning whilst maintaining the required focus on operational recovery and performance.

Large scale transformation programmes need support in coordination and development to enable effective work cross-boundary.

UEC priority action 1 – population health approach

Population health approach

Develop and deliver an effective population health approach to improve outcomes and reduce health inequalities, by improving engagement with our population and partner agencies to drive improved communication, service design, understanding of patient expectation and behaviour.

How we will secure delivery

Actions for 24/25

- Co-design (place and SEL) of services to meet 2024/25 operating plan requirements
- Co-design our approach to patient engagement for UEC services
- Understand the needs of the patients within our Core20 from a UEC perspective
- Use data to support targeted population approaches to support reduction in inequalities
- Needs analysis of education and training for UEC health professionals in relation to health inequalities (working alongside place and providers)
- Continue with and develop the Clinical and Professional forum and use this to engage front line team in service design
- Identify measures and a means of gathering data to enable reporting on health inequalities outcomes and variation

Actions for 25/26

- Implementing patient engagement plans including sustainable ways of building in patient involvement in service design
- Implement processes to ensure early risk identification, detection and intervention and proactive planned care support particularly where these are identified as part of Core20
- Provide education resources and training for health professionals in SEL
- Working with partners to support health education of the local population to support their health and family's wellbeing to reduce the likelihood of need from UEC
- Implement data gathering to support reporting on health inequalities measures

Intended outcomes in 5 years time

- Reduction of unwarranted variation in population access to UEC (using existing data in Understanding and addressing the impact of inequalities across South East London - Findings to-date and proposed model of change May 2022 as baseline)
- Established reporting will demonstrate improvement in outcomes against health inequalities measures
- Closer working between Place Based and SEL partners to understand how patients access UEC services (maturity of system working as ICB)
- Wider understand in UEC services of the impact and opportunity to influence health equality as part of UEC care provision (audit).

UEC priority action 2 – system approach to quality and safety

System approach to quality and safety

Implement a system approach to quality and safety with risk based management and action that will support whole system ownership of risk, safety and quality across all UEC services including children and young people (e.g. Integrated urgent care (111/999), acute, MH etc), including for front line teams so that staff, patients and services remain safe.

How we will secure delivery

Actions for 24/25

- Continue to provide and develop our System Control Centre functions including live data feeds and further develop collaboration among system partners to provide support and mutual aid and system resilience
- Contribute to SEL violence and abuse reduction strategy
- Identify quality measures that can be used alongside performance measures and levers for data collection and reporting
- Working with regional and national colleagues where identified projects impact on quality and safety (e.g. to improve flow, ambulance handovers)
- Work with partners to improve streaming and triage, signposting and communicating with patients (e.g. waiting times) including for those with disabilities (seen and unseen)
- Continue work on improved ambulance handover times to support patient safety.
- SCC aims are improving the use and scope of the RAIDR system with automated data feeds and seek to improve and build on current repatriation process with providers across SEL.

Actions for 25/26

- Building on actions identified in 24/25 including system agreement and implementation of risk based management for UEC
- Embed quality and safety measures within improvement work

Intended outcomes in 5 years time

- Same standard of care across all providers reducing unwarranted variation for key parts of the service
- Real-time mutual aid to system partners
- Improved performance delivery so SEL is sustainably meeting core standards (4 and 12 hours, ambulance handover times, and Category 2 response times)
- Reduction in serious incidents
- Identified quality outcomes measures to sit alongside existing performance measures
- Improved experience for those with disabilities (visible and unseen) when accessing UEC services

UEC priority action 3 – integrated out of hospital offer

Integrated out of hospital offer

Further enhance our integrated out of hospital offer which delivers a consistent model of care including population health management, community MDT care, 111 IUC, enhanced rapid response, high frequency user service and care home support along with integrated UEC services for children and young people and those with urgent mental health needs

How we will secure delivery

Actions for 24/25

- Develop a clear communications plan across SEL that informs residents how to access the right care for their health needs.
- Continue to develop appropriate care pathways for 999 to reduce the pressure on Emergency Departments and further expand services to increase capacity.
- Review the existing High Intensity User services to establish a baseline and compare with high frequency users of other urgency care services (e.g. primary care, 999) and complete gap analysis.
- Redesign the 111 IUC offer with SEL partners to better integrate with local systems and improve patient care. Understand the Fuller Review vision and local neighbourhood models to build and integrated system that works better for patients.
- Procure and start the mobilisation of a new 111 service.
- Further develop the Mental Health 111 #2 offer to better integrate crisis services together.
- Increase numbers on all referral pathways to UCR services, UCR car pilot and review progress of the integrated VW/UCR pathways across SEL

Actions for 25/26

- Continue to develop system working across SEL to fully deliver an integrated out of hospital offer.
- Develop high frequency user services that are adaptable to the changing needs of the population and how people access services, and that support to reduce health inequalities as part of Core20plus
- Launch the new 111 IUC service for SEL with local Integrated Delivery Units.
- Review 999/111 demand for UCR services and assess feasibility of pulling from the LAS stack model

Intended outcomes in 5 years time

- System-wide approach to managing integrated urgent care to guarantee same-day care for patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority.
- Redesigned 111 so it is integrated with local systems and allows for patients to get the care they need.
- Improved digital offer to patients to better manage their care.
- Patients have a clear understanding of how and when to access urgent and emergency care across SEL and trust the service they receive.
- A fully integrated out of hospital offer that delivers quality care to the population of SEL.
- To demonstrate effectiveness of high frequency user services by reducing unwarranted multiple UEC attendances/contacts (reduction in high frequency users).
- People accessing UEC services are clear on the options available to them, can easily identify which option is the most appropriate for their need (even when in crisis) and how to access that care.

UEC priority action 4 – streaming to direct patients to the right place first time

Streaming

Stream people to the most appropriate place to receive urgent and emergency care (including mental health and children and young people) from point of contact (e.g. 111, 999, primary care, ED) and appropriately align resources to deliver capacity to meet demand to ease pressure on services and secure better and safer patient experience and deliver performance targets.

How we will secure delivery

Actions for 24/25

- Improve and enhance hospital front door streaming to most appropriate setting including Urgent Treatment Centres, Same Day Emergency Care, Emergency Departments, frailty and out of hospital services such as primary care, community services including admission avoidance services and mental health crisis care through effective redirection and onward sign posting:
  - Learning from baseline streaming audits completed in 23/24 and supporting sites to establish alternative pathways where appropriate
  - Increase collaboration across professional boundaries (e.g. surgical, GP)
  - Patient surveys to support redesigning of front door pathways
- Continued focus on SEL SDEC improvements via the SEL SDEC working group and support sites to meet national requirements where necessary
- Develop relationship with local partners (pharmacies, GP practices, health services, etc.) to support redirection of patients that do not need UEC care.
- Using data sources to assess alignment of resource to deliver demand.
- Support system partnership working with LAS to deliver ambulance targets (e.g. use of ACPs, increase ambulance capacity, handover delays etc.)

Actions for 25/26

- Continue work identified in 2024/25
- Use evidence base to identify optimal alignment of resources to meet demand
- Undergo evaluation of any implemented solutions to inform future decisions
- Involve patients in the design of our streaming and direction options and how to make these easily understandable for our population

Intended outcomes in 5 years time

- Deliver A&E and wider UEC targets
- Further improvement towards pre-pandemic levels around key metrics
- Evidence that 25% of opportunities identified in previous missed opportunities audits have now been met
- Each UEC contact is appropriate to level of patient acuity (audit)
- Improved patient experience when accessing UEC services in SEL (audit)
- People accessing UEC services can make decisions based on their need, existing wait times and what is available to improve their outcomes

UEC priority action 5 – hospital flow and discharge

Hospital flow and discharge

Prioritise a number of focused initiatives to strengthen in hospital flow & discharge for both physical and mental health for all ages including children and young people - minimising time in hospital with SAFER flow bundle, weekend discharge, MDT reviews with therapy and social work teams, enhanced out of hospital service to support discharge, with particular attention on vulnerable populations and complex cases.

How we will secure delivery

Actions for 24/25

- Closer working with Mental Health and Children and Young People's UEC priorities to support delivery of transformation goals (aligned to priorities identified in those work programmes)
- Working with local system plans to realise increased bed capacity (G&A, stepdown, and community and virtual wards) to achieve bed 92% bed occupancy)
- Take collaborative approach to delivery of local authority plan and use of BCF investment to support discharge through adult social care
- Targeted work to develop robust discharge pathways for those who are complex/difficult to discharge, for example, dementia and delirium
- Working with acute partners on learning from flow models to sustain improvements to reduce discharge delays for those who do not meet criteria to reside

Actions for 25/26

- Evaluation of approaches taken during 2024/25 to take the learning and continue a collaborative approach to flow and discharge promote parity of approach across mental and all ages including children and young people and to meet the needs of vulnerable populations and complex cases.
- Identify quality and outcomes measures that can be used along side performance measures and levers for data collection and reporting

Intended outcomes in 5 years time

- Improve patient flow and to reduce bed occupancy to at least 92%
- Increased physical capacity in inpatient settlings to reflect changes in demographics and health demand as well as improve support for patients in the community.
- Improved discharge metrics (LOS, weekend discharge, readmission rates)
- Reduced delays to medically fit for discharge
- Able to report on quality measures that evidence flow and discharge improvements have resulted in improved patient experience and outcomes

UEC priority action 6 – continuous learning approach

Continuous learning approach

Cultivate a future-focused and continuous learning approach by facilitating the SEL UEC System Leadership [Board] to focus on longer term aspirations and outcomes to support action 1-5, alongside operational performance and pressures.

How we will secure delivery

Actions for 24/25

- SEL UEC Board to have an annual planned improvement focussed session to give assurance that population health, integration and quality objectives are influencing the approaches being taken at local UEC board level as well as through SEL workstreams
- Review key pathways involving transitions of care and shared care, and work with care teams to identify how digital capabilities and information sharing can improve the pathway
- Ensuring that our UEC assurance process is robust and revising as necessary
- Ensuring existing governance models are fit for purpose and deliver the system improvement we expect to see
- Using the SEL Clinical & Professional Forum to create a learning environment for change (working with ECIST)

Actions for 25/26

- Agree an evaluation framework that also identifies where behaviour and culture have thus far been barriers to sustained improvement
- SEL UEC Board to hold a long term planning session as part of annual objective setting process with identified collaboration with services that don't sit directly within UEC

Intended outcomes in 5 years time

- Shared strategic aims between UEC Board, providers/Provider Collaboratives and local care partnerships for the delivery of UEC services across SEL
- Aligned to priority 2 there will be clear outcomes measures sitting alongside performance measures that the UEC Board use to support decision making, these will include population health and quality measures and the development of patient reported measures.
- A proactive system that is able to anticipate the demands and the needs of the population.
- A newly designed UEC system that delivers what patients need.
- Improved evaluation of improvement that is actively used to inform planning and decision making including in investment.

UEC enabler requirements

Workforce

- Different workforce models - opportunity to resource services differently to use workforce more flexibly and to offer more flexibility to staff groups to reduce vacancy rates and improve retention rates
- Workforce engagement to understand the issues and barriers that result in people leaving their roles.
- Work with local schools and colleges to attract more local people into NHS roles or into education that will lead to NHS employment.
- Development of transformation expertise and resource to work alongside operational teams to secure integrated pathway change and innovation including how to address health inequalities when planning and developing service models

Digital

- Using digital technology to streamline services and provide a digital offer (for populations that want to use this platform) to reduce demand on other areas – to support patients and population (similar to principles in Fuller report)

Estates

- Support for sites where estate prevents expansion or relocation of services to support better hospital flow.
- Support for sites in economically deprived areas where estate is not fit for purpose and impacts on the way that services can be delivered and accessed by local populations.

Data

- Data that provides quality outcomes rather than purely performance. Improved access to GIRFT and other quality data.
- Robust demand and capacity planning to identify capacity gaps, including population health factors.
- Access to data to support targeted population approaches to support reduction in inequalities, early risk identification, detection and intervention and proactive planned care support.

Mental Health

Overview of our current system

It is estimated that nationally one in four adults and one in six children experience mental illness, yet across London only a quarter of those experiencing difficulties are receiving treatment. Need and demand for mental health services varies across SEL's six boroughs, however, SEL's mental health index is the highest of the five ICS' in London. Often people with mental health illness have poor health outcomes with people with severe mental illness (circa. 20,000 people in SEL) living 10-15 years less than the general population; this 'mortality' gap is higher in five out of six SEL's boroughs, when compared to the London average.

Strengths / opportunities

- Ring-fenced funding for mental health through the Mental Health Investment Standard and Service Development Funds; opportunity to align further through the ICS Medium Term Financial Strategy and ensure this continues.
- Expansion and adoption of community transformation programme led at Place offers the opportunity to intervene earlier and provide tailored intervention which meets the needs of the different populations within SEL. Opportunity to focus on early years and family approaches to reduce the burden of mental health during the life course of an individual.
- Mental health identified as a priority as part of the ICP strategy; opportunity through this work to also consider the wider determinants of health.
- Opportunities to work with the voluntary and community sector and diversify roles and the support offer – multiple voluntary, community and social enterprise sector (VCSE) organisations, many of which are integral to local communities.

Challenges

- Known disparities in access, outcomes and experience of care for of mental health services. For example, children from black and mixed heritage backgrounds are poorly represented in CYP mental health services, yet black men are over-represented in adult inpatient services.
- Significant mortality gap for people with severe mental illness with these individuals living 10-15 years less than the general population.
- High dependency on the acute care pathway across SEL remains.
- Delivery of national access ambitions for several mental health service lines, coupled with long waiting times for services due to high demand.
- Workforce availability – challenges in workforce availability and retention across health and care staff working in mental health services
- Wider systemic issues, e.g. Cost of Living Crisis that will impact on our communities' mental health and emotional wellbeing, inflationary pressures.

What we've heard from the public

- Mental health for both adults and children and young people is one of the key priority areas of the upcoming Integrated Care Partnership Strategy. Members of the public reflected on the need for timely early intervention and support through different routes (not just statutory services).
- Through the South London Listens Programme, our communities have told us how important good mental health is to them, wider than just mental health services. The actions from the Programme focus on co-designed solution which will build community resilience and improve mental health for all residents.

Mental Health - Our vision and objectives

Our vision

To ensure our residents receive mental health and emotional wellbeing support across their life course, which is timely, culturally appropriate, anti-discriminatory, trauma-informed, co-ordinated and holistic, and enables the development of resilient communities in which more people live longer, healthier and more independent lives in the community.

Our key objectives – what we want to achieve over the next five years

Over the next five years, we want to:

1. **Build community resilience and prevent mental illness from developing through collaboration and partnership**: Working with local communities, VCSE, local authorities, primary care and other members of our Local Care Partnerships, to develop and test tailored early intervention and mental health support offers as part of the expansion of our community offer supporting the development of resilient communities across South East London, focusing on the whole life course.

2. **Ensure secondary and tertiary mental health services are safe, effective and efficient for those who need them**: To provide high quality, culturally competent, and safe care in our secondary and tertiary mental health services, including timeliness of response and delivery of any applicable access and performance targets

3. **Drive forward opportunities to integrate care including mind and body approaches**: To integrate care across health and care, and with VCSE partners to provide a holistic approach to health service delivery, including supporting our residents with severe mental illness to better manage their physical health and reduce the mortality gap.

4. **Reduce health inequalities, particularly for our CORE20Plus population**: Through delivery of objectives 1 – 3, embedding population health management approaches and the development of tailored and co-produced interventions, to increase in the number of people accessing mental health and emotional wellbeing support from our CORE20Plus population and specifically focusing on reducing over-representation from our black and ethnic minority groups in our inpatient services.

Mental Health - Our priority actions

Our priority actions – what we will do

1. **Acute & Crisis Care**: Develop a consistent, equitable and comprehensive model for acute and crisis care which focuses on providing proactive, joined-up care, ensures availability of crisis care outside of emergency departments, enables timely and effective discharge from acute mental health services and enables people to receive care and support in the least restrictive setting as possible, empowering them to take ownership of their own care.

2. **Early Intervention & Community Support:** Working collaboratively with residents, primary care, VCSEs and local authorities, expand the provision of early intervention and community-based support offers for adults through both statutory and non-statutory organisations, and across health and care services, focusing on upskilling community organisations and building mental health community resilience, with targeted interventions for our Core20Plus population.

3. **Children & Young People's Mental Health & Wellbeing**: Ensure the sustainability of children and young people's mental health and emotional wellbeing services, including the provision of targeted early intervention through cross-agency working, increasing the support offers in schools, timely and rapid access to specialist services, improvements in health inequalities and access to care and support, and provision of support for parental mental health.

4. **Older Adults Mental Health & Wellbeing**: Ensure delivery of a consistent offer for older adults mental health services that provides fast access to dementia diagnosis, delivers high quality pre- and post-diagnostic care, enables people to live well for longer and supports family members and friends providing care.

5. **Improving Physical Health for People with SMI:** Ensure people with severe mental illness can access tailored physical health interventions and support to reduce the mortality gap, through the completion of a high-quality physical health check and supported by effective population health management approaches and mind and body integration.

Mental Health – Our progress to date

Key Successes in Delivery in 2023/2024

- **Acute and crisis pathway**: Completion of an external review on demand and capacity. This has resulted in a testing of new continuous flow model to support admissions and discharges from working-age adult mental health inpatients, and a planned expansion of the NHS bed base across south east London due to take affect from April 2024. A new adult crisis house also opened in 2023/24.
- **111 Press 2 for Mental Health and Section 136 Hub**: 111 Press 2 for mental health and a Section 136 Hub now in operation, under the South London Partnership umbrella.
- **CYP mental health**: Working with Black Thrive and as part of the national connectors programme, the ICB has engaged with several schools across south east London to co-produce a set of tailored interventions to support CYP mental health, particularly children and young people with Black heritage.
- **Physical health for people with severe mental illness**: With support from the King's Health Partners Mind and Body Programme, we have successfully tested and piloted a framework to support community mental health teams to be better manage the physical health of service users accessing their services.

Key Challenges to Delivery in 2023/2024

- **Acute and crisis pathway** – Continued number of high presentations to our emergency departments with long waits for inpatient beds across the sector. Little movement in the numbers of patient clinically ready for discharge across the ICS, resulting in longer lengths of stay and poor system flow.
- **CYP mental health** – Despite progress in reducing the number of CYP waiting over 52 weeks, the waiting time remains high. With a high focus on reducing waiting times, there has been little capacity to deliver some of the other ambitions for CYP mental health (e.g. VCSE development, single points of access).
- **Neurodiversity** – Demand continues to outstrip the current available capacity across adults and children, particularly for ADHD diagnosis.
- **Understanding the impact of community mental health transformation**: It has been difficult to quantify the impact of the investment into community mental health teams, although various stocktakes are underway,.
- **System wide financial pressures** – Challenges in the operational delivery particularly relating to the acute and inpatient pathway have resulted in additional financial pressures for mental health.

Learning and Implications for Future Delivery Plans

- **Ensuring effective acute flow to enable investment and focus on other areas:** Pressures on the mental health urgent and emergency care pathway have dominated the focus in 2023/24. It is important the system ensures the appropriate capacity and flow is in place for 2024/25 to then enable the system to focus on the wider pathway in later years.
- **Streamlining the deliverables for each financial year:** Recognition that plans for 2023/24 were perhaps ambitious across all the key priorities and therefore moving into 2024/25, there will be a streamlined approach to service delivery.
- **Focus on data and outcome recording and improving the quality of this data**: Common datasets across the six boroughs will be a key focus in 2024/25 to ensure the system can appropriately and effectively understand the impact of the investment and transformation for our local residents. There will be a concerted effort across both mental health trusts to improve the data quality within the mental health services dataset (MHSDS).

Mental health priority action 1 – Acute & Crisis Care

Acute and Crisis Care

Develop a consistent, equitable and comprehensive model for acute and crisis care which focuses on providing proactive, joined-up care, ensures availability of crisis care outside of emergency departments, enables timely and effective discharge from acute mental health services and enables people to receive care and support in the least restrictive setting as possible, empowering them to take ownership of their own care.

How we will secure delivery

Actions for 24/25

- Delivery against the programme plan for mental health acute and crisis care. This will include: (i) opening of additional NHS beds in south east London to support flow and ongoing use of the private sector delivery; (ii) reductions in length of stay, including delivery against South East London Discharge Framework; and (iii) improvements to flow within emergency departments.
- CYP crisis house to open for south east London in December 2024.
- Under the South London Partnership, a review of all crisis alternatives to take place with a view to understand impact.
- Delivery of the agreed actions captured as part of the mental health and LDA quality transformation programme. transformation

Actions for 25/26

- Following completion of a baseline assessment, ongoing delivery and implementation of the programme plan for acute and crisis care, in line with learning and recommendations from 2024/25.
- Increase focus on the delivery of personalised and trauma-informed care geared around more psychological, holistic centred approaches aimed at tackling individual mental health and wellbeing.

Intended outcomes in 5 years time

- Availability of same day emergency care access for people experiencing mental health crisis through a variety of settings (less focus on emergency departments).
- Zero inappropriate out of area placements for South East London residents.
- Average length of stay for both providers consistently within national benchmarks.
- Patients clinically ready for discharge and occupying mental health beds less than 5% of the total South East London bed base.
- Bed occupancy rate at 85%.
- Patients who require an inpatient admission (whether in emergency departments or in home treatment team/community team caseloads) are allocated a bed within 4 hours of identification of need.
- All patients who are entitled to S117 aftercare are offered a personal health budget (100%) with uptake to be monitored and measured regularly.
- Reduction in the number of people being detained under the mental health act, including Section 136

NB. Patient reported measures to be developed during 2024/25.

Mental health priority action 2 – Early Intervention & Community Support

Early Intervention and Community Support

☆ ICS Strategic Priority

Working collaboratively with residents, primary care, VCSEs and local authorities, expand the provision of early intervention and community-based support offers for adults through both statutory and non-statutory organisations, and across health and care services, focusing on upskilling community organisations and building mental health community resilience, with targeted interventions for our Core20Plus population.

How we will secure delivery

Actions for 24/25

- Ongoing delivery of the adult community mental health transformation programme, maximising the investment made available and learning from various stocktakes and evaluations of programme delivery from 2023/24. .
- Through Local Care Partnerships and the South London Listens Programme, and in collaboration with residents and VCSEs, to continue to develop, build and test alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population (e.g. neighbourhood hubs, local awareness campaigns).
- Development and design of a new model of care learning from national and international models and evidence, with a focus on Lewisham in the first year.
- Testing of primary care models to provide choice for depot antipsychotics.
- Development of a new stepped care pathway for ADHD.

Actions for 25/26

- Continue to embed delivery of community and primary care mental health and wellbeing services, including implementation of the new care pathway for ADHD.
- Implementation of a new model of care in Lewisham with expansion and roll out to other boroughs, depending on the learning from 2024/25.
- Through Local Care Partnerships, and in collaboration with residents and VCSEs, to continue to develop and build alternative models and opportunities for early intervention and support for mental health and emotional wellbeing.

Intended outcomes in 5 years time

- Each PCN/neighbourhood within South East London to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population.
- Increases in the number of people accessing employment support.
- Increased access to Talking Therapies (including for people with long term conditions) and equitable recovery outcomes for all population groups in South East London.
- Increased investment in VCSE providers with noted improvements in the diversity of the VCSE provider landscape for both adults and CYP.
- Upskilling of at least 250 community leaders and volunteers as Be Well Champions, and establishing a minimum of 75 hubs providing regular wellbeing activities/spaces and signposting
- Increase in the number of local listening and action campaigns and outcomes, led by VCSEs.

NB. Patient reported measures to be developed during 2024/25.

Mental health priority action 3 – Children & Young People's Mental Health & Wellbeing

Children and Young People's Mental Health & Wellbeing

☆ ICS Strategic Priority

Ensure the sustainability of children and young people's mental health and emotional wellbeing services, including the provision of targeted early intervention through cross-agency working, increasing the support offers in schools, timely and rapid access to specialist services, improvements in health inequalities and access to care and support, and provision of support for parental mental health.

How we will secure delivery

Actions for 24/25

- Continued investment into community CAMHS to reduce the number of children and young people on secondary and tertiary care waiting lists.
- Development of a local integrated single point of access in each Place and delivery against the iThrive model.
- Continued expansion of perinatal and maternal mental health services.
- Continued expansion of support via schools including mental health support teams in schools and other co-produced offers.
- Establishment of a home treatment team specifically for the boroughs of Bexley, Bromley and Greenwich to ensure access to an equitable service offer.
- Development of a stepped care pathway for neurodiversity, with due consideration of CYP with special educational needs (SEND).

Actions for 25/26

- Further reduction in the number of children and young people on secondary and tertiary care waiting lists
- Continued expansion of the mental health and emotional wellbeing support available through schools either via mental health support teams or locally designed/implemented solutions.
- Implementation of a new stepped care pathway for neurodiversity which supports timely and effective access to diagnosis/assessment. Mapping of the wider support offers to begin to take place.

Intended outcomes in 5 years time

- All Places will meet the principles and framework of the iThrive Model including joined-up approaches to deliver care and an integrated single point of access for access to mental health and emotional wellbeing support.
- Improved partnership working across health and children's services.
- 100% coverage of either mental health support teams in schools and/or other locally tailored support offers
- All children and young people who need to access secondary and tertiary mental health services to receive assessment and treatment within at least 18 weeks, with an overall reduction in referrals for community CAMHS due to earlier intervention and better support offers elsewhere.
- Consistent delivery of the national waiting times standards for CYP eating disorders for all residents in south east London.
- Reduction in the number of children and young people in inpatient beds and children and young people presenting in crisis.
- Increases in the numbers of parents (both mothers and fathers) accessing parental support including maternal mental health services and perinatal.
- Reporting of patient reported outcome measures (baseline tbc in 2024/25).

Mental health priority action 4 – Older Adults Mental Health & Wellbeing

Older Adults Mental Health & Wellbeing

Ensure delivery of a consistent offer for older adults mental health services that provides fast access to dementia diagnosis, delivers high quality pre- and post-diagnostic care, enables people to live well for longer and supports family members and friends providing care.

How we will secure delivery

Actions for 24/25

- Development of common standards for older adults community mental health services which includes timely dementia diagnosis and high quality pre- and post-diagnostic care. Self-assessment of all services to be carried out.
- Development of clear actions plans for each service to deliver the 66% dementia diagnosis rate by the end of the financial year.
- Working with local authorities, to develop local initiatives to prevent loneliness and isolation for older people (through our Local Care Partnerships).

Actions for 25/26

- Implementation of the agreed framework for older adults community mental health services.
- Working through Local Care Partnerships, to develop actions and initiatives that enable those with long-term conditions to access better joined up physical and mental health care.

Intended outcomes in 5 years time

- Each Place to have a clear and consistent pathway for dementia diagnosis and post-diagnostic care across all communities.
- At least 66% of people aged 65 years and over to receive a dementia diagnosis (as a percentage of the estimated prevalence based on GP registered populations).
- 100% of people referred to receive a dementia assessment within 6 weeks whether that be in primary care or memory assessment clinics.

NB. Patient reported measures to be developed during 2024/25.

Mental health priority action 5 – Improving Physical Health for People with SMI

Improving Physical Health for People with Severe Mental Illness

Ensure people with severe mental illness can access tailored physical health interventions and support to reduce the mortality gap, through the completion of a high-quality physical health check and supported by effective population health management approaches and mind and body integration.

How we will secure delivery

Actions for 24/25

- Delivery of the proposed improvement trajectory for the delivery of physical health checks for people with SMI in primary care, supported by dedicated funding through the mental health trusts for outreach teams.
- Working with the Cancer Alliance, to understand uptake of cancer screening for people with SMI and develop a targeted improvement plan.
- Ongoing implementation of a physical health framework to empower community mental health teams to support the physical health of their service users.
- Development of common standards and outcomes to ensure a range of interventions are available for people who receive a physical health check and require intervention and support, supported by population health management approaches and co-production/co-design with service users.

Actions for 25/26

- Ongoing improvements in the delivery of the total number of physical health checks completed for people with SMI.
- Delivery of a consistent offer for interventions and support following a completion of a physical health check across south east London.

Intended outcomes in 5 years time

- Over 90% of people with a severe mental illness have an annual physical health check completed and recorded.
- Range of interventions available and accessed by service users to support them in managing their diet, weight, alcohol consumption, smoking status and other elements, through a consistent core offer for South East London.
- Increase in the take-up of cancer screening services from people with severe mental illness N.B Measure to be defined over time and once baseline data is established.

NB. Measures reflecting management of other physical health needs including blood pressure and weight management and patient reported measures will be developed over the course of 2024/25.

Enabler requirements

Workforce

- Development of a clear workforce plan that supports delivery of the system's mental health delivery ambition, and includes statutory and non-statutory services.
- Ongoing dedicated workforce resource to support the development, co-ordination and oversight of a mental health workforce plan, as well as supporting with transformation models to ensure the workforce meets the needs.
- Training and support for staff to ensure service delivery is anti-discriminatory and trauma informed.
- Organisational development support to build integrated teams across community and primary care settings, in line with the ambitions of the mental health community mental health services transformation programme.
- Training and support to build awareness of mental health and emotional wellbeing needs across all health and care staff, to enable better detection and recognition and earlier intervention.

Digital

- Interoperability and the ability to better share data between primary and secondary health care services e.g. to support the completion of physical health checks and reporting of these health checks.
- Ability to share data and information across health and care providers and voluntary and community sector providers to support effective crisis management and develop integrated community mental health teams

Estates

- Estates plans across the providers needs to:
    - Ensure access to safe estate which enables face to face contact and delivery of services, located as close to the patient as possible.
    - Support effective remote working and the use of digital/virtual appointments. There needs to be the appropriate space in providers to support the delivery of confidential conversations and patient care.
- Estates across providers need to be able to support the development and co-location of integrated teams.

Data

- Improve mental health data through the Mental Health Minimum Dataset (MHMDS).
- Using MHMDS to develop a core, common dataset for South East London to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes. This needs to be able to provide data and outcomes at both a system level and through Local Care Partnerships.
- Expansion of business intelligence data, with knowledge of MHMDS, to build and develop population health management approaches across ICS partners.

Children and Young People (CYP)

Overview of our current system

Children and young people (CYP) account for approximately 22% of our South East London population. Many long term conditions, such as asthma and diabetes, develop in childhood and continue to adulthood. Asthma is the most common long term condition in children and affects a locally reported 3.5% of the total children and young people aged between 0-24 years in South East London; it is one of the top ten reasons for admission to emergency departments in England. Service provision for children and young people's services varies across the six Places in South East London due to historic differences in commissioning and the provider landscape.

Strengths / opportunities

- Strong provider landscape with two tertiary children and young people's centres in the geography with pockets of excellent practice. Opportunity to harness this skill and expertise to expand services, develop and test new and alternative models of care, and consider services that are best delivered at scale.
- Through partnership working, opportunity to focus on early years and family approaches provide early intervention and reduce the burden of disease over the life course. CYP are an area of focus within the ICP strategy providing further opportunities to consider the wider determinants of health.
- Development of integrated child health teams, linked to the Fuller Review, to support children and young people through primary care and to join up care across health, social care and education including for both physical and mental health.

Challenges

- Pattern of long term conditions in children and young people, with higher levels of long term conditions seen in children and young people from more deprived backgrounds.
- Impact of the wider determinants of health including housing and education which impact particularly the management of long-term conditions.
- Ensuring parity for children and young people across the system. Historic disproportionate investment into children and young people's services with the majority of health care funding allocated to adult services.
- Complexity of children and young people's services with different system partners involved in care, and the ability to share routine data and information effectively.
- High dependency on the emergency pathway for children and young people, with high levels of attendances at our emergency departments and 111 calls.

What we've heard from the public

Children and Young People tell us they are often not involved in decisions about their care. They find healthcare difficult to access especially if they have a disability or learning disability and they sometimes don't feel listened to or valued. Young People would like mental health prioritised, more choice over their healthcare and better consideration/understanding of diversity. Young people and healthcare professionals also need educating about child rights

CYP - Our vision and objectives

Our vision

To deliver an integrated, informed and proactive model of care for children and young people with expert community and primary care services that enable children and young people to stay well in their local communities, supported by timely access to high quality specialist services.

Our key objectives – what we want to achieve over the next five years

Over the next five years, we want to:

1. **Work in partnership to ensure every baby and child receives the best possible start to life**, through a joined-up approach to support and care in the early years, bringing together services for babies, mothers and families.

2. Embed population health management approaches to **provide holistic, family-based approaches to care**, tailored to local need and demographics, supported by **high quality and timely care pathways** which facilitate step-up and step down care with secondary and tertiary health services.

3. Develop **integrated models of care for children and young people at a neighbourhood level** that bring together health and care services across specialist health services, primary and community services, mental health, and local authorities including education to improve care co-ordination and support for families and reduce health inequalities.

4. **Promote and develop the self-management of long-term conditions** in children and young people, supported by their families, to enable them to better manage their conditions now and into adulthood and to **develop clinical services** to support CYP in managing their health.

5. Work in partnership to embed models of care which **enable safe transition** into adult services.

6. Review and develop **urgent and emergency care pathways** to ensure CYP services are appropriately accessed and responsive to need.

CYP - Our priority actions

Our priority actions – what we will do

The ICS wide CYP transformation programme will set out a programme of work to deliver on the objectives described below, working collaboratively with system partners, Local Care Partnerships and other ICS wide transformation programmes as required. Core to any CYP transformation will be the principles of Population Health Management and learning from areas of best practice within South East London.

1. **Early Years** - Develop a model of care that brings together the provision of services for babies, mothers and families to support early years including school readiness*.
2. **Addressing inequality** - Deliver a consistent and sustainable service offer for children's community services across South East London.
3. **Integration and inequality** - Implement and expand the provision of integrated models of care across South East London and development of a SEND strategy for SEL.
4. **Long Term Conditions** - Ensure effective long term condition management for children and young people including asthma, epilepsy, diabetes, obesity and sickle cell, embedding population health management approaches into service design and delivery and meeting the requirements of Core20PLUS5 and for our SEND population.
5. **Transition** – Support the development of models of care that support transition into adult services for those aged 16-25 years of age.
6. **Urgent and emergency care** - Develop pathways and services that support safe, effective and appropriate CYP access to Urgent and Emergency Care including Emergency Departments**.
7. **CYP mental health and wellbeing** - Deliver improvements in children and young people's mental health and emotional wellbeing***.

** Priority linked to the SEL LMNS Programme.* *** Priority linked to the SEL UEC programme.* **** Priority linked to the SEL ICS Mental Health Programme.*

CYP – Our progress to date

Key Successes in Delivery in 2023/2024

- **Early Years** – developed early years strategic direction via workshops
- **Childrens Community Services** – core offers developed and agreed at place level for ASD diagnostic pathway, hospital at home and continence services. Gap analysis completed for each provider against core offer. Planning in place for implementation from April 2024.
- **Integrated Child Health Models -** development of an ICS wide dashboard for local child health teams, implementation of the model across Bromley
- **Long Term Condition Management** – assessment at place for readiness to implement asthma bundle, restart of the asthma network, development of primary care guidelines for CYP asthma working with Clinical Effectiveness in SEL (CESEL), development of a training package for asthma bundle with access to all SEL staff
- **Urgent and Emergency care –** completion of UEC reviews across providers in SEL and set up of task and finish group to address issues identified, inclusion in winter planning for CYP UEC
- **Mental health –** completed scoping of a youth worker led model to support CYP who self-harm and report to A&E, all trust appointed mental health champions to support staff in their development and approach to CYP with mental health eeds, developed a model for CSA wellbeing service

Key Challenges to Delivery in 2023/2024

- Ability to alter national funding streams to enable implementation of transformation objectives
- Ability to spread and scale a model across SEL
- Timelines for projects and matching them to commissioning cycle
- Limited capacity to deliver completely on the breath of the BCYP programme across SEL and Place
- Increasing mental health needs across all CYP services and how they can be responded to in an integrated way

Learning and Implications for Future Delivery Plans

- Need to consider commissioning timelines when setting out targets for roll out / implementation of programmes
- Need to be increase engagement with CYP in early planning for work programmes
- Need to be clear about Place and ICS priorities and how they work together
- Clinical engagement is key

CYP priority action 1 – Early Years

Early Years

★ ICS Strategic Priority

To develop a model of care that brings together the provision of services for babies, mothers and families to support early years including school readiness.

How we will secure delivery

Actions for 24/25

There are two key areas of focus for 24/25

- Reducing inequalities in early years
- Infant mortality
  - Convene system partners to understand risks and issues for SEL
  - Define work to be completed around reducing infant mortality taking a population health management approach
  - Commence work across system partners

Actions for 25/26

Ongoing work around reducing inequalities in early years

Intended outcomes in 5 years time

- Agreed co-designed 'start for life' core offer in place between local authorities, health providers and Voluntary, community and social enterprise sector (VCSE). Digital, virtual and telephone services designed around needs of babies, parents and carers fully implemented and embedded as part of this offer.
- Health input to support first 1001 days available in Family Hubs across South East London.
- Joint common dataset for early years across health and care including across social services, maternity and children's services. This captures improvements in metrics related to maternity services including rates of smoking in expectant mothers and breastfeeding rates.
- 100% of all CYP to receive a review at one years of age and at 2 years of age.
- Increased access to parenting support programmes including for mental health and wider (linked to the actions included under CYP mental health)
- Increase in the number of under 2s accessing a dentist resulting in a reduction in the number of attendances at A&E as a result of oral decay.
- Reducing infant mortality rates for SEL

CYP priority action 2 – Children's Community Services

Consistent and Sustainable Children's Community Services

Deliver a consistent and sustainable service offer for children's community services across South East London, resulting in improved access, reduced variation and increases capacity in community-based services for children, young people and their families.

How we will secure delivery

Actions for 24/25

Working across providers with coordination by the Community Provider Network we will:

- Implement the ASD diagnostic pathway across SEL
- Implement the Continence core service offer across SEL
- Implement the Hospital at Home core service offer across SEL
- Review and develop a SEL offer for community paediatric service and SLT services.
- Development of workforce plan
- Focus on community waits across SEL

Actions for 25/26

- Focus on Population health management for Core 20+5 populations in access to community services

Intended outcomes in 5 years time

- At least 80% of all CYP community services to have agreed common service standards which includes a common set of outcome measures that be reported both a local and system level.
- At least 70% of the developed common service standards to be implemented through Local Care Partnerships.
- Reduction of inequality in health outcomes CYP in South East London (NB. exact definition to be considered as the common standards for each service are developed).
- Planned winter response and reduction in emergency attendance for CYP between December and February (annually).
- Establishment and delivery of a clear transformation programme for children with SEN.

CYP priority action 3 – Integration and Inequalities

Integration and inequalities

Develop integrated models of care for children and young people at a neighbourhood level that bring together health and care services across specialist health services, primary and community services, mental health, and local authorities including education to improve care co-ordination, support for families and reduce health inequalities.

How we will secure delivery

Actions for 24/25

- Development of remaining 3 boroughs plans for integration to deliver Fuller recommendations
- Working with Local Authority to explore and implement options for integration models within family hubs
- Development of a SEL SEND strategic vision and objectives to support Place based delivery of SEND services0
- Working with the Mental health team to focus on the development of a Child Sexual abuse service model for South East London to deliver a South London shared point of access, provision of multidisciplinary assessment, increasing access to emotional support offer, ensuring CYP and their families access their agreed care package, and lead on developing seamless pathways and ways of working for CSA wellbeing services

Actions for 25/26

- Firm proposal around neighbourhood based care models for CYP
- Work plan for CSA services (to be developed based on the learning from 2024/25)

Intended outcomes in 5 years time

- All places to have full PCN coverage of integrated models or the child health models
- Overall shift in activity from hospital based to community based care, resulting in improved health outcomes in CYP population and care delivered in the most appropriate setting. This translates into a reduction in
    - CYP contacts through emergency departments.
    - Non elective hospital admissions.
    - Increased CYP and family experience of care.
- Parity in approaches to SEND across SEL and data to support decision making and commissioning
- Implemented new CSA model in South East London

CYP priority action 4 – Effective Long Term Condition Management

Effective Long Term Condition Management

To ensure effective long term condition management for children and young people including asthma, epilepsy, diabetes , obesity and sickle cell, incorporating population health management approaches into service design and delivery and meeting the requirements of Core20PLUS5 and our SEND population.

How we will secure delivery

Actions for 24/25

- SEL Focus on deliverable for the '5' population across SEL
- Begin implementation of Asthma friendly schools in SEL working with system partners
- Commence implementation of CGM and Hybrid Closed Loop (HCL) systems across SEL for CYP
- Monitor expanded CEW clinics for CYP with severe obesity
- Scoping and planning for Epilepsy core 20+5 offer (working with STPN)
- Engagement event for CYP with Diabetes (working with Healthwatch)

Actions for 25/26

- Working with Business intelligence to understand CYP with co-morbidities
- Working with Primary care to improve monitoring and recording for CYP with LTC

Intended outcomes in 5 years time

Asthma

- Reduction in over-reliance on reliever medications for Asthma (reduce % of CYP with a reliever: preventor ration greater than 1:6)
- Decrease in number of asthma attacks (reduce unplanned hospital admissions, presentations in ED, prescriptions of oral steroids)

Diabetes

- Increase real time continuous glucose monitoring and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds
- Increase in proportion of CYP with type2 diabetes receiving annual health checks

Epilepsy

- Increased access to epilepsy speciality nurses
- Access to first year of care for CYP with LD or autism

CYP priority action 5 – Transition

Transition

Develop models of care that support transition into adult services for those aged 16-25 years of age

How we will secure delivery

Actions for 24/25

- Working with providers to ensure CYP with diabetes who are 16-18 are able to access HCL systems regardless of their being in a CYP or adult service
- Ongoing work with LDA team, Continuing care team and Sickle cell programme around transition for these groups of CYP

Actions for 25/26

N.B Actions to be defined in in 2024/2025, in line with the agreed work programme.

Intended outcomes in 5 years time

- All providers and Places to have adopted the transition principles as part of their core offer for CYP and as business as usual for services.
- Improvements in the experience of care for young people transitioning through services

CYP priority action 6 – Urgent and Emergency Care

Urgent and Emergency Care

Develop pathways and services that support safe, effective and appropriate CYP access to Urgent and Emergency Care (UEC) including Emergency Departments.

How we will secure delivery

Actions for 24/25

- Review and develop pathways and services that support safe, effective and appropriate CYP access to UEC using reviews form 2023/24 as a baseline, working with partners to ensure alternatives are available.
- Focus on front door access and care improvements
- CYP to be included in the ICS wide communications plan (see UEC plan)
- Review of SDEC services to meet requirements
- Input into re-procurement of 111 services to strengthen CYP support

Actions for 25/26

- TBC as workplan develops

Intended outcomes in 5 years time

- Deliver A&E 4 hour target of 76%.
- All UEC and A&E will use South East London pathways to ensure CYP are appropriately accessing services via UEC/A&E through a South East London core offer which offers access to same day emergency care equitably across the geography.
- Reductions in presentations at A&E for certain patient groups through implementation of other UEC care – measurement to be defined during 2023/24, including the development of quality outcome measures to sit alongside any performance or activity measures.
- Each UEC contact is appropriate to level of patient acuity (audit)

CYP enabler requirements

Workforce

- Development an ICS-plan to support recruitment and retention into community paediatric services, linked to wider initiatives on AHP workforce development.
- Training and support for staff to ensure service delivery is anti-discriminatory and trauma informed.
- Organisational development support to build integrated teams across community and primary care settings, and across health and care services in line with the priorities set out for Integration.

Digital

- Interoperability and the ability to better share data between primary and secondary health care services in order to build and expand Integrated Model. Over time, this needs to include access to local authority held data to support multi-agency and partnership working. This will also support the development of population health management approaches to improve care and outcomes for children and young people.
- Access to digital health passport for long term condition management both for individuals, their families and services. Linked digital health passports across service provider especially primary care and acute.
- Development of and access to a Healthier Together website for SEL

Estates

- Ability to co-locate multi-agencies and partnerships involved in the delivery of children and young people's services.
- Primary and community space in order to expand the Integration agenda across SEL.

Data

- Effective data sharing for clinical programmes and for partnership working across health based organisations and health and care.
- Ability to triangulate datasets for CYP bringing together maternity, acute, community and mental health datasets to provide a comprehensive understanding of children and young people's services, outcomes and care, to then better support the delivery of population health management approaches.
- Ability to easily share access to an ICS wide CYP dashboard which includes the metrics and datasets above.

Learning Disability and Autism (LDA)

Overview of our current system

South East London ICS is responsible for the health and care of and estimated 9,000 people with a Learning Disability and an estimated 21,000 Autistic people. Nationally and locally we know that life expectancy for people with a Learning Disability is lower than the general population and have higher rates of death from avoidable causes than for the general population - 49% vs 22%. Between 20-30% of Autistic people also have a Learning Disability and 70% of Autistic people also have a mental health condition and 40% have two or more mental health conditions. In March 2023, the number of people adults and children and young people per million receiving care in mental health hospitals, was higher than Long Term Plan ambitions of 30 and 15 per million and reflective of an increase in new identification and diagnoses of Autism in the SEL population. By March 2025 we anticipate that the numbers in hospital per million will be more in line with ambitions outlined in operational planning of 42 Adults and 6 children and young people given the small population increase.

Strengths / opportunities

Inpatient Reduction and Admission Prevention (all age)

- The rate of admission for adults has halved since 2019 from an average of eight (8) admissions per month to four (4). This has led to a significant reduction in non-secure and secure inpatients and the achievement of target. Intensive Support Teams and Autism Support Services have contributed to the reduction.
- Case Management and resources to undertake Care Education Treatment Reviews (CETRS) is well established. Work on Dynamic Support Registers (DSRs) and implementing a consistent offer across south east London is a further opportunity to prevent admissions.
- The SELECT Key Working Service is well implemented and supports admission prevention for children and young people.

Improving quality of life/care – whole population

- Well established SEL steering groups for Annual Health Check and LeDeR – (Learning from the lives and deaths of people with a Learning Disability and Autistic people)
- Specialist LDA Prescribing Advisors to stop over prescription of psychotropic medication in adults and children (STOMP and STAMP

Challenges

Strategic response to Autism

- Significant variation in the development and implementation of place-based Autism Strategies.
- Significant waiting times for Autism Assessment for diagnosis and post diagnostic support across all ages.

Care, Support, and Housing

- Underdeveloped provider market for:
  - ❑ good quality housing and accommodation options within south east London.
  - ❑ delivery of good quality care and support packages.

Workforce

- Difficulty in in recruiting and retaining good quality learning disability workforce for example Learning Disability Nurses and support staff.
- *Variable clinical confidence in embracing STOMP assessments in primary care*

What we've heard from the public

The key messages from our SEL LDA User, Parent, Carer Forum for Co-production is; the need to improve community services and alternatives to hospital admission; support for the expansion of Key Working and autism support services. We also heard from Learning Disability and Autism ambassadors as part of the ICS strategy development process that people need more support in the community around mental health and being safe – most people had experienced 'mate crime'. The issues of training and time that workers have available to support with talking about feelings, support to live healthily such as with cooking rather than microwave meals, support with attending and taking part in healthy activities and groups were seen as important to support with prevention. The need for confidence training for people and support from key workers as well as the health professional being seen was highlighted as important in accessing health services as was the rolling out of health passports with personal health profiles to support a more holistic approach to care and support without people having to tell their story many times.

Our vision and objectives

Our vision

South East London Learning Disability and Autism Programme **vision** is for people with a Learning Disability and Autistic people to achieve **equality of life chances**, **live** as **independently** as possible and to have the **right support** from mainstream health and care services.

Our key objectives – what we want to achieve over the next five years

The top things that we want to achieve over the next five years builds on achievements in the last four years where the objectives were to

- Reduce long term inpatient care by reducing the reliance on inpatient beds
- Improve quality of life and quality of care by delivering co-ordinated care
- Enable community living by commissioning to improve community services and capacity.

In the next five years:

1. In addition to further reducing the number of inpatients, the focus will be on ensuring appropriate admissions, reducing length of stay, repatriating people to south London and improving the quality of inpatient and community services.
2. Reducing health inequalities in terms of improving outcomes and access for people with a Learning Disability and Autistic people, in both hospital and community settings.
3. Significantly reduce the waiting times and the number of people of waiting lists for autism diagnostic assessment across all ages and develop post-diagnostic support for people with an autism only diagnosis.
4. Develop community alternatives to hospital admission to meet the needs of current inpatients as well as prevent admission by providing safe and effective care and support in the community.

Our priority actions

Our priority actions – what we will do

The Learning Disability and Autism Programme will set out a programme plan to deliver and achieve the objectives set out. Given the significant achievement made toward achieving the objectives in the Long Term plan, the LDA programme will continue to support and maintain priority actions that have been achieved and embedded. The first three (3) priority actions require a strategic response with ICS partners as these have challenged the system in previous years. All other actions fit broadly into reducing long term inpatient care by reducing the reliance on inpatient beds and improving quality of life and /care by delivering co-ordinated care and includes work in progress.

1. **Implementation of the SEL LDA Strategic Response to Autism** – includes significantly reducing the waiting times and the number of people of waiting lists for autism diagnostic assessment across all ages and develop post-diagnostic support for people with an autism only diagnosis.

2. **Develop the SEL Care and Support offer in the community with ICS partners** - local authorities, ICB and provider collaborative. Includes understanding the current costs within the ICS, developing the market, developing providers for inpatient secure, non-secure and community options, accommodation and housing

3. **Develop the Learning Disability and Autism workforce** to deliver quality services, care and support to people with a Learning Disability and Autistic people.

4. **Reduce long term inpatient care** by reducing the reliance on inpatient beds

5. Improve quality of life and /care by **delivering co-ordinated care.**

LDA priority action 1 – Strategic response to Autism

Name of priority action

Implementation of the SEL LDA Strategic Response to Autism – includes significantly reducing the waiting times and the number of people on waiting lists for Autism diagnostic assessment across all ages and development of post-diagnostic support for people with an Autism only diagnosis to prevent admission to mental health assessment and treatment units and suicide (risk)

How we will secure delivery

Actions for 24/25

- Implementation of an SEL Autism Strategic Framework in support of the six (6) SEL Place-based Autism Strategies.
- Continue implementation of Adult Autism pathway with a focus on reducing variation and improving equity for diagnostic assessments across all six (6) boroughs.
- Development of the Autism Dashboard to understand SEL population/ prevalence and the health inequalities experienced by the autistic population .
- Monitor and evaluate clearance of waiting list and times for Autism Diagnosis with providers.
- Implementation of the SEL Core Offer for CYP Autism Assessment Pathway developed in 23/24 to intervene early and reduce variation across all six (6) boroughs.
- Implement the Partnership for Inclusion of Neurodiversity in Schools (PINS) programme and autism support via the Emotionally Based School Avoidance (EBSA) project.
- Work with each borough to ensure community services meets the needs of the LDA population

Actions for 25/26

- Work with each borough to ensure provision of community services meets the needs of the LDA population and can be evaluated.

Intended outcomes in 5 years time

1. Waiting times for Autism Assessment and Diagnosis will be 12 weeks in all SEL boroughs for adults and children and young people.
2. Improved needs led Autism support services in each SEL borough including improved offer in boroughs to support neurodiverse children and young people
3. Fully functioning Autism Dashboard to understand need and trends in SEL.
4. Improved training opportunities focused on the needs of people with a Learning Disability and Autistic people are better understood and met within mainstream provisions.

LDA priority action 2 – SEL care and support offer

Name of priority action

Develop the SEL Care and Support offer in the community with ICS partners - local authorities, ICB and provider collaborative. Includes understanding the current costs within the ICS, developing the market, developing providers for inpatient secure, non-secure and community options, accommodation and housing

How we will secure delivery

Actions for 24/25

- Fully implement the LDA Pathway Strategy and Panel in partnership with the Mental Health and Community Provider Collaborative (South London Partnership – SLP) who are responsible for secure inpatients and their discharge to the community as the least restrictive environment.
- Continue development of FIND - Forensic Intellectual and Neurodevelopmental Disabilities service to meet needs in the community.
- Recruitment of a SEL LDA housing lead to update and support implementation of a SEL housing plan across SEL boroughs – including alternatives to admission and scoping of crash pad/crisis offer of CYP especially those transitioning and where mental health is not primary factor.
- Build on the analysis of inpatient and community provision costs to inform commissioning decisions and future requirements across health and care.

Actions for 25/26

- With ICS partners – local authorities, ICB and SLP provider collaborative implement community housing and accommodation options for secure and non-secure patients, including bespoke options required.

Intended outcomes in 5 years time

1. Adequate and timely community accommodation and support for people admitted to secure and non-secure settings.

2. Reduction in the number of Adults and Children and Young People in hospital over five (5) years to 30 and 15 per million respectively.

LDA priority action 3 – LDA Workforce

Name of priority action

Develop the Learning Disability and Autism workforce to deliver quality services, care and support to people with a Learning Disability and Autistic people.

How we will secure delivery

Actions for 24/25

- Continue to build on develop and expand the SELECT Key Working Service to meet the need of children and young people and particularly those 18-25.
- Working collaboratively across ICS partners, as required to capture workforce needs into SEL Workforce transformation plans.
- Review of the workforce in community learning disability and autism services across SEL to identify gaps in services of staff/professions and models of working.
- Update and review the Learning Disability and Autism Workforce Baseline Data Collection information to understand gaps in services including vacancies.
- Develop and build on recruitment and retention plans for LDA services with partners in ICS.
- Utilise our Anchor institutions and partners in the ICS to encourage employment of people with a Learning Disabilities and Autistic people
- Delivery of Oliver Mc Gowan Mandatory Training (OMT) across SEL.
- Implement Care Education Treatment Reviews (CETRs) and Dynamic Support Registers (DSR) guidance and support for staff.

Actions for 25/26

- Continue to implement mandatory training across SEL.
- Continue to implement workforce transformation plans with partners specifically recruitment and retention plans for LDA workforce and establishment/clarification of the minimum vacancy rate for LDA services.

Intended outcomes in 5 years time

1. Fully developed Key Working service for children and young people up to 25 with 100% of inpatients (blue rated) with and allocated keyworker and 90% of CYP rated red and amber on Dynamic Support Registers (DSRs) allocated within service.
2. Fully operational and effective Learning Disability and Autism services staffed at appropriate agreed level.
3. At least 75% of staff in ICS completed Oliver McGowan Training.
4. Increase the number of people with a Learning Disability and Autistic people employed in local anchor institutions with support and adjustments made within workplaces.

LDA priority action 4 – Reduce long term inpatient care

Name of priority action

Reduce long term inpatient care by reducing the reliance on inpatient beds with focus on admission prevention.

How we will secure delivery

Actions for 24/25

- Support local areas to develop and improve Dynamic Support registers (DSRs) for all ages and implement operational procedures for the new DSR and CETR guidance.
- Fully implement Local LDA Steering groups in all six boroughs.
- Continue with business as usual Case Management for inpatients.
- Continue focused inpatient surgery and targeted work with people in assessment and treatment over five (5) years.
- Fully operationalise Dynamic Support Registers and place based steering groups that lead on admission prevention and discharges from hospital

Actions for 25/26

- Ensure business as usual for Dynamic Support Registers and place based steering groups that lead on admission prevention and discharges from hospital.

Intended outcomes in 5 years time

1. Reduction in the number of adults and children and young people in hospital over five(5) years to 30 and 15 per million respectively.

LDA priority action 5 – Coordinated care

Name of priority action

Improve quality of life and /care by delivering co-ordinated care.

How we will secure delivery

Actions for 24/25

- Implement identified projects to achieve Annual health Checks (AHCs) for people 14+ - for example LDA health Ambassador roles and AHC Co–Ordinator roles.
- Implement STOMP Clinics (Stopping the Overprescribing of Psychotropic Medication)
- Continue to implement the Learning from the lives and deaths of people with a learning disability and Autistic people. (LeDeR Programme)
- Host Commissioner oversight visits within all Learning Disability and Autism setting including mental health hospitals.
- Support implementation of a SEL Core Offer for Community Health services for SEND (Special Educational Needs and Disability) with the Community Provider Network and CYP Programme.

Actions for 25/26

- Fully embed good quality effective AHCs and improve the capacity needed in primary care networks (PCNs).
- Implement learning from initial and focused LeDeR reviews across SEL within place and in primary care.
- Undertaking quality oversight of inpatient hospital setting by placing commissioners, using Host Commissioner framework and guidance.
- Embed SEND guidance and consistent Local Offers with the SEL SEND Group/Network.

Intended outcomes in 5 years time

1. Achievement of over 75% of people with a learning disability and autistic people having annual heath checks.
2. Reduction in avoidable deaths for people with a Learning Disability and Autistic people to 20% (currently 49% nationally)
3. Reduction in treatment gap and improved equity of health and social care delivery, and preventable deaths based on themes identified by SEL LeDeR
4. Increased understanding of reasons for deaths of:
    - People from Black, Asian and Minority Ethnic communities.
    - The wider autistic community.

Enabler requirements

Workforce

- Collaborative working across ICS partners, as required to capture workforce needs into SEL Workforce transformation plans.
- Review of Learning Disability and Autism Workforce Baseline Data Collection information
- Anchor institutions to actively facilitate and encourage the employment of local people with a learning disability and autistic people.

Digital

- Access to acute and primary care systems for implementation National Reasonable Adjustment Digital Flag in support of Guy's and St. Thomas (GSTT) "Fast Follower" pilot work.

Estates

- Access to advice from Estates Team to support the development of community options and bespoke developments.

Data

- Operationalise Learning Disability and Autism Dashboards that were developed during 2022/23.

Planned Care

Overview of our current system

A focus of the system is to reduce the backlog of patients awaiting specialist appointments and procedures. Whilst steady inroads have been made, particularly in respect of reducing the number of patients waiting a very long time for treatment, there is still a lot to do. Growing waiting lists have been an issue for many years, so there is a need to increase the systems historic levels of activity to improve this position. We are working to strengthen communication between primary and secondary care, improve referral pathways and ensure patients are seen as quickly as possible in the most appropriate setting. In addition, our focus is to try and increase capacity to diagnose, treat patients, work more collaboratively to pool resources, and become more productive by improving the efficiency of services.

Strengths / opportunities

Collaboration – The formation of the Acute Provider Collaborative (APC) has resulted in closer working than ever before between hospitals. Specialty teams now routinely work together to provide mutual aid, develop joint pathways and share staff and expertise

Community provision – We have developed some of the most comprehensive out of hospital services in the country for specialties such as Ophthalmology and Dermatology. We are thus in a good position to build on these foundations for services such as ENT and for diagnostics

Challenges

Physical capacity – In order to manage the backlog, and to make sure we have sustainable services in the longer term, we know we are going to need additional physical resources. This includes, beds, theatres and diagnostic equipment, in order that we can balance emergency demand with planned outpatients and procedures

Staffing – There are a number of specialties where there are significant staffing challenges. To mitigate this we have tried to use the Independent Sector, and insourcing companies, but we want to ensure that we have sustainable staffing models and offer good jobs, to local people. We are exploring alternative ways of working and cross site working as part of our collaborative solutions to these challenges

Inequalities – We know that waiting times and access to care varies across SE London. We need to make sure that we prioritise those in the greatest need, but that this is done equitably across the ICS

What we've heard from the public

People have told us that increased waiting times has placed significant burden on their physical and mental health and wellbeing, work and financial stability and relationships (Joint Programme for Patient, Carer and Public Involvement in COVID recovery, 2022, and SEL ICS working with people and communities strategy engagement, 2022). Whilst they wait people want to be kept informed, supported to manage their conditions, and access to support services and peer support. The recent MSK community days (March 2024) co-designed with the MSK lived experience group helped to address this issue and were well received.

Planned care - Our vision and objectives

Our vision

We want elective services to be equitable, deliver high quality care and be responsive to the needs of our population. Our aim is to work collectively as a system to ensure that patients have better access to specialist advice when they need it and that we reduce the number of times patients need to come to hospital, and working in partnership with the relevant tiers of the system to ensure care is offered as close to where patients live whenever possible. We will also ensure that through system working we speed up the time to treatment and adopt new ways of working and best practice pathways, to ensure services offer patients the highest quality care.

Our key objectives – what we want to achieve over the next five years

- **Reduce waiting times and deliver equitable, sustainable waiting lists** - By working together, we have made good progress in seeing and treating the patients with the longest waits and for those who are waiting, equalising waits between hospitals and different patient groups. Whilst this is a good start, we want to go much further. To achieve this, we need to maximise the amount of activity we undertake, make best use of collective resources and capacity, and maximise productivity and efficiency in both non-admitted and admitted care pathways. We need to make sure that every appointment genuinely adds value and that we look to streamline pathways wherever possible.
- **Be much more patient-centric** – Our patients consistently tell us that they find long waits for appointments and treatment incredibly frustrating, and that not knowing what is happening can be frustrating and isolating. Improved communication between hospital services and primary care and patients is key to delivering patient centric care, this will require both digital and non-digital solutions.
- **Ensure patients are seen in the most appropriate setting, by the most appropriate professional** – We will work collaboratively with the relevant tiers of the ICS on the successful delivery of community services, such as those in ENT, Dermatology and Ophthalmology, to bring more services closer to home. This should reduce waiting times, and free up capacity at hospital sites. Aligned to this we will look to improve communication between primary and secondary care services to allow clinicians to better communicate about their patient to ensure pathways are used as appropriately as possible.
- **Improve equality of access to timely and high quality services** - by working together as a system make best use of collective capacity and ensure we are working together to align pathways, protocols and processes that deliver consistent and high quality care for patients

Planned care - Our priority actions

Our priority actions – what we will do

1. Implement **personalised outpatients**, ensuring patients can access care conveniently and in a way that best meets their needs. This will be achieved through optimising models such as Patient Initiated Follow-up (PIFU) and virtual appointments. We will support utilisation of digital and non-digital solutions by provider Trusts that will enable patients to have more control and information about their care, and easier access to contact hospital teams.

2. Ensure patients are seen in the **right place, first time, by the right professional**. We will do this by improving the quality and timeliness of advice and guidance; implementing clinical triage of referrals across a wide range of specialties; and working collaboratively with the relevant parts of the system to improve referral management systems, access to guidance and further developing the community services offer.

3. **Minimise waiting times and improve treatment capacity.** The system will look to maximise available capacity to improve waiting times. We will review how capacity is used on a system basis rather than by organisation and look to improve this through better and more organised use of mutual aid. Further to this the system will review the possibility of having single points of access for specific services where appropriate and continue to implement and maximise use of treatment hubs across SEL, to increase capacity for high volume low complexity surgery. For those who are waiting we will monitor the waits across different patient groups to ensure we provide equitable access to all.

4. Continue to improve quality of services **and work towards achieving GIRFT standards and best practice pathways,** through the work of the elective clinical networks. The networks bring together services across sites to align pathways, protocols and processes and design and implement new ways of working that improve care for patients.

5. **Implement the SEL Community Diagnostic Centre (CDC) rollout programme** to create additional diagnostic capacity through an initiative that straddles all four key objectives – contributing to reducing waiting times; ensuring patients can be seen in the most appropriate environment through the provision of more local services and the development of ‘one stop shop’ diagnostic services; and improving equity of access to diagnostic services.

Planned Care – Our progress to date

Key Successes in Delivery in 2023/2024

- Established Single Point of Access (SPOA)/triage in Ophthalmology and Dental
- Referral guidelines developed in Urology, ENT and Menopause with similar work progressing in other high priority specialties
- Continued the rollout of PIFU
- Eltham CDC opened providing enhanced diagnostic capacity, as well as more direct access investigations for GPs. Significant mobilisation work also completed throughout the year, ahead of QMS CDC opening.
- Launched Teledermatology for dermatology services across 4 of our 5 acute sites, allowing a faster time to review for patients and more efficient use of capacity by speciality secondary care teams.
- Supported the expansion of community ophthalmology offer, through the introduction of new care pathways for people with learning disabilities and care home residents.
- Patient portal, MyChart launched at Guy's and St Thomas' NHS Foundation Trust and King's College NHS Foundation Trust through the roll out of EPIC.
- Established a waiting times website to provide GPs with current waiting times

Key Challenges to Delivery in 2023/2024

- Ongoing Industrial Action has impacted capacity throughout the patient pathway and across the year.
- EPIC roll out at both GSTT and KCH simultaneously has led to specific data and capacity issues and has taken the focus and attention of the workforce.
- Increasing demand leading to capacity pressures in challenged services
- Tight financial controls and constraints which can lead to delays in progressing key transformation projects

Learning and Implications for Future Delivery Plans

Triage difficult to take forward during a large IT change. Now this is complete renewed focus of the system. There are benefits from improving these and A&G across pathways to free up time and capacity to see and treat appropriate patients.

Planned care priority action 1 – implement personalised outpatients

Implement personalised outpatients

Change the way services are delivered to ensure patients have greater control over how, when, and where outpatient services are delivered in order to best meet their individual needs. This will be achieved through scaling up models such as Patient Initiated Follow-up (PIFU) and virtual appointments. We will support utilisation of digital and non-digital solutions by provider Trusts that will enable patients to have more control and information about their care, and easier access to contact hospital teams.

How we will secure delivery

Actions for 24/25

- Increase the uptake and, where appropriate, standardise the PIFU offer across SEL. As well as moving new patients onto PIFU, this will involve reviewing patients on existing waiting lists to see if they are suitable for PIFU.
- Increase use of remote monitoring pathways across SEL, utilising wearable technology where appropriate.
- Review use of virtual consultations and identify opportunities for greater use.
- Continue to support utilisation of Patient Portals, such as MyChart.

Actions for 25/26

- Support providers in optimising MyChart functionality to ensure that patients have access to the features which improve their experience and optimise their care.
- Establish PIFU and remote monitoring as business as usual across all specialties and all trusts.
- Support data driven approaches (such as Factor50) across three acute trusts to deliver stratification of waiting lists according to clinical need and urgency.

Intended outcomes in 5 years time

- Patients have convenient access to their personal health information (including results) and are able to message their care teams and update their contact information via well established patient portals.
- Patients are empowered, informed and able to exercise choice over their appointments - initiating follow-up appointments when they need them and able to choose how they access their care (e.g. in person, telephone or video).
- Models such as PIFU and remote monitoring are business as usual across all specialties and all trusts.
- Data is routinely utilised to support stratification and prioritisation of waiting lists.

Planned care priority action 2
Right place, First time

Ensure patients are seen in the right place, first time, by the right professional

Ensure patients are seen in the right place, first time, by the right professional. This will be supported by improving the quality and timeliness of advice and guidance; implementing clinical triage of referrals across a wide range of specialties; and working collaboratively with the relevant parts of the system to improve referral management systems, access to guidance and further developing the community services offer.

How we will secure delivery

Actions for 24/25

- Support establishment of a pan-SEL community ENT service, which will offer an intermediate tier of care and increase ENT capacity significantly.
- Further enhance the integration of the community and secondary care dermatology services, with the community services triaging on behalf of secondary care.
- Improve uptake of Ophthalmology new care pathways for people with learning disabilities and care home residents and ensuring the service is sustainably commissioned / procured.
- Further develop community MSK pathways, to include developing a single point of access (SPOA), working with stakeholders across the pathway to optimise services and improve integration.
- Improved use of advise and guidance and implement clinical triage of referrals across multiple specialties at all sites.
- System to reprocure community ear wax service to ensure work is streamed away from secondary care.
- Consider introduction of SPOA in other specialities

Actions for 25/26

- Effective use of referral management systems in primary care.
- Further expand triage.
- Review Demand and Capacity of new ENT service.

Intended outcomes in 5 years time

- Comprehensive community offer in place across south east London for ophthalmology, dermatology and ENT.
- Community and secondary care services are integrated, with teams working together and as part of integrated neighbourhood teams to ensure patients are seen in the most suitable setting.
- Primary care professionals are able to routinely access high quality, timely advice from other healthcare professionals across all specialties.
- Primary care professionals are able to easily access the latest guidance and care pathway information so they can determine the next best step in the patients care.
- Patients experience fewer journeys to hospital as pathways are streamlined and a one-stop service is offered wherever possible.

Planned care priority action 3 – minimise waiting times and improve treatment capacity

Minimise waiting times and improve treatment capacity

The system will look to maximise available capacity to improve waiting times. Review how capacity is used on a system basis rather than by organisation and look to improve this through better and more organised use of mutual aid in addition to exploring opportunities for service reconfiguration. Further to this, the system will review the possibility of having single points of access for specific services where appropriate and continue to implement and maximise use of treatment hubs across SEL, to increase capacity for high volume low complexity surgery.

How we will secure delivery

Actions for 24/25

- Continued focus on maximising use of current capacity along with the provision of additional lists in available NHS capacity.
- Where financially possible, continued use of the IS to increase local capacity.
- Continue to take a system planning approach in the most challenged specialties.
- Continue discussions with key specialties about moving to SPOA and process / pathways and implement where possible. Initial focus on MSK/orthopaedic pathway and Hernia pathway.
- Continue to optimise use of gynae and general surgery treatment hub at Queen Mary's Sidcup; ensuring lists are utilised/booked to specified levels, establish SPOA and pathways for certain procedures, increase use of overnight capacity
- Modify operating model at Orpington so that patients from across SEL have access to orthopaedic treatment at the site and it operates as a system hub
- System planning to take account of additional inequalities identified within waiting lists
- Rerun demand and capacity analysis to understand the impact of the implementation of hubs and inform the HVLC clinical strategy for SEL.

Actions for 25/26

- Open the SEL urology and ENT hub capacity at University Hospital Lewisham.
- Review benefit of upfront system planning and SPOA for equalising waiting times across the system and continue roll out programme.
- Continue work to maximise use of hubs across SEL; ensuring high productivity and efficiency, equality of access to patients, system use of resource.

Intended outcomes in 5 years time

- Upfront system planning embedded as a way of working across multiple specialties
- Equalisation of waiting times in identified specialties
- Sustainable waiting lists across the system through better direction and management of demand
- Upfront system planning embedded as a way of working across multiple specialties
- Reduction in maximum waiting times in line with national expectations

Planned care priority action 4 – quality of services

Quality of services

Continue to improve quality of services and work towards achieving GIRFT standards and best practice pathways, through the work of the elective clinical networks. The networks bring together services across sites to align pathways, protocols and processes and design and implement new ways of working that improve care for patients.

How we will secure delivery

Actions for 24/25

- Continuing to develop role and maturity of the clinical networks and the long term clinical vision for each of the networks
- Consideration of whether current complement of networks is sufficient to achieve overall system objectives
- Networks key objectives include prioritising GIRFT metrics and addressing these across sites to ensure improved patient care and productivity
- Networks continue to look at patient pathways and where necessary develop plans to reduce variation; reducing inequality and improving quality of care consistently across SEL

Actions for 25/26

- Ongoing assessment of where networks have got to and outstanding areas of improvement required
- Developing a rolling programme of work in response to changing operational challenges.
- Strengthen plans to address key metrics across all our Trusts

Intended outcomes in 5 years time

- Delivery of performance targets including GIFRT metrics, consistently across all sites
- Reduction of overall waits and parity of waits across sites
- Implementation of best practice pathways and agreed clinical strategics for network specialities to improve patient care

Planned care priority action 5 – Implement Community Diagnostic Centres (CDC)

Implement CDC rollout programme

Implement the SEL Community Diagnostic Centre (CDC) rollout programme to create additional diagnostic capacity through an initiative that straddles all four key objectives – contributing to reducing waiting times; ensuring patients can be seen in the most appropriate environment through the provision of more local services and the development of 'one stop shop' diagnostic services; and improving equity of access to diagnostic services. The programme has already seen success via the opening of Phase 1 of CDC at Eltham Community Hospital providing additional system capacity in Phlebotomy, Respiratory diagnostics, Ultrasound and Cardiac diagnostics.

How we will secure delivery

Actions for 24/25

- Continued collaboration across providers for clinical pathway design
- Implementation of Soliton Share + to enable sharing of images and Switftqueue for patient booking across SEL
- Opening of Phase 2 at Eltham CDC covering CT, MRI and X-ray services operational from March 2025
- Roll out of SEL-wide GP Order Communications system for radiology
- Securing UKAS IQIPS accreditation for services at the Eltham CDC
- Deliver final construction phase for the spoke CDC at Queen Mary Hospital (Sidcup) with CT, MRI and X-ray services operational from March 2025

Actions for 25/26

- Roll out of SEL-wide GP Order Communications system for pathology
- Securing UKAS IQIPS accreditation at the QMS CDC
- Enhancing clinical pathways to align to best practice and the implementation of digital enablers
- Embedding the CDCs as part of the population health offer in SEL including potential scope of new service delivery models such as one-stop-pathways, virtual wards

Intended outcomes in 5 years time

All CDCs will be accessed equitably by the whole SEL population with the following same outcomes across both sites:

- Multiple referral routes into the service, with primary care having direct access for a number of tests
- Single point of access from primary, community and secondary care
- Multiple methods of booking to suit patients and health professional
- Interconnected digital infrastructure
- Reporting to the referrer in a timely manner
- Diagnostics tests required should be carried out in as few visits as possible

Planned care - enabler requirements

Workforce

- Job plans to ensure there is ringfenced time for activities such as clinical triage and advice and guidance, and for operating time at hubs. These are value adding activities, so it should not be assumed they can be done in addition to existing responsibilities.
- The ability for clinicians in SEL to work across all sites (in either a planned or ad hoc way) and the expectation of system and cross site working is set for both new appointments into the system, and with existing staff
- System recruitment into specific specialties to increase overall capacity and support implementation of community and hub working e.g. ENT
- Alternative roles / ways of working to mitigate against staff shortages

Digital

- The implementation of EPIC offers great opportunities for developing a fully functioning patient portal. There is an opportunity to harness the tools such as MyChart present to support patients in managing their care.
- There are compatibility issues between e-RS and EPIC. These will need to be resolved if we are to make sure that both primary and secondary care have good oversight of appointments, and can have two-way discussions over referrals

Estates

- Suitable spaces for community services in SEL, to ensure a consistent and effective offer that will support reducing demand in to acute settings. These locations need to be accessible for local people and have the necessary clinical set-up.
- Space for outpatient procedures to optimise use of theatre capacity

Data

- Comprehensive suite of timely, accurate SEL wide data available to monitor performance against in year metrics
- Link primary, secondary and social care data to provide a wider range of patient information to help inform future prioritisation and optimisation of patients waiting for treatment
- Routine capture of the anaesthetic physical status of all patients waiting for surgery to help inform both the operational management of the waiting list but also ensure strategic planning of services meet the needs of patients

Maternity

Overview of our current system

The South East London (SEL) Local Maternity and Neonatal System (LMNS) is a partnership between providers, commissioners, user representatives and other stakeholders working together to improve maternity and immediate neonatal care and is the maternity arm of the Integrated Care system (ICS). The LMNS has responsibility for overseeing maternity and neonatal and maternity improvement and quality and safety.

Strengths / opportunities

Collaboration/Sharing and Learning - Significant work has taken place over recent years to establish relationships and system wide working to improve maternity and neonatal care across SEL enabling maternity and neonatal services to share and learn together leading to joint service delivery that supports good care wherever you live or whoever you are.

Transparency – an increase in openness and transparency means that the LMNS is in a better position now than ever to understand the challenges that maternity and neonatal services and the people that use the services face and work together to tackle these.

Equality and Equity Action Plan

Several community engagement projects have taken place over the last year, which has provided the LMNS with key information and feedback from the communities we serve with a focus on those that are underrepresented.

Challenges

Inequalities – Black, Asian and mixed ethnicity women and birthing people, and those living in deprivation continue to have disproportionately poorer maternal and neonatal outcomes compared to their white counterparts

Workforce – Maternity and neonatal services are experiencing significant staffing challenges with the delivery of basic services and can affect improvement or transformation programme implementation. This is not specific to SEL and is a national problem.

Communication

Unfortunately, we know that women and birthing people in SEL do not always feel listened to or receive good communication and inclusion about their care and choices.

Co-production

Planning the delivery of services does not always take place with service users.

What we've heard from the public

Women and birthing people want to be treated with kindness and compassion, listened to and involved in their care decisions.

Areas for improvement include:

- Better communication and information, especially when English is not the first language
- Improved understanding of cultures
- Individualised care
- Inconsistent access to antenatal and postnatal care and impact of the absence of family support and financial constraints on wellbeing within under-represented communities.

Maternity - Our vision and objectives

Our vision

South East London Local Maternity and Neonatal System (LMNS) has an ambition that women, birthing people, babies, and their families experience high quality, joined up, compassionate care during pregnancy, labour, birth and beyond.
They should be informed and supported to make choices that are right for them, and where there is a higher chance of complications and additional or different care is required, this is planned with the woman/birthing person, individualised to their needs and provides safe care with a positive outcome.
As a system we will continually strive to improve maternity and neonatal services and the experience of women, birthing people and their families.

Our key objectives – what we want to achieve over the next five years

- Deliver the actions set out in the LMNS refreshed **equality and equity** action plan ensuring that all women and birthing people receive high quality safe care
- Work as a system to **reduce unwarranted variation** across the maternity units and boroughs ensuring fairness to all.
- **Reduce preventable maternal and neonatal morbidity and mortality** through the delivery of national improvement programmes and local learning.
- **Embedding pelvic health services** and improving postnatal physiotherapy as per national guidance and local feedback.
- Support maternity services to deliver a **model of care that is personalised** for all women and birthing people.
- Embed the maternal medicine network ensuring that women and birthing people with **complex medical conditions** are cared for in the right place by the right people.
- **Strengthen perinatal mental health services** including implementation of the maternal mental health service via mental health providers, ensuring that women/birthing people who have suffered a bereavement, and/or have a fear of childbirth receive the psychological support they need.
- Continue to **engage and hear from our maternity and neonatal communities** ensuring that they are central to care planning.
- Look to provide a **preconception health offer** that will support the planning of health pregnancy
- Work towards creating a **sustainable maternity and neonatal workforce** through future planning, continued recruitment and support for staff retention and consider staffing models which will support the reduction of clinical staffing gaps.
- Collaborate with CYP programmes of work **to ensure birth to age 5 plans are joined up** enabling best use of resource and skill.
- Ensure there is appropriate **sustainable funding for the LMNS operational team** which is critical to the success and delivery of the maternity programme.

Maternity - Our priority actions

Our priority actions – what we will do

1. **Reduce inequalities and increase equity in maternity/neonatal services for women/birthing people and staff** - ensuring that care is personalised with the woman/birthing person at the centre and that there are equal opportunities for all staff especially those from minority backgrounds

2. **Reduce avoidable maternal and neonatal mortality and morbidity through local and national programmes –** continue current programmes of work to reduce morbidity and mortality, and implement new initiatives and expectations of the 'Three-year delivery plan for maternity and neonatal services'

3. **Continue to work closely with the Maternity and Neonatal Voices Partnerships (MNVPs) to collaborate and co-produce LMNS plans and work** – our priority will be to support each of the six MVPs within SEL, ensuring they are the user voice within maternity services, and expand their membership ensuring they are representative of the communities that we serve.
   Improve engagement with local communities to support future work – continuation of the SEL LMNS engagement plan to hear the voice of under-represented women and birthing people and integrate these voices into future service delivery improvements and transformation.

4. **Preconception health –** work with system wide partners to provide a preconception health offer.

5. **Workforce –** support maternity services with workforce and staffing plans utilising any recruitment resource available and improving retention rates of staff.
   Create a stable and substantive LMNS operational delivery team that can traverse across the system and operationalise the key actions required to deliver on the LMNS improvement plan.

Maternity priority action 1 – reduce inequalities

Reduce inequalities

Reduce inequalities and increase equity in maternity and neonatal services for women/birthing people and staff

How we will secure delivery

Actions for 24/25

- Commence the implementation the LMNS refreshed Equality and Equity action plan.
- Continue to prioritise actions and next steps through engagement with key stakeholders.
- Ensure all actions are overseen by the LMNS inequalities workstream and LMNS board.
- Review what additional resource/expertise is required to implement the plan.
- Engage with a wider network of stakeholders external to maternity to enable wide collaboration.
- Report on the SEL LMNS community engagement and recommendations from the outreach work
- Review maternity staffing data and support trusts with their equality and diversity plans via the LMNS workforce and education workstream.
- Support trusts with LMNS wide education and development of maternity and neonatal staff including future leaders
- Continue to review data collection and quality and work to address any gaps.
- Review the extent of digital exclusion across SEL
- Ensure maternity services are embedded within Family Hubs to increase access for women and birthing people from diverse communities on a local level

Actions for 25/26

- Offer training and resources to help maternity providers implement best practice in using interpreters and cultural competency
- Devise workplan for the next two years
- Ensure maternity services are embedded within Family Hubs to increase access for women and birthing people from diverse communities on a local level
- Develop a LMNS maternity passport for women and birthing people with disabilities

Intended outcomes in 5 years' time

- We will have improved maternal and neonatal outcomes for Black, Asian, and ethnic minority women/birthing people, those living in deprivation and their babies, ensuring that ethnicity and socio-economic background does not impact on a having a positive and safe maternity experience.
- We will communicate and listen well to women and birthing people ensuring we are able to do this for everyone even when English is not their first language
- All staff working within maternity and neonatal units across SEL will have the same opportunities to develop and progress their careers, especially those from minoritised groups.
- All women/birthing people will experience culturally respectful and knowledgeable care from care providers that are valued and respected within their workplace.
- SEL LMNS will have an ongoing relationship with our maternity communities ensuring that feedback and co-production is a consistent part of service creation and delivery with the woman/birthing person/family at the centre.
- Quality of data will be robust and provide the basis for service improvement and where resource is required.

Maternity priority action 2 – maternal and neonatal mortality and morbidity

Maternal and neonatal mortality and morbidity

Reducing avoidable maternal and neonatal mortality and morbidity through local and national programmes

How we will secure delivery

Actions for 24/25

- Continue to monitor maternity and neonatal quality and safety through LMNS process monitoring and system wide sharing and learning.
- Use data to provide targeted interventions to reduce perinatal mortality
- Support providers with the implementation of the Patient Safety Incident Response Framework (PSIRF)
- Continue work to improve data capture particularly around ethnicity and deprivation.
- Continue to oversee the implementation of key programmes and models shown to reduce poor outcomes e.g., the Saving Babies Lives Care Bundle (SBLCB), stop smoking services, 1001 days and Core20PLUS5.
- Review models of personalised care that would benefit those most in need.
- Start to implement the SEL preconception plan
- Continue to review data and evidence around enhanced continuity of carer for those most in need.
- Review maternal medicine network (MMN) pathways to ensure they remain best practice and evidence based and update, as necessary.
- Continue implementation of neonatal optimisation programmes as per the LMNS OPTIC workstream, including right place of birth for preterm babies.
- Ensure pelvic health services are embedded within the provider trusts.

Actions for 25/26

- Continue to implement and oversee actions required from national programmes and the three-year delivery plan for maternity and neonatal services.
- Utilise evaluation of preconception, maternity and neonatal interventions to plan for future services.

Intended outcomes in 5 years' time

- We will have improved maternal and neonatal outcomes for Black, Asian, and ethnic minority women and birthing people, those living in deprivation and their babies ensuring that ethnicity and socio-economic background should not impact on a positive and safe maternity experience.
- Continue to reduce perinatal morbidity and mortality for women and birthing people and their babies across SEL.
- Provide personalised care pathways for all women/birthing people.
- Make certain women/birthing people with medical conditions are cared for by the right professionals in the right place.
- There will be reduced numbers of women and birthing people smoking at time of birth as they will receive the appropriate support to quit.
- Improved postnatal care pathways that provide the individualised care that women/birthing people need.
- Continue to improve the number of premature babies being born in the most appropriate place with the most appropriate neonatal care.
- There will be established care pathways that ensure mothers and babies are not separated if a baby requires extra support.
- There will be reduced rates of maternal obesity and pathways of support in place
- Perinatal mental health services will have been established ensuring those in need experience joined up individualised support with their mental health.

Maternity priority action 3 – Maternity and Neonatal Voice's Partnerships (MNVPs) and service user collaboration

Maternity voice partnerships and service user collaboration

Continue to work closely with the Maternity and Neonatal Voice's Partnerships and improve engagement with local communities.

How we will secure delivery

Actions for 24/25

- Oversee plans to implement MNVP guidance as appropriate to SEL ensuring the neonatal aspect if fully integrated within current structures.
- Support and strengthen each local Maternity and Neonatal Voice's Partnership (MNVP) enabling them to work in the most inclusive and advantageous way through collaboration across the LMNS and using available resource to commission experts to support this.
- Support MNVPs to build on membership that represents the communities we serve, utilising external support with engagement.
- Consider further community engagement opportunities that will support collaboration with underrepresented pregnant women and birthing people, in response to the LMNS community engagement project findings.
- Continue to collect and monitor the maternity experience of women and birthing people through maternity services and local engagement.
- Ensure that multiple sources of service user feedback are used to continually inform service planning and transformation, and that service users can see the impact of their feedback on service delivery.

Actions for 25/26

- Continue to support collaboration and co-production with the MNVPs and service users ensuring that their voices are embedded in service planning and provision
- Continue to review the needs of MNVP chairs

Intended outcomes in 5 years' time

- Maternity and Neonatal Voice Partnerships (MNVPs) will be representative of the communities that we serve
- MNVPs will be fully embedded within the LMNS, and user representatives will be involved in maternity service planning and transformation.
- The neonatal patient advisory group (PAG) will have direct involvement with service planning and transformation.
- SEL LMNS will have a continuous programme of service user feedback and community engagement that will feed into service planning and transformation.
- Data collection and quality will have improved significantly enabling a better understanding of local community demographics and the needs of those communities.

Maternity priority action 4 – maternal medicine network

Maternal medicine network

Continue to embed the SEL LMNS Maternal Medicine Network (MMN)

How we will secure delivery

Actions for 24/25

- Ensure that the SEL MMN is a fully commissioned service in line with NHSE recommendations.
- Carry out engagement and information sharing events within the community with a focus on areas of deprivation and women/birthing people from Black, Asian and Ethnic Minorities
- Continue to build on collaboration and co-production with all stakeholders including clinicians, commissioners and women and birthing people.
- Continued roll out of the educational programme for staff utilising local experiences
- Continue multi-disciplinary meetings to discuss specific cases and care planning.
- Oversee local key performance indicators and audit the metrics associated with these.
- Analyse clinic data to support KPI delivery
- Using effective communication to make sure women and birthing people and staff have the information to navigate the network and care pathways.
- Continue to support Kent & Medway MMN and Sussex MMN as they continue to establish their networks.

Actions for 25/26

- Review the function of the network through audit and implement any changes required to the programme
- Consider research opportunities around the MMN and medical complexities that will feed into future service delivery.

Intended outcomes in 5 years' time

- SEL MMN will be fully embedded within SEL care pathways
- The network will have supported the sub hubs of Kent & Medway and Sussex ensuring they are fully established recognising that SEL MMN will continue to support them in some clinical capacity
- An established dataset which provides insight into SEL medical complexity that informs future service planning and care pathways will be in place.
- Working with women and birthing people with lived experience of serious medical conditions will be embedded within the network ensuring that services are co-produced.
- The MMN will have a network wide team that will make certain women/birthing people are cared for in the right place by the appropriate people.

Maternity priority action 5 – workforce

Workforce

Midwifery/Obstetric/Neonatal and LMNS workforce challenges

How we will secure delivery

Actions for 24/25

- Prioritise initiatives that support workforce retention and staff wellbeing across SE London.
- Oversee SEL initiatives via the LMNS workforce & education workstream.
- Ensure that there are progression pathways for maternity support workers who wish to undertake midwifery training.
- Support the student expansion programs to fill workforce gaps including midwifery students, obstetricians, neonatal nurses and other healthcare professionals such as sonographers and pelvic health physios.
- Work as a system to review potential to standardise preceptorship programs and share good practice initiatives that support newly qualified midwives
- Continue to participate in international recruitment programs.
- Secure sector wide data collection of workforce analysis.
- Secure recurrent funding for LMNS workforce to oversee, support and deliver the maternity programme
- Publicise and celebrate good practice where positive feedback is received from patients

Actions for 25/26

- Review workforce analysis and support planning that addresses workforce gaps with consideration for innovation on how the workforce is utilised to meet the demands of the service
- Be part of the wider Integrated Care System discussions to improve collaboration between maternity services and GPs, Health Visitors, Mental Health practitioners and others involved in maternity services

Intended outcomes in 5 years' time

SEL maternity and neonatal services will have sustainable workforce plans in place that;

- Provides the infrastructure that enables maternity and neonatal services in SEL to be a great place to work.
- Supports successful recruitment to key positions including succession planning for leadership positions.
- Supports the retention of staff because their value, knowledge and skill is recognised.
- Ensures midwifery and nursing students are supported appropriately so they want to remain working within the system.
- Attracts international professionals.
- Enables a flexible and adaptable workforce.
- Provides working environments supportive of staff health and wellbeing.

The ICB;

- The LMNS operational team are resourced appropriately to deliver the maternity programme

Maternity and Neonatal enabler requirements

Workforce

- Support for the workforce which includes training and development of staff.
- Succession planning for leadership positions in maternity services.
- A substantive/longer term LMNS operational team to deliver the aspects of the maternity programme required of the LMNS and support the providers with their responsibilities.
- Improved recruitment and retention of the maternity/obstetric and neonatal workforce
- Implementation of MSW competency framework
- Support of the student expansion programme
- Consideration of innovative models of care across maternity workforce
- Standardisation of banding payment across SEL maternity providers to reduce competition

Digital

- ICB and trust to achieve high levels of digital maturity.
- Support the collaboration between GSTT and KCH on implementation of their EPIC IT system to enable better communication across all professionals providing care for women and birthing people.
- Support women and birthing people to access their digital records, empower them to contribute to their care planning and support their access to key information regarding their pregnancy, birth and postnatal care.
- Ensure that IT systems have the interoperability within multiple maternity providers as well acute and primary care providers.
- Standardisation of Maternity IT systems and or interoperability among separate systems to enable collaboration and sharing of information with key professionals including GPs and Health Visitors.
- Mitigation for those experiencing digital exclusion

Estates

- Support to ensure that maternity services can deliver care in appropriate venues within the community, with a focus on areas of deprivation and most need. This should include the use of Family Hub sites across SEL to increase access for patients and integration between services.
- Support to ensure that maternity services have appropriate estate facilities to deliver the increased complexities now faced within maternity services.
- Be an active stakeholder in the development of the family hubs across SEL

Data

- Increased data and analytical support to enable continued data collection, review and analysis that will provide intelligence to inform service planning and dissemination of resources.

Cancer

Overview of our current system

Cancer services are structurally complex and involve a number of teams and programmes working together, supported by SEL Cancer Alliance. The cancer programme covers the entire patient pathway from prevention and screening, timely presentation and earlier diagnosis, time to diagnosis and treatment, and to living with and beyond cancer and personalised care. Within SEL, cancer patients often experience a shared pathway between acute providers, with GSTT or KCH providing complex specialised treatment. Our providers are also tertiary centres of excellence for key tumour groups and receive a significant number of referrals from outside London. SEL has areas of high deprivation, and a younger and more diverse population, which shapes priorities for cancer services. For example, responding to higher incidence of prostate cancer among black men. SEL has 45,000 patients living with and beyond cancer, our early diagnosis rate (53.0%) is in line with London and England but, as with the rest of the country, well below the Long Term Plan (LTP) ambition of 75%. Our 1 and 5 year survival rates (75.4% and 54.7% respectively) are both in line with the national and London (2021 – most recent data). We receive around 89,000 suspected cancer referrals a year and conduct around 8,700 first treatments for cancer per year. Demand into our services has been growing by between 5-10% year on year.

Strengths / opportunities

- **Relationships**: Strong relationships between a number of tertiary and specialised services with a Cancer Alliance on the same geographical footprint as the ICB. An engaged clinical workforce in primary and secondary care and the ability to share resources / work together, such as with joint appointments.
- **Patients**: The ability to work closely with patients and ensure co-production of key projects.
- **Data**: We are able to understand our performance drivers and inequalities at a granular level through data available to us and have been one of the first systems in the country to produce Best Practice timed pathway information.
- **Funding**: Confirmed national transformation funding specifically for cancer over the next few years, overseen by SEL Cancer Alliance.
- **Innovative Pathways**: A number of key pathways in development or early establishment such as Rapid Diagnostic Clinics (RDC), Telederm, Targeted Lung Health Checks (TLHC), Faecal Immunochemical Testing (FIT), new diagnostic models.
- **Community Diagnostic Centres (CDC):** Offer an opportunity to the system to increase diagnostic capacity, a key aspect of cancer pathway delays.

Challenges

- **Population**: Challenges in ensuring accessible and equitable services responding to the needs of the diverse SEL population, for example, addressing inequalities in cancer screening uptake.
- **Workforce**: Shortages in key areas that impact cancer pathways such as radiology.
- **Demand & Capacity**: Long term capacity shortfalls in some key tumour pathways and in a number of diagnostics which cancer pathways are reliant on. Increasing demand on systemic anti-cancer therapy (SACT) services
- **Competing Demands**: Cancer pathways touch on many aspects of the healthcare system and utilise the same workforce to drive improvements required and supporting services – e.g. imaging and pathology. System pressures also reduce capacity of organisations to focus on improvement.
- **Inter Trust pathway transfers**: The SEL system has been designed for a large number of pathways to require shared care across multiple providers. This requires pathways and transfer processes to be highly efficient to avoid additional delays.

What we've heard from the public

People welcomed the focus on early detection and diagnosis. Communication and information are key themes identified by patients and the public with a focus on the needs of the population : information around long term side effects of cancer treatment and support available, opportunities to discuss worries or fears, fully understanding the referral process for diagnosis, ease of contacting and involvement in decision making around treatment. Patient experience improvement initiatives for the coming year are based on this feedback, and co-design of our quality improvement workstreams is a key feature of this work. Patient Experience events are held across the year with patients and staff to review patient feedback and agree areas of focus and priority.

Cancer - Our vision and objectives

Our vision

To work in a collaborative model to deliver high quality cancer services across community, primary, and secondary care in South East London. Our aim is to ensure that patients receive timely diagnosis, high quality treatment, excellent experience, and improved clinical and quality of life outcomes.
South East London ICS and the South East London Cancer Alliance bring together a range of local organisations – including NHS bodies, local government, charities, and patient groups – with shared goals of: Fewer people getting cancer; More people surviving cancer; More people having positive experience in their treatment and care; Ensuring everyone receives the same high quality services, no matter who they are or where they live; More people being supported to live as well as possible after their treatment is over.
Underlying all objectives of the SEL Cancer Programme are the principles of improving patient experience, reducing health inequalities, encouraging innovation and involving patients in service improvement and transformation and ensuring national & local data and evidence underpins the work programme.

Our key objectives – what we want to achieve over the next five years

- Support the national ambitions to **improve early stage (stage 1 and 2) diagnosis and survival rates** in SEL.
- **Reduce variation and inequity in access** to cancer services and treatment and waiting times within SEL, through collaborative working in the sector to improve and standardise cancer pathways and close working with other referring regions and pan London.
- Faster Diagnosis and Cancer Waiting Times Standards **– improving 28 day diagnosis and 62 day treatment** performance from current levels.
- **Improve productivity** through pathway change (e.g. procedures under local anaesthetic rather than general)
- Improved clinical workforce productivity, e.g. **optimising non-clinical roles** in cancer and allied healthcare roles, **implementing stratified follow up pathways** (reducing outpatient appointments), training, shared roles.
- Accelerate implementation and further **development of innovative pathway**s such as Non Specific Symptoms (NSS) pathways (also known as Rapid Diagnostic Clinics) and Telederm.
- **Support innovation** across the whole cancer pathway, including **pathway redesign**, reviewing workforce skill mix, and exploring **use of technology** to mitigate capacity and workforce risks and working with the national team on delivering innovations, such as the NHS-Galleri Trial.
- **Improve patient experience of cancer services** and engagement with people on cancer pathways (as reported in the National Cancer Patient Experience Survey).
- **Improve quality of life outcomes**, through supporting initiatives for personalised care.
- **Involve patients and carers** in our service transformation work.
- **Use of data** to identify variation and inform population level decisions / priorities for cancer in SEL including targeted interventions to address equity gap

Cancer - Our priority actions

Our priority actions – what we will do

1. **Early Diagnosis and Prevention**
   Design and deliver interventions to improve awareness of cancer symptoms and screening programmes, support timely presentation and effective primary care pathways, targeted cancer screening uptake interventions, targeted case finding and surveillance and delivering Targeted Lung Health Checks (TLHC) across South East London.

2. **Faster Diagnosis and Improved Performance**
   Implement best practice timed pathways for priority tumour groups, improve front-end processes leading to diagnosis, and further developing Non Specific Symptom pathways. As well as Implementing actions to support wider pathway recovery including all key performance metrics through to treatment.

3. **Personalised Cancer Care**
   Supporting acute providers and primary care to implement stratified follow up, implement the key personalised care interventions for all cancer patients, support improvement in the national Quality of Life and National Cancer Patient Experience survey response among SEL cancer patients, and respond to findings.

4. **Clinical Outcomes and Treatment Variation**
   Ensuring the system implements key Getting it Right First Time (GIRFT) and national recommendations to improve survival outcomes as set out in the LTP and reduce variation across the Cancer treatment Pathway.

5. **Research and Innovation**
   Facilitate and promote research to ensure that national funding is utilised to embed key national innovations and enable specific local research and innovation supported by partnership working including with industry e.g. the Small Business Research initiative.

Cancer – Our progress to date

Key Successes in Delivery in 2023/2024

- Targeted cancer awareness and screening campaigns for lung, breast, prostate and cervical cancer, aimed at groups with lower cancer screening uptake rates or later stage diagnosis.
- SEL Targeted Lung Health Check programme invited all eligible population in Southwark and Greenwich for a lung health check.
- Non-specific symptoms (NSS) clinics moved to recurrent contract funding with increased coverage over the year (80% GP practices referred).
- NHS-Galleri trial (multi-cancer early detection blood test) continued - final round of blood draws started September 2023 with high retention of participants.
- Successfully increased proportion of Lower GI urgent suspected cancer referrals with a FIT result.
- Teledermatology pathway implemented at each provider.
- Personalised Stratified Follow Up (PSFU) implemented for breast, colorectal and head and neck cancer pathways. SEL in top 5 nationally for personalised care and support planning at diagnosis
- Lymphoedema service commissioned and launched in Greenwich.
- Physical activity and symptom management resources developed, hosted on SELCA website.
- Strong system working to improve pathways so that more patients are receiving a diagnosis earlier in their pathway and fewer patients are waiting beyond 62days.

Key Challenges to Delivery in 2023/2024

- Ongoing Industrial Action has impacted capacity throughout the Cancer pathway and across the year.
- EPIC roll out at both GSTT and KCH simultaneously has led specific data and capacity issues and has taken the focus and attention of the workforce.
- Increasing demand leading to capacity pressures particularly on front end diagnostics.
- Tight financial controls and constraints which can lead to delays in progressing key transformation projects.

Learning and Implications for Future Delivery Plans

- South East London Cancer Alliance completed a self-assessment with our key stakeholders which has identified areas where the Alliance can strengthen partnerships and collaboration which will support the delivery of the objectives over the next few years.
- Need for collaborative working across system partners, including agreeing higher priorities and pragmatic solutions.
- Leveraging national funding to accelerate implementing cancer improvement work streams which benefit the local population.
- Identify opportunities of technological developments, particularly to address workforce and other capacity issues.
- SELCA health inequalities programme and review of data will inform work to address priority equity gaps in access, experience and outcomes for cancer patients.
- Patient engagement and co-production will underpin the development and implementation of the SELCA annual work programme.
- Build on community engagement approach during 2023/24, working with partners and their wider networks, including charities, public health teams and community groups.

Cancer priority action 1 – early diagnosis and prevention

Early Diagnosis and Prevention

To continue to make progress in delivering improvements in the proportion of patients diagnosed at stage 1 and 2. This requires a robust population awareness function for cancer awareness, signs and symptoms, timely presentation of early symptoms to primary care, effective primary care pathways to facilitate early identification and referral, as well as improved screening uptake and coverage to support identification of pre-symptomatic cancer patients to link with ICS priority on prevention. SEL Cancer Alliance is also supporting local delivery of new national programmes to support early detection and diagnosis, including Targeted Lung Health Checks (TLHC), the community pharmacy pilot and the NHS-Galleri Trial.

How we will secure delivery

Actions for 24/25

- Expand TLHC to 50% coverage of the SEL population by March 2025, prioritising Lambeth and Lewisham for roll out based on deprivation and smoking prevalence to support access and addressing health inequalities.
- Implement Communications and Engagement plan including a communications calendar identifying and promoting local, regional and national awareness campaigns.
- Support Primary Care Networks (PCNs) to deliver the cancer early diagnosis Directory of Enhanced Services (DES) requirements with a focus on improving early diagnosis in areas with high deprivation and in improving referral practice for Lung, Bowel and one other tumour group (TBC – likely Oesophageal).
- Work collaboratively with Public Health, screening providers and partners within the ICS to improve uptake and coverage of cancer screening programmes and TLHC, utilising the SEL screening inequalities group.
- Working to ensure 80% of Lower Gi referrals include a FIT result and refining pathways for patients with a FIT <10.
- Agree consensus on universal prehabilitation offer and develop implementation plan (tertiary prevention)
- Support Capsule sponge into business-as-usual models of care and explore potential in primary care.
- Continue to support delivery of the NHS-Galleri Trial and Lynch syndrome education and mainstreaming plan.

Actions for 25/26

- Build on communications and engagement plan, using assets developed by SELCA and other partners.
- Expand TLHC further in line with national programme and 100% SEL coverage model/plan.
- Continuing to embed FIT usage and referral pathways for FIT <10 pathways.
- Build on support to PCNs to deliver the cancer early diagnosis DES requirements
- Continue to fund and support delivery of promising innovations.

Intended outcomes in 5 years time

All actions are aimed at leading to an improved early diagnosis rate across SEL.

- TLHC to be fully expanded in line with national programme expectations, in preparation for becoming a national screening programme.
- Improvement in cancer screening uptake and coverage across all three National screening programmes and support the implementation of any new technologies.
- FIT pathway fully established with 80% or above Lower Gastro-Intestinal (GI) referrals accompanied by a FIT result.
- Key national innovations to be established in the system where supported by evidence including: Capsule sponge, Liver surveillance testing, Lynch syndrome testing.

Cancer priority action 2 – faster diagnosis and improved performance

Faster Diagnosis and Improved Performance

To deliver improvement in the time to diagnosis once a patient has been referred from primary care or screening services, ensuring service delivery is aligned with national best practice timed pathways, leading to improvements in the national 28 day Faster Diagnosis Standard (FDS). Improvements across the pathway will help patients through improved coordination of their pathway and better communication and understanding about the whole process. Ensuring that our patients are directed into the right pathway, first time, with faster access to diagnostics and an earlier agreement with the patient on the right type of treatment for them in the best clinical setting and that this benefit is seen across patient groups reducing any inequalities in performance that exist.

How we will secure delivery

Actions for 24/25

- Focus on national and local priority tumour pathways to identify opportunities to strengthen existing clinical models and close gaps in service delivery. Building on the 2023/24 work that created BPTP+ milestone dashboards, SEL will benchmark against nationally published best practice timed pathways. Engaging with trust level patients and groups where appropriate on agreed models. This will contribute to supporting SEL trusts recovering performance against CWT standards.
- Review and refine Teledermatology pathways in SEL to maximise potential and improve outcomes, performance and experience for patients. Address seasonal variation in Dermatology pathways.
- Continue support to providers with SELCA led 'deep-dives' and audits into key pathway bottlenecks, sharing good practice and understand the granularity of pathway constraints through data analysis.
- Cancer system to engage with planned transformational changes to pathology service in SEL maximising the benefit of these changes to support cancer pathways.
- Provide expertise to ensure externally funded projects are reviewed and evaluated in a timely manner, resulting in service development and information sharing across pathways and providers in SEL.
- Explore the potential of automation for processes on challenged pathways.

Actions for 25/26

- Continue work on referral guidance ensuring Primary Care is aware of key changes and updated guidance to re-direct patients away from an urgent suspected cancer pathway to more appropriate pathways.
- Evaluate and potentially expand innovative changes started in previous years; this could include Head & Neck triage and the use of AI and Automation in pathways.
- Develop our broader system level of understanding and collaboration to ensure patients are having the appropriate diagnostics and treatment in the right place at the right time.

Intended outcomes in 5 years time

- NSS fully embedded in the system and available to 100% of the population with high recognition and utilisation from primary care.
- All appropriate internal secondary care cancer services to have access to NSS clinics, supporting reduction in pressure on site-specific cancer pathways, reduction in re-referrals for suspected cancer, and improved patient experience.
- Patients will experience cancer pathways that demonstrate the seven principles of a faster diagnosis service.
- Waiting times to diagnostics for patients on cancer pathways support earlier diagnosis and reduce time to treatment from referral.
- Treatment capacity has kept in line with growth expectations and our services are in line with national service specifications for cancer services
- Telederm fully established.
- The system consistently meeting the national FDS standard
- The system has improved the performance against the 31day and 62day standards, reducing the number of patients waiting longer than 62days for treatment irrespective of the Trust treating the patient.
- Our cancer pathways are utilising the latest technology advances to support patient experience, access and outcomes. This includes the use of AI and automation where this is clinically and operationally appropriate.

Cancer priority action 3 – personalised cancer care

South East London Integrated Care System

NHS South East London

Personalised Cancer Care (PCC)

Work to improve the Quality of Life for all cancer patients by:

- Ensuring fully operationalised personalised stratified follow up (PSFU) is in place
- Increasing the spread of responses from our diverse cancer patient population in the National Quality of Life (QOL) Survey and using results to help tackle inequalities.
- Ensuring that existing personalised care activities (personalised care and support planning, health and wellbeing information and support, treatment summaries and cancer care reviews) are being offered to everyone
- Developing plans to improve access to interventions which improve Quality of Life (eg pre/rehab, psychosocial support, lymphoedema management) based on the National QOL survey results
- Continuing commitment to codesign principles, working with patients and carers as partners, and aligning PCC work with wider the personalised care framework within the ICB

How we will secure delivery

Actions for 24/25

- Full implementation of PSFU in prostate, thyroid and endometrial cancer and commence evaluation.
- Support to providers in business planning for PSFU sustainability to move into business as usual.
- Ongoing support to Trusts to embed personalised care support planning for all patients at diagnosis and end of treat, maintenance and further development of SELCA PCC and QOL data dashboard
- Work with Epic to enable personalised care reporting nationally in COSD v10
- PCC health inequalities project work to address barriers to access to support
- Support N Bexley cancer care coordinator project and scope use of additional roles reimbursement scheme (ARRS) roles for PCC in other boroughs
- Continued work on embedding psychosocial support framework and support resources with partners
- Agree consensus on universal prehabilitation offer and develop implementation plan
- Mapping, gap analysis and improvement plan of access to cancer related fatigue services
- Support workforce development of behaviour change skills to embed physical activity as routine care
- Execute SE London lymphoedema services system improvement action plan
- Ongoing workforce education and development to nursing, AHPs, support staff in personalised care

Actions for 25/26

- Support to Trusts to address local health inequalities in access to personalised care and support
- Evaluation of psychosocial care project and recommendations for further work
- Implement SEL universal prehabilitation offer and develop improvement plan for gaps in targeted and specialist prehab, ongoing support to address specialist cancer rehab workforce gap, execute fatigue plan
- Rollout of use of ARRS roles to support PCC to other boroughs
- Gap analysis and improvement plan for addressing key QOL outcomes eg returning to work, intimacy

Intended outcomes in 5 years time

All patients will have the opportunity to discuss and have their physical, psychosocial and practical needs addressed throughout their cancer journey, based on what matters most to them.

- At least 70% of patients to be offered a personalised care and support plan based on a holistic needs assessment at diagnosis
- PSFU and digital tracking to be rolled out and embedded in all appropriate tumour groups, with continuous evaluation of patient experience of this pathway
- Personalised care interventions to be routinely offered through a comprehensive end of treat clinic for patients on a PSFU pathway
- Availability of a range of psychosocial support depending on level of need, including peer support, social prescribing, Psychological Therapies (IAPT) and psycho-oncology, with clear links into mental health services
- Equitable access to services across SE London to address physical health concerns including physical activity, rehabilitation and lymphoedema management
- Embed sustainable process to measure quality of life including Patient Reported Outcome Measures (PROMs)

Cancer priority action 4 – clinical outcomes and treatment variation

Clinical outcomes / Treatment variation

Ensure the system has robust processes to review and benchmark quality and clinical outcomes. Ensuring the system implements key GIRFT and national recommendations to improve quality, clinical outcomes and survival to reduce variation across the pathway and across all population groups.

How we will secure delivery

Actions for 24/25

- Oversight of 31 day operational performance to review pathway delays to treatment by treatment modality and tumour group and as required work with providers to support pathway improvement work.
- Align work with NHS National Cancer Programme treatment variation work programme. Action key recommendations from the National Cancer Audits and relevant GIRFT reports to identify areas of unwarranted variation and / or best practice to inform improvement priorities
- SEL Tumour and cross cutting groups developing annual scorecard - completed for five tumour groups including the common cancers. Allows the systematic use of data to review and benchmark the quality and clinical outcomes for SEL cancer patients.
- SEL Tumour and cross cutting groups work closely with SELCA health inequalities programme to implement actions to address priority equity gaps in access, experience and outcomes. This includes work to reduce treatment variation in older people.
- Work with SEL & Kent Radiotherapy ODN to support the performance and quality of SEL radiotherapy services
- Support GSTT led project to develop SEL Oncology Model to review the current status of SACT provision in SEL and develop report with recommendations on managing future demand including on the optimal clinical model.
- Work with the Genomic Medicine Service Alliance (GMSA) to support work on mainstreaming of genetic testing and GLH to support timely delivery of cancer genomic testing (molecular diagnostic).
- Working with Trusts to improve data quality and optimise use of Epic

Actions for 25/26

- Utilise range of data including performance data and annual scorecard to identify key areas of transformation support and resource.
- Finalise work with GMSA to mainstream genetic testing
- Continue to oversee the implementation of national treatment variation recommendations from the national cancer audits / GIRFT report
- Support SEL Oncology Model project

Intended outcomes in 5 years time

- Established systematic processes to review and benchmark quality and outcome data for SEL population to identify unwarranted variation and equity gaps
- Implemented priority actions including targeted work to address variation in quality and outcomes identified in local, regional or national data including national audits and GIRFT to improve survival
- Provider organisations thinking and acting in a systems way about clinical models and available resources reduce variation and improve outcomes for SEL cancer patients – e.g. SACT
- Strong collaborative working between GMSA and SELCA to support delivery of genomics agenda

Cancer priority action 5 – research and innovation

Research and Innovation

Facilitate and promote research to ensure that national funding is utilised to embed key national innovations and enable specific local research and innovation supported by partnership working including with industry.

How we will secure delivery

Actions for 24/25

- Work in collaboration with SEL partners including Trusts, KHP, KCL to:
  - Continue Pilot for Cytosponge (Capsule sponge) at GSTT site and review opportunities to pilot in a primary care setting.
  - Continue Pilot for one stop Trans Nasal endoscopy (TNE) at GSTT site
- Identify opportunities for partnership working and funding opportunities – e.g. Small Business Research Initiative (SBRI) call and work with the Health Innovation Network (HIN).
- Review possible automation and AI opportunities within key tumour pathways specifically diagnostic demand management
- Communicate updates on current research & clinical trials at tumour and cross-cutting group meetings to promote uptake and trial recruitment
- Ensure tumour group are a vehicle to update on current research /clinical trials and consider change of practice
- Participate in cancer alliance pan-London Research Board, hosting a research fellow in SEL.
- Continue to support early adoption of innovation and research outputs to inform and transform clinical programme e.g. PSMA PET, Endominer
- Continue close working relationship with Guys Cancer Academy, providing funding for development of educational resources which includes strong evaluation and impact methodology.
- Transformation funding to support service improvement work based on local research activity

Actions for 25/26

- Embed capsule sponge service where supported by evaluation.
- Evaluate one stop TNE - and consider the opportunity for wider roll out at LGT and KCH
- Build on support for Artificial Intelligence (AI) and Research and development (R&D) opportunities within key tumour pathways working in collaboration with HIN.

Intended outcomes in 5 years time

- SEL to implement services where evaluation of the pilot provided evidence to support – this may include Capsule sponge and new diagnostic models
- Collaborative work with GMSA and provider organisations to implement a sustainable model for mainstreaming for genetic testing including Lynch and Breast Cancer gene (BRCA)
- Utilise new genomic tools to improve prediction and early diagnosis capabilities - e.g GRAIL's Galleri study
- Establish use of real-world evidence and patient registers and registries to inform work programme
- Work with partners to facilitate and promote research and the use of evidence obtained from research to support earlier diagnosis and improved survival
- Reflect the diversity of SEL population in clinical research to proactively increase the racial, age, gender, and geographic diversity of clinical trial participants and those in real world data set.

Cancer enabler requirements

Workforce

- A clinical and non-clinical cancer workforce which is resilient and can adapt to new pathways and cross-sector working.
- National support in key areas of national workforce shortages such as Radiology and Oncology.
- Mutual understanding of Cancer Care between Primary and Secondary Care
- Support cancer clinical leaders in primary and secondary care through training, courses and development opportunities.
- Better use of artificial intelligence and other automated technology to support role redesign and address workforce gaps.
- Improved cross sector support to manage capacity risks and with joint appointments.

Digital

- Improved access to local care record for all clinicians
- Continued utilisation of the Somerset Cancer system at all Providers
- A smooth transition to the Epic system at both GSTT and KCH ensuring that the updated systems continue to capture and record key Cancer information
- Referral Repository system to be agreed across SEL and to include required Cancer referral information updated regularly.
- Improved availability and utilisation of clinical decision support tools for Cancer.
- Central digital decision making to engage with Cancer as a specialist programme on decisions which impact Cancer.

Estates

- A clear understanding of demand and capacity across key cancer services that enables system partners to understand where estate capacity should be prioritised to support cancer pathways.
- Decision making around existing NHS estate space is a transparent and clear process.
- Clinical Diagnostic Centres (CDCs) to involve Cancer in establishment to ensure benefit of additional capacity leads to improved cancer pathways.
- TLHC project to review all available sites to support improved uptake of invites and CT scanning for high risk patients.
- Additional Endoscopy capacity to be prioritised across the system with new suites approved where required.

Data

- Better utilisation of available cancer data resources including: screening, inequalities, prevalence, NSS, FIT.
- Improved data completeness to benefit the systems staging data, MDT outcomes and improve our understanding of Best Practice Timed Pathways (BPTP)
- Linking primary and secondary care data sets using governance in the ICB to enable granular and informative views of cancer data sets. Supporting a holistic view on inequality of cancer care from pre-primary care to post-secondary care

Improving outcomes for patients with Long Term Conditions (LTCs)

This LTC Programme section should be read in conjunction with the Primary Care Programme section

Overview of our current system

SE London is diverse and vibrant, but faces significant challenges to achieving good health and care outcomes for people living with LTCs. There are high levels of deprivation in SEL, particularly in the 'inner' boroughs (Lambeth, Southwark, Lewisham and Greenwich), but also much deprivation variation within each, which contributes to significant health inequalities. The proportion of the population who are black and minority ethnic ranges from 19% in Bromley to 46% in Lewisham. Preventable mortality, smoking prevalence and alcohol related hospital admissions are higher for most of our boroughs than the London average. SEL is the worst performing London ICS in terms of good control of blood pressure and 5 out of the 6 SEL boroughs have higher-than-London average levels of childhood obesity at school reception age. However, it is served by excellent secondary care providers and there is also much high quality, innovative out-of-hospital care, focused on improving or preventing LTCs. The population's needs are complex, requiring a combination of consistent and reliable core offers to residents in some aspects of care and very bespoke and locally responsive approaches in others. Through the establishment of the newly formed Neighbourhood Based Care Board (NBCB), SEL ICS will have a clear strategic focus on ensuring that proactive and integrated neighbourhood-based care models exist to embed the integration and personalisation principles of the Fuller Stocktake, address-the health inequalities that exist within the geography and pursue a prevention agenda focused on the 5 biggest mortality/ morbidity risk factors (the 'Vital 5')

Strengths / opportunities

- Development of integrated neighbourhood care model for multimorbidity, utilising Fuller principles of personalisation, person centred care and primary/secondary integrated care
- SEL ICS's key priority focus on improving performance against the 5 biggest risk factors (the 'Vital 5') for morbidity/ mortality (blood pressure, smoking, alcohol, poor mental health, obesity)
- SEL Framework of Care for LTCs to be overseen by a new SEL LTC Steering Group and co-produced with strong Place involvement
- High quality workforce across health and care, including acute, MH, community and primary care systems, including use of HCP outside established pathways
- Expansion of SEL community members group, utilising community champions to advise ICB of further opportunities for cultural tailoring of pathways and services

Challenges

- Pressure on workforce (high vacancy rates, high demand) across our health and care providers
- Significant demand and waiting lists across health and care providers, with little spare capacity in any parts of the system
- Although there are many examples of excellent care, there is also large unwarranted variation in health outcomes across SEL, with significant variation in health outcomes
- Significant financial pressures on SEL ICS system – requiring innovative approach across system partners
- Developing a standardised patient reported outcome tool to measure patient experience of the LTC Framework of Care across the system has proved challenging

What we've heard from the public

- Public engagement exercises carried out in 2021 and 2022 demonstrate that all patients consulted desire a person-centred, holistic approach to care, which is well coordinated across care settings. Specific to the Black African/Caribbean and South Asian population, there was a desire for culturally tailored services and advice; which also recognised issues of race and racism and the impact of this on perceptions and beliefs about the NHS.
- Patients using new technology informed the ICB that they were happy to use this, once the rationale was well explained and the technology worked smoothly for patients
- We have also heard that integrating services and improving primary care and community care is particularly important for people with long term conditions and complex needs and to address health inequalities. For example, targeted engagement work with Black people with chronic pain found that a holistic approach involving multiple professionals is required to address needs.

LTCs - Our vision and objectives

Our vision

Our overall aim is to develop a neighbourhood-based framework of care for patients with one or more Long Term Conditions across SE London, that is coordinated, integrated, person-centred, prevention focused, and diverse and tailored to all our communities. We will ensure parity of physical and mental health care for everyone with an LTC. We will create ICB-wide standards of care which are culturally tailored and supported by effective risk-stratification and excellent real-time data and information ('Population Health Management'). Planning of localised services will be delegated to place, while improvements in outcomes, equity and access aim to be consistent across the ICB. This will align with our vision for Neighbourhood-based Care (NBC), where we will co-produce enhanced integration across LTC pathways and aim to reduce unwarranted variation. The SEL LTC Framework of Care has defined the shared outcomes and standards to ensure neighbourhood teams are able to succeed and hold each other to account for the delivery of improved outcomes for our patient in South East London.

Our key objectives – what we want to achieve over the next five years

Our priorities over the next five years include:

1. Through the LTC Steering Group. we will support the introduction of the LTC Framework of Care (a Population Health Management (PHM)-based **framework of care for multi-morbidity, frailty and LTCs**) at place, by working with patients, NHS and Local Authority staff, commissioners and voluntary and community groups across the ICB, to ensure that LTC care is measurably coordinated, integrated, person-centred, prevention focused, and diverse and tailored to all our communities, with parity of physical and mental health care.

2. We will build on work which has already been undertaken across South East London, with **improved access to timely diagnostics**, clinical decision making tools and guidance, and **tailored self-management support** for patients.

3. Building on the pathway review work already underway for obesity, we will undertake a systematic programme of **end to end pathway reviews** of the single or grouped long term conditions in South East London which could be better managed. Each review will aim to co-produce an effective and efficient clinical pathway, supported by a suite of supportive tools and aligned incentives across our system.

4. Through the NBC Board, we will scope priority areas of strategic focus and seek out opportunities to work with other programme boards across our Integrated Care System to **strengthen our approach to the prevention and early detection of long term conditions** through the lens of tackling health inequalities, including the 'Vital 5', top 5 risk factors for poor health (smoking, mental health, blood pressure, obesity and alcohol) as well as ensuring improved integration and personalisation

5. As part of the emerging Integrated Care System governance, and as an output of the series of LTC workshops, we will put in place a Long Term Conditions Steering Group which will be responsible for **monitoring the impact of changes to agreed pathways on patient outcomes and experience**, as well as overseeing the implementation of a strategic framework for the management of Long Term conditions within South East London.

LTCs - Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1

Multiple LTCs / Frailty

- Build on our SEL Framework of Care for LTCs, working with Place colleagues to ensure care is proactive, holistic, person-centred and culturally tailored aligned with this framework and the wider work around NBC and INTs.
- Implement trailblazer multi-morbidity model of care projects within our neighbourhood teams, continue to engage stakeholders in the process to build true integration and seek to develop a single definition of an Integrated Neighbourhood Team (INT)
- Formally stand up the LTC Steering Group to oversee pathway reviews, consider outcomes and recommend actions to ensure consistency and reduce unwarranted variation
- Complete the end-to-end Obesity Pathway Review for single and combined LTCs, and consider further LTC pathway reviews with responsibility for planning agreed at Place
- Evaluate the interim outcomes of the 6 multi-morbidity model of care INT pilots in order to spread and adopt the model at scale across SEL
- Develop a cohesive risk-stratified model to support patients at risk, or living with, frailty
- We will develop a self-care hub for key LTCs, including multi-morbidity, which will act as a resource guide for people with LTCs

2

Diabetes and Obesity

- Continue the SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in variation for 3TT ('levelling up' the poorer performing practices) in core diabetes outcome/ care process measures
- Complete the end-to-end Obesity pathway review, resulting in recommendations for pathway and triage improvements and enhanced integration across the tiers
- Focus on establishing innovative pilots (particularly for SEL's South Asian communities) to address unwarranted variation and poorer outcomes
- Take forward the Diabetes & Obesity Delivery Board's strategic priority areas, as detailed in the Board's workplan

3

Cardiovascular Disease (CVD)

We will undertake an end to end pathway review of patients suffering from Cardiovascular Disease, including:

- Continue our focus on improving Blood Pressure control, building on the work undertaken in 23/24
- Develop core principles for an integrated community Cardiac model with community and acute cardiac team members working with PCNs to move care closer to home.
- Developing a coordinated and personalised prevention offer coordinated across multiple agencies
- Improving identification of, and earlier intervention for, patients at risk of cardiovascular disease
- Improving the effective management of blood pressure, lipids and stroke prevention
- Reviewing demand and capacity at all points of the pathway (including diagnostics) and develop approaches to better manage demand through integrated care models
- Understanding the impact of variations in clinical practice and move towards common standards and approaches.
- Improve the current pathway and package of support for patients following a cardiac event.

LTCs – Our progress to date

Key Successes in Delivery in 2023/2024

- Co-designed a SE London Framework of LTC Care with stakeholders and patients founded on the principles that care is coordinated, integrated, person-centred, prevention focused, and diverse and tailored – aligning with the key proactive care principles in the Fuller Report and existing Place LTC strategies
- Worked with all 6 SEL Place teams to think through the Framework of Care and the implications for local delivery
- Secured significant funding to allow 6 large pilots in each SEL borough, testing a model for Integrated Neighbourhood Team (INT) working, focussed on multiple LTC patients, testing vertical and horizontal integration, with a focus on spread, scale and sustainability in the longer term
- Brought all SEL Hypertension stakeholders together throughout 23/24 to work through how to meet the key NHSE Hypertension target, including SEL-wide webinar sessions and working with CESEL on a Hypertension resource pack for Primary Care
- Brought together diverse stakeholders to commence a SEL-wide Obesity Pathway Review, with a timeline for recommendations in mid-24/25, that seeks to bring coherence to our fragmented specialist and non-specialist obesity services

Key Challenges to Delivery in 2023/2024

- Management Cost Reduction (MCR) exercise has put a significant strain across all parts of the ICB and wider ICS – the implications of workforce loss will be a key risk going forward into 24/25 and beyond
- Our ambitious plan for a London wide LTC Prevention platform, driven by SEL, SWL and NWL ICBs, with the support of the HIN, has found London-wide consensus challenging in this difficult year – we will be deferring timelines on this, but renewing our approach to this important Prevention strategy in 24/25
- Workforce pressure, in both primary, acute and community care has impacted on all parts of the ICS and each of the 6 LCPs
- Significant system-wide financial pressures across the ICS
- Operational delivery pressures, particularly for our acute partners, in terms of very long elective waiting lists, implications of industrial action and movement of GSTT and KCH to a new EPR system have contributed to a very challenging set of circumstances across 23/24 – with implications for all other ICS partners.

Learning and Implications for Future Delivery Plans

- MCR has enabled revision of structures and directorates within the ICB – there are important opportunities for a more coherent Community-Based Care directorate, which the LTC team now sits under, and which aligns with new governance around Neighbourhood-based Care (NBC)
- The implications of MCR require important and significant OD work to ensure all parts of the ICB are effective, efficient and understand roles and responsibilities
- The LTC Steering Group, which will emerge from the Framework of Care co-design work – which will be stood up in Q1 24/25 and will sit under the NCB Board - will both offer a structure to take forward the LTC Framework of Care, coherent INTs and a consistent approach to proactive neighbourhood-based care and Fuller implementation

LTC priority action 1– multiple LTCs

Multiple LTCs

★ ICS Strategic Priority

We have worked with patients, community groups and system partners, particularly primary care at place, to build an ICB-wide Framework of Care for single and multi-LTCs, with an agreed vision for consistent standards to support holistic, person-centred and proactive care. The Framework of LTC Care aligns with Place-based work on proactive care and our wider strategic vision for Neighbourhood-based Care (NBC) and Integrated Neighbourhood Teams (INT). Via the LTC Steering Group, which will be formally stood up in Q1 24/25, we will also undertake pathway reviews to understand challenges and possible solutions for priority LTCs, starting with Obesity. We are developing integrated multimorbidity teams (continuing good work that has already begun at place/ PCN level), with multi-disciplinary case management principles to risk stratify, coordinate care (ideally through a lead point of contact for the patient) and develop integrated care plans, in order to improve LTC outcomes and patient satisfaction through a fully integrated way of working across community and acute. For instance, our multi-morbidity model of care project embodies these principles across SEL for our population with CKD and other morbidities and/or complexities. Wherever possible, we will continue to streamline our prevention services to give maximum benefit for the patient with multiple LTCs. Our work incorporates medicines management optimisation, polypharmacy and maximising the opportunities of new drugs. We are working with partners to co-produce a standardised approach to identifying and recognising frailty, risk stratifying our population and delivering integrated care models for those living with frailty.

How we will secure delivery

Actions for 24/25

- Build on our ICB-level Framework of Care for LTCs
- We will galvanise system colleagues to ensure care is proactive, holistic, person-centred and culturally tailored aligned with this framework and the wider work around NBC and INTs.
- Formation (in Q1) of a SEL ICB LTC Steering Group, with place-based commissioning and clinical leadership membership, to oversee LTC strategy and delivery
- Develop and agree methodology for place based LTC Pathway Reviews and baseline / recommend targets – initially focussed on Obesity and Diabetes but covering further priority LTCs in future years (e.g. Respiratory)
- SEL ICB Diabetes and Obesity Dashboard will incorporate metrics to measure Outcomes that Matter to people with diabetes and serve as an exemplar for other LTC
- Implement trailblazer multi-morbidity model of care projects within our neighbourhood teams and enable spread and scale across SEL in the latter half of 24/25, continue to engage stakeholders in the process to build true integration and seek to develop a single definition of an Integrated Neighbourhood Team

Actions for 25/26

- Pathway review work will incorporate pathway and process mapping, demand and capacity modelling at each stage of the pathway, gap analysis against clinical best practice and guidance, mapping of commissioning arrangements and clinical audit of non-elective admissions
- Using the SEL ICB LTC-related Dashboards, we will ensure LTC strategy focuses on health inequalities, taking into account vital 5 work and Core20plus5
- Develop a SEL model of care for patients living with frailty through a series of system workshops, with a focus on consistent approaches to the identification, risk-stratification and management of frailty delivered through integrated neighbourhood teams.

Intended outcomes in 5 years time

- We will create stronger links between acute and community-based care, resulting in a lower trajectory for unplanned admissions and A&E attends
- Patients from Black, Asian and Minority Ethnic communities backgrounds will have a range of bespoke, tailored health and education services to match cultural needs
- We will develop co-produced proactive models to engage with underserved communities and those experiencing health inequality, resulting in improved health outcomes for these cohorts
- The majority of SEL patients diagnosed with an LTC, including frailty, will receive an holistic review of their care, proactively identifying their physical and mental wellbeing needs and where necessary psychological care will be provided
- Clinical and non-clinical staff working to meet the needs of those with multiple LTCs will work in an integrated manner, benefiting from the streamlined nature of care that is normalised across SEL.
- Care for people with LTCs and frailty will include as standard MDT working, named coordinators for all patients, (with co-produced and person-centred care plans, shared with acute teams, 111 and LAS) and seamless handovers between care providers, optimising the use of diagnostics and remote monitoring

LTC priority action 2 - Diabetes and Obesity

Diabetes and obesity

★ ICS Strategic Priority

We will work to enhance current integrated diabetes and obesity pathways within SEL which improve outcomes and prevent disease, helping to recover (and then exceed) 'core offer' diabetes care and outcomes to pre-pandemic performance (particularly diabetes treatment outcomes and related care processes, where SEL had been excellent performers pre-pandemic). This will be done in part through agreed diabetes and obesity strategic priorities, in part by the implementation of the SEL-wide LTC Framework of Care, being taken forward with Place and building on the good work at place, PCN and neighbourhood level and in part by our wider work implementing NBC, INTs and proactive care.

How we will secure delivery

Actions for 24/25

- Expand our SEL-wide diabetes outcome scheme, aimed at PCN-level improvement and reduction in unwarranted variation ('levelling up' the poorer performing practices) with a focus on improving diabetes treatment targets
- Take stock on our ambitious diabetes/ LTC prevention offer, working with SWL and NWL ICSs, with the aim to drive forward the development work for an LTC Prevention platform, either London wide or through a collaboration of early-implementer ICBs
- Focus on spreading and scaling innovative pilots (e.g. HEAL-D, Up! Up!) addressing poorer outcomes in underserved communities SEL wide, most at risk of health Inequalities
- Conclude the SEL-wide Obesity Pathway review – finalising recommendations for improving the coordination and delivery of SEL obesity services, including use of new pharmacotherapies and work with ICS partners on an implementation/ commissioning approach.
- Implement improvements for patients with Type 1 Diabetes including the delivery of increased technologies (i.e. CGM and Hybrid Closed Loop) and patients with early onset Type 2 diabetes

Actions for 25/26

- By end of 25/26, implement the diabetes prevention platform, alongside other London ICSs, with the intention of expanding to wider LTCs within 3 years
- Working with LCPs to ensure the maximum impact of the SEL-wide diabetes outcome scheme
- Embed improved integrated pathways for multiple LTCs, including diabetes and obesity, and including integration of mental and physical healthcare, developed during 23/24 as part of ICS LTC Framework of Care and MMMoC workstreams

Intended outcomes in 5 years time

- Comprehensive, culturally tailored, integrated pathway framework established for LTCs, with clear SEL-wide principles, but with local autonomy in terms of delivery
- Significantly reduced unwarranted variation in outcomes for patients with diabetes across SE London
- Patient empowerment, through a comprehensive prevention offer, primarily through the diabetes/ LTC prevention platform, including tailored offers to hardly heard communities, most at risk of suffering health inequalities
- 'Best-in-London' performance against national diabetes outcome measures (e.g. 3 Treatment Targets)
- Optimal utilisation of preventive weight management offers (i.e. tiers 1 and 2) to allow specialist obesity capacity to offer timely interventions for those most in need, with effective use of obesity pharmacotherapy
- Strong commitment to and performance against person centred outcome measures, through a consistent promotion and use of holistic care planning
- Reduced conversion rate from pre-diabetes to diabetes, through identification and take up of preventive offers, including excellent tailored services to our underserved communities

LTC priority action 3 - Cardiovascular disease (CVD)

CVD prevention and improvement

★ ICS Strategic Priority

We will work to improve detection and early treatment of people with CVD, i.e. Atrial Fibrillation, raised Blood Pressure and raised Cholesterol (the 'ABCs'), with a particular focus on communities at risk of health inequalities, seeking to reduce variation in health outcomes. We will develop and implement integrated Cardiovascular Pathways and Services within SEL which improve both the clinical and care outcomes for patients living with CVD and other LTCs and also the prevention of CVD within the broader population. We will support the full Elective Recovery of cardiac surgery position and reduce inequality of cardiac outcomes.

How we will secure delivery

Actions for 24/25

We will:

- Continue our focus on improving Blood Pressure control, building on the work undertaken in 23/24
- Develop a personalised coordinated prevention (e.g. SEL Decathlon pilot)
- Improving identification of, and earlier intervention for, patients with or at risk of CVD
- Improving the effective management of blood pressure, lipids and atrial fibrillation
- Reviewing demand and capacity at all points of the pathway (including diagnostics) and develop approaches to better manage demand through integrated care models
- Understanding the impact of variations in clinical practice and move towards common standards and approaches.
- Improving the current pathway and package of support following a cardiac event

Actions for 25/26

- Undertake an equalities health review of CVD and identify priority actions to reduce health inequalities
- Develop and test integrated out of hospital models of care for the management of heart failure which integrates workforce, processes and clinical management across primary, community and acute care settings
- Undertake a review of stroke and neuro-rehabilitation.
- Work with the Cardiac Network to improve timely access to electrophysiology and ablation
- Embed the learning from SQUIRE pilot to improve stroke rehabilitation in SEL

Intended outcomes in 5 years time

- Reduce Under 75 mortality from Cardiovascular Disease
- 80% or more of the expected number of people with hypertension are diagnosed
- 80% or more of the total number of people diagnosed with hypertension are treated to target as per NICE guidelines
- 60% or more of the total number of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent are prescribed lipid lowering therapies to 60%
- 85% or more of the expected number of people with AF are diagnosed
- 90% or more of the total number of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029 - reducing stroke incidence in SEL
- Increase referrals to cardiac surgery to align more with the London average
- Improve Transcatheter Aortic Valve Implantation take-up across black and minority ethnic populations
- Reduction in unwarranted variation across the system, including a narrowing of the differential between White and Black, Asian and Minority Ethnic communities groups in terms of hypertension control

LTC enabler requirements

Workforce

- Working with Place, maximise utilisation of Additional Roles Reimbursement Scheme (ARRS) roles, ensuring integrated team working and innovative approaches across ICS partners to problem-solving recruitment challenges
- Flexing workforce so that people are seen in the right place, right time, by the most appropriate support person – this includes utilisation of currently under-used parts of the workforce, e.g. community pharmacy, social prescribers and care coordinators.
- ICS partner commitment to valuing their workforces, making SE London a great place to work

Digital

- SEL ICB will spread existing well-evidenced technology, such as digitally assisted pathways, self-management and remote monitoring tools (including safe and earlier hospital discharge for patients requiring clinical monitoring), automation software and better use of shared records
- To support the digital offer to our citizens, SEL ICB will work with other London ICSs to develop a diabetes/ LTC prevention portal to empower LTC self-management in SE London
- The further development of Population Health Management (PHM) analytics (including predictive tools) is a critical enabler – we will work with LTC stakeholders to maximise use of existing PHM tools within the SELBI environment

Estates

- Working with system partners, SEL ICB will ensure sufficient estates capacity out of hospital across the whole SEL geography
- Appropriate modernisation of current estate to enable teams to integrate and to work more flexibly together (e.g. offer group consultations) – ensuring bigger, more digitally connected, and with a variety of sized clinical spaces, to ensure the implementation of Fuller review recommendations

Data

- Adoption of a SEL-wide Population Health Management (PHM) approach, which builds on the early success of SEL wide LTC platforms (i.e. the LTC co-morbidities dashboard and the diabetes and obesity dashboard), offering SEL-wide insights and drill-down across LTC areas, which are used at SEL, Place and PCN level
- PHM insights-led commissioning approach, at both SEL and Local Care Partnership levels

Primary Care

Overview of our current system

South East London is made up of 6 boroughs with a range of primary care services serving our population including 195 general practices, 35 primary care networks, 7 GP federations and 324 community pharmacies. General practice across the system have been configured in a variety of ways including some 'at scale' arrangements, partnerships of GPs and other health care professionals and corporations. Community pharmacy, dental and optometry contracting and commissioning will be delegated from NHS England to the ICB from April 2023. Primary Care serves a diverse population made up of some of the most deprived and most affluent communities, more than 200 ethnicities and speakers of 150 languages, and from all social and economic backgrounds.

Strengths / opportunities

- General Practice is all about **relationships** and has built a significant amount of **trust** with their registered lists and despite some people finding it hard to access services the feedback through the GP Patient Survey remains broadly positive and provides the opportunity for developing the dialogue about integrated neighbourhood teams with local communities
- **Established local partnerships** - supporting the growth and development of neighbourhood teams
- Relationship with community pharmacy and their position in local communities
- Local Care Partnership appetite to **develop primary care leadership** alongside partners other than general practice
- Well established virtual provision and a range of **digital** tools to support PC
- Further opportunity to develop **collaborations** from good working relationships between boroughs and with SEL teams
- **Additional Roles Reimbursement** investment
- **Next Steps for Integrating Primary Care –** Fuller Review recommendations
- **Primary Care Leadership Group**
- The delegation of **community pharmacy, optometry and dental commissioning** and contracting from NHS England to the ICB

Challenges

- **Workforce recruitment and retention** – aging workforce (GPs and nurses) challenging to attract new workers and trainees, relative to more metropolitan boroughs
- **Complexity** - Increasingly, more complex care is being delivered in the community
- **Resilience** - Supporting GP practices to improve their sustainability
- and resilience
- **Estates –** older GP estate with lease challenges and limited opportunities to accommodate an expanded workforce
- **Inequalities –** significant in borough variations in health outcomes based on geography and demography
- **'Access' –** getting people the right support, in the right place at the right time
- **Continuity** – for patients requiring with long term conditions and/or multiple complex comorbidities
- **Covid backlog –** management of Long Term Conditions and onward referrals
- **Reducing the variation** in clinical care and increasing the quality of care consistently across providers of primary care services
- **Collaboration** across pathways between primary, secondary and community care
- Maturity of the primary care system as PCNs continue to get established, federations working to understand their role and practice resilience issues being addressed
- **Organisational development** – primary care system having the time to develop their partnerships, collaborations and leadership

Primary care - Our vision and objectives

Our vision

All residents of South East London access high quality, personalised, integrated primary and community care services when they need it, delivered in a sustainable way. Continually improving people's experiences of health and care services, making primary and community care a great place to work, and take proactive action against health inequalities to support our local communities to enjoy better health and wellbeing outcomes throughout their lives.
Primary Care services will work with partners to actively identify inequality and its causes and address them collectively and sustainably by:

- Helping people stay well for longer – as part of an ambitious and joined-up approach to prevention
- Delivering proactive, personalised care – supported by integrated neighbourhood teams for people with more complex needs, including those with multiple long-term conditions.
- Streamlining access to care - providing people who use health services infrequently with much more choice about how they access care, and ensuring care is always available in their community when they need it.

Our key objectives – what we want to achieve over the next five years

- **Improve patient experience** when using primary and community care services through integrated health and care services
- Deliver **integrated health and care closer to home** for individuals with multiple long-term conditions to support them to achieve better quality of life, supported by digital tools
- **Reduce health inequalities** by improving access, experience and outcomes for our Core20PLUS5 population
- Reduce avoidable use of unplanned care and avoidable exacerbations of ill health
- **Embed population health management** approaches in care delivery, using data to identify need and how to address it
- Achieve high levels of **staff retention and job satisfaction**, through opportunities for development, multidisciplinary working and effective coordination
- **Grow a health and care workforce** that collaborates to support people to stay independent and healthier for longer and is supported through integrated digital tools
- **Embed personalisation and supported self-care** into our service model
- Maximise the opportunities to support all of our primary care contractors being able to secure these objectives

Primary Care Themes

Access: To address the challenges of access, workforce and estates whilst embracing the opportunities afforded by best practice and national policy, including the Fuller recommendations

Sustainability: To support and enable general practice and PCNs to offer a sustainable model of primary care that is the first point of contact and principle point of care for the population

Partnership/Collaboration: To deliver the national, regional and local requirements in partnership with the ICB, Local care partnerships, and general practice

Population Health: To support and enable general practice and PCNs to provide a consistently high level of care, address unwarranted variation, and improve access, quality and population health outcomes

Resilience: To provide a model to support the resilience and sustainability of primary care with innovative workforce models and a range of support offers

Integrated: To support the development of integrated neighbourhood teams and integrated same day urgent care services

Equity: Supporting primary care to continue to build trust and relationships with their patients, two key ingredients to mitigating the social and structural drivers of inequities

Personalisation/proactive: To support patients to take a more active role in improving and managing their own health and be better information about which professional is best able to help them

Development: To enable Local Care Partnerships to lead the development of the transformation strategy for primary care within the ICB

Primary care - Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1. **Integrated neighbourhood teams** - Through our local care partnerships we will develop and embed integrated neighbourhood teams to support populations, establishing a workforce spanning primary, community, voluntary sectors and beyond, utilising technology and systems.

2. **High quality primary and community care** - We will deliver high quality primary and community care, and minimise unwarranted variation in clinical care and outcomes across all our communities, using data and digital solutions effectively.

3. **Sustainability of general practice** - We will improve the sustainability of general practice as part of a place-based, integrated systems, building a pipeline of skilled clinicians and professionals. This would include developing further the flexible staffing pool arrangements across SEL, increasing the number of clinical and non-clinical roles (including those funded by the Additional Roles Reimbursement Scheme), while helping existing staff to continuously learn and develop. We will continue to support opportunities for voluntary, community and social enterprise sector partners to become a meaningful part of the primary care team.

4. **Improve access** - We will work to increase capacity and improve access for all residents and achieve positive experiences of care through new technologies, innovative models of care, fit-for-purpose estate and direct access to care and diagnostics. We will work with practices, PCNs and their patients to develop models which support delivery of same day demand in the most efficient way.

5. **Cutting bureaucracy –** We will improve the primary care secondary care interface by standardising approaches to pathway and service design, convening and supporting interface forums and enhancing mutual understanding of clinical and operational pressures across organisational boundaries

Primary care - Our progress to date

Key Successes in Delivery in 2023/2024

- Focussed work on improving utilisation of ARRS funding has resulted in a significant increase in utilisation [include %]
- Completion of population health data packs and workshops in 5/6 boroughs, with identification of key focus areas across each PCN
- Co-production of integrated neighbourhood teams in all boroughs for patients with multiple long term conditions (starting with cardiometabolic diseases)
- Closer working with community pharmacies i.e the delivery of Pharmacy First
- Implementation of primary care workforce plan
- Delivery of the Primary Care Access Recovery Plan, particularly telephony improvements, access improvement plans and self-referral pathways.
- Local Support Level Framework and GPIP plans in place tailored to local requirements
- Development of BI tools to support primary care: Quality, Access, LTC and ARRS
- SEL Dental Transformation and Development group established

Key Challenges Delivery in 2023/2024

- Varying levels of primary care system maturity and development
- Capacity / capability to support strategic planning at all levels of the system.
- Having the necessary infrastructure for expansion of workforce and development initiatives, and the required links into the People programme.
- Differing levels of quality in read coding of activity in primary care which impacts on data quality feeding strategic planning and population health analysis.
- Developing effective integrated models between general practice, primary care and wider community/social care.
- Reducing unwarranted variation in clinical outcomes across SEL.
- Impact of management cost reduction on system capacity and ways of working
- Developing effective collaborative system leadership across primary care
- Lack of clarity regarding future GP contract
- Systematic and sustainable improvements to the primary and secondary care interface.

Learning and Implications for Future Delivery Plans

- Collaboration across primary care, PCNs, Federations and LCPs will be key to delivery of plans in light of capacity constraints. This needs to be supported through delegation and effective collaborative decision-making structures
- PCNs need continued support and dedicated time to mature structures, developing strategy and cohesion – particularly in developing our networks beyond general practice.
- Our practices are open to change and are receptive to data highlighting areas where improvements can be made, but demand continues to grow limiting space for transformation
- We need to continue to develop the relationship between the ICB and primary care, with the ICB acting as an enabler and supporter of primary care and PCNs.
- New models of care require significant investment in OD and cultural change with our front-line teams

Priority action – Integrated Neighbourhood teams

Integrated neighbourhood teams

★ ICS Strategic Priority

Through our Local Care Partnerships we will develop and embed integrated neighbourhood teams to support populations, establishing a workforce spanning primary, community, voluntary sectors and beyond, utilising technology and systems.

How we will secure delivery

Actions for 24/25

- Develop a systematic approach to integrated workforce planning using learning from pilots delivered in 2023/24
- Support the Neighbourhood-based Care Board to develop a shared vision for the future of primary care and model of proactive, neighbourhood based care.
- Develop standardised approaches to population segmentation, stratification and proactive care that enable Integrated Neighbourhood Teams to flourish.
- Develop and agree approaches to align sustainable financial and commissioning models that support integrated neighbourhood teams
- Undertake a stocktake of Fuller implementation for the ICB Board.
- Deliver key improvements to the primary and secondary care interface

Actions for 25/26

- Test digital innovations that support integrated neighbourhood team delivery (subject to funding)
- Delivery priority actions arising from the stock of Fuller implementation
- Understand and manage impacts of new GP contract settlement on Fuller implementation and maximise opportunity
- Deliver further improvements to the primary and secondary care interface

Intended outcomes in 5 years time

Collaboration between all providers across defined geographical areas, working seamlessly to support their local population's needs.

- Alignment of the clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams.
- Collaboration between previously siloed teams and professionals doing things differently and improving patient care for whole populations.
- Teams from across PCNs, wider primary care providers, community care, mental health, secondary care, social care teams, and Voluntary, community and social enterprise sector (VCSE) staff working together to share resources and information.

Priority action – high quality primary and community care

High quality primary and community care

★ ICS Strategic Priority

We will deliver high quality primary and community care, and minimise unwarranted variation in clinical care and outcomes across all our communities, using data and digital solutions effectively.

How we will secure delivery

Actions for 24/25

- Develop aligned system-level approaches to incentivising shared outcomes, with a focus on proactive care and reducing variation in access, experience and outcomes for health inequalities groups. This will include reviewing learning from hypertension and diabetes initiations
- Develop a self-care hub bringing together key information for patients on self-care and self-management tools that support long term condition management
- Improve system-wide reporting on quality and outcomes in primary care
- Improving community waiting times
- Continued relationship development between the Community Provider Network and Local Care Partnerships

Actions for 25/26

- Review and maximise opportunities from new commissioning framework for immunisations and vaccinations, ensuring this builds in learning on outreach models
- Developing integrated delivery models for out of hospital services (between primary, community and secondary care) where system capacity and capability is currently unable to meet demand.

Intended outcomes in 5 years time

Improved understanding of our population's needs, identification of causes and actions to address health inequalities as place-based systems, underpinned by data accessible to primary and community care providers, and partners.

- Active contribution healthy lifestyles prevention pathway
- Support for the prevention and early diagnosis of chronic conditions
- Use of personalised care to support patient groups, for example immunocompromised, long term conditions
- Supported self-care
- Improved immunisation uptake
- Development of a neighbourhood-level response to outbreaks and incidents
- Further development of antibiotic stewardship
- Accessible and integrated population health data and clinical effectiveness dashboards

Priority action – improve sustainability of general practice

Improve sustainability of general practice

★ ICS Strategic Priority

We will improve the sustainability of general practice as part of a place-based, integrated systems, building a pipeline of skilled clinicians and professionals. This would include developing further the flexible staffing pool arrangements across SEL, increasing the number of clinical and non-clinical roles (including those funded by the Additional Roles Reimbursement Scheme), while helping existing staff to continuously learn and develop. We will continue to support opportunities for voluntary, community and social enterprise sector partners to become a meaningful part of the primary care team.

How we will secure delivery

Actions for 24/25

- Embed within the SEL workforce plan a campaign to attract and recruit additional primary care staff
- Optimisation of pharmacy first, and wider integration with pharmacy
- Work with front-line teams on an Organisational Development Plan for primary care
- Review impact of pay variation and London Living Wage on workforce
- Finalise the SEL primary care resilience tool to ensure targeted support
- Develop a general practice extranet that reduces administrative burden for practices and the ICB .

Actions for 25/26

- Understand impact of new GP contract settlement on general practice sustainability and develop appropriate support
- Develop a workforce hub on the general practice extranet that provides practical support
- Work with the primary care system to develop and test approaches to succession planning and shared employment models that support greater sustainability for practices.
- Continued discovery and proof of concept around automation of primary care

Intended outcomes in 5 years time

Primary Care workforce and estate meet the capacity to provide high quality care, closer to patients' homes, making SEL a great place to work and live.

- Integrated services being delivered in the home and in localised settings including GP premises and community facilities.
- New models of care to improve services and reduce costs (including estate costs) and deliver sustainable services going forward, taking a flexible approach to estate provision.
- Recruitment of more newly qualified GPs, practice nurses and other primary care roles to address an ageing workforce and future shortages
- All staff roles embedded and utilised effectively, underpinned by collaborative workforce planning and data driven decisions
- Primary care is an attractive place to work, with staff recruited from and reflective of the populations that they serve.
- VCSE organisations are part of the primary care team, providing additional skills and knowledge

Priority action – improve access

Improve access

★ ICS Strategic Priority

We will work to increase capacity and improve access for all residents and achieve positive experiences of care through new technologies, innovative models of care, fit-for-purpose estate and direct access to care and diagnostics.

How we will secure delivery

Actions for 24/25

- Continue to deliver the requirements of the primary care recovery plan
- Deliver the requirements of the NHSE Dental Recovery Plan
- LCP engagement with practices on approaches to the delivery of same day access that support practice sustainability, meet patient need and that complement integrated urgent care services.
- Make improvements to the primary and secondary care interface to reduce unnecessary burden on primary care
- Roll-out of new remote consultation tools and cloud-based telephony

Actions for 25/26

- Implementation of primary care led approaches to same day access.
- Review options to further widen the upstream options for patients, including the role of the voluntary and community sector, community pharmacy and additional new self-referral pathways

Intended outcomes in 5 years time

Digital enhancements will enable service transformation in South East London to deliver the best healthcare outcomes for our citizens at all stages of their lives.

- Reduce unnecessary variation and duplication – take what works best and make it available across SEL to optimise existing investment
- Seamless access to online and video consultation appointment booking and health records via a single entry point utilising the NHS App
- An equitable offer and experience of primary care services
- Streamlined access and reduced appointment wastage using online triage
- Shared and joined up of back office functions to improve efficiencies across PCNs
- Increased digital maturity and optimised online presence
- Work at scale across PCNs utilising cloud based telephony

Primary care - Enabler requirements

Workforce

- Data-led workforce planning; understanding workforce profile (including ageing workforce) and developing plans in response
- Making SEL an attractive place for staff to work and stay
- ARRS workforce planning and Training Hubs to support PCNs to understand their workforce, how it can be maximised, and support them to recruit to new roles
- Training hubs to support practices and PCNs to consider how to attract staff and act as supportive employers
- Utilising supply routes such as Training Nursing Associates/Nursing Associate ARRS roles
- Develop plans with training hubs for involving VCSE providers in the primary care team to support retention, reduce burnout of wider primary care workforce and benefit from their strengths within local communities

Digital

- Continue working with PCNs to explore innovative ways to improve digital maturity and collaborative working to manage demand and improve patient pathways
- Efficient scaling and adoption of digitally sustainable solutions across the wider system
- Support PCNs to collaborate with broader health and social care teams, acute trusts, mental health and community services
- Improve patient access by supporting PCNs to optimise processes for more online consultation (when appropriate) to improve referral to the right clinician first time
- Further improve on the good utilisation of the NHS mobile app across primary care
- Improve use of individual and group video consultations, social media, practice websites, telephony, record access, repeat prescriptions and online appointment booking
- Develop clear support around social media use and best practices guidance for optimising website design and use
- Support practices and PCNs to manage access to patient records in a safe and robust way and empowering patients to take control of managing their health
- Identify opportunities to utilise Remote monitoring and the universal care plan

Estates

- Produce baseline data packs for each PCN
- Complete space utilisation studies across primary care sites in South East London
- Develop PCN estates strategies that are aligned to PCN clinical strategies
- Support practices and the ICB with strategic planning to optimise the current GP estate and provide further evidence to support business cases as required (including Lloyd George digitisation)
- Ensure a pipeline of prioritised schemes for the London Improvement Grant (LIG) and other capital funding opportunities

Data

- Improving the accuracy and quality of reporting of primary care activity - working with each practice to analyse, diagnose and facilitate how appointments should be mapped and coded to ensure accurate reporting in-line with National Slot Categorisation
- Development of more robust workforce data and capacity/demand data
- Use of demand and capacity tools to improve insight at practice and PCN levels to ensure workforce planning is optimal
- Use of risk stratification tools to give clinicians better opportunities to identify and prioritise people who may benefit from a proactive care offer
- PHM tools with actionable dashboards for integrated neighbourhood teams that enable drillable patient level data
- Dashboards which clearly demonstrate unwarranted variation in access, experience and outcomes. Outcomes/clinical effectiveness - variation

Palliative and End of Life Care (PEOLC)

Overview of our current system

Death and dying are inevitable.
In 2022 10,211 people died in South East London. 5,121 of these people died in hospital, for many, if they had been asked where they would want to die, they would have chosen a setting outside of hospital. It is estimated that around 50-75% of deaths are 'amenable to palliative care', but at present it is not clear what proportion of people are referred for support. At any one time, nationally, it is estimated that one third of people who are in hospital today will die in the next year, many of these admissions might have been avoided with proactive open communication and personalized care planning.
Palliative and end of life care must be a priority across services and care pathways. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preference and wishes.

Strengths / opportunities

- We have a well established PEoLC group and CCPL leads in most boroughs
- New London universal care plan (UCP) well utilized in many parts of the system and opportunities to further embed this.
- Bexley in particular has had success in 'finding their 1%' of people likely to die in the next year. Of these patients, almost 70% have a personalized care plan. There is scope to learn from this work and achieve similar results for the relevant % across other boroughs
- We have almost completed work to define a core offer for community Specialist Palliative Care providers;
- Pilot project to support patients and their families transitioning from CYP to adult EoL services
- Significant opportunity to address inequalities in many areas, starting with people with LD
- Projects started to implement End of Life Care virtual wards into wider acute/community pathways
- We have excellent services locally and a world leading PEoLC research institute

Challenges

- There are significant gaps in workforce across generic EoL (GP, DN, hospital, care home) and specialist palliative care (SPC) services. Where we have workforce, they may lack confidence on EoLC.
- Local SPC provision is reliant on significant charitable funding which may present problems in the current cost of living crisis (also a strength)
- There are significant inequalities in access to care – and much work to be done, e.g. moving away from a white-European approach to death and dying
- Our data is not joined up and so we are not able to fully understand pockets of excellent or weak performance.
- Outcomes in PEoLC are not well documented at present

What we've heard from the public

We have heard that the priorities for our patients are "to manage and choose the support" they need and to be empowered to begin planning at an earlier stage through honest conversations including families so people can understand their choices. We have also heard the need to better integrate care between services and to ensure seamless access to advice, care and treatment out of hours, including access to medications so people do not have to go into hospital. Social isolation was an issue for some. We are keen to progress more integrated engagement with our communities building on best practice across the UK, such as compassionate communities and death literacy.

PEOLC - Our vision and objectives

Our vision

Our vision is to ensure that people of all ages at the end of their lives* are identified early so that they can be supported to make informed choices, receive 24/7 care in the place of their choice and that they receive the best quality, personalised care, with people close to them supported by people who are empowered, skilled, confident and timely.

Our key objectives – what we want to achieve over the next five years

Our key objectives align to the National Palliative and End of Life Care 22-25 strategic priorities of accessibility, quality and sustainability.

Accessibility

- People likely to be in the last year of life are identified as early as possible
- All patients in the last year of life are offered a Personalised Care and Support Plan (PCSP)
- High quality care and advice is accessible 24 hours a day, 7 days a week for patients, family, carers and professionals in all settings
- There is equitable access to PEOLC for all, focusing on underserved populations

Quality

- Patients receive standardized and high-quality Palliative and End of Life Care irrespective of age, condition or diagnosis
- There is a confident workforce with the knowledge, skills and capability to delivery high quality Palliative and End of Life Care
- End of Life Care is seen as everyone's business, with patients identified and support through effective multi-disciplinary teams

Sustainability

- Specialist palliative care services, including hospices, are sustainable in the longer term, with sufficient NHS investment to achieve this.
- We have sufficient SEL specialist palliative care workforce to meet patient need and future demand, and non-specialist staff supporting end of life care patients feel confident and supported to deliver effective end of life care.
- We have thriving neighbourhood-based support which maximises the role of neighbourhood and third sector organisations in delivering support to patients, families and carers (e.g social prescribing and compassionate neighbours)

** n.b: Although we are generally talking about 'last year of life' there will be some people where a palliative care approach may be earlier. For others, they may be identified in the very last weeks, days or hours.*

PEOLC - Our priority actions

Our priority actions – what we will do

1. **Proactive and personalised care** - We will improve early identification of people approaching end of life and ensuring proactive, personalized care and support planning.
2. **Improve our service offer** - We will ensure PEoLC services are accessible 24/7 for patients, carers and professionals in all settings that are rated as 'good' or above across all areas of SEL
3. **Improve access** - We will identify groups who are marginalized and improve access for these groups
4. **Workforce** - We will support our workforce to have the confidence and skills they need to provide end of life care and work with the People programme to ensure that has End of Life Care is integrated into all health and care career pathways in SEL.
5. **Population Health Management** - We will use population health management approaches to ensure that EoLC is integrated into the model of care for all population groups, starting with the frail elderly and those with long term conditions.
6. **Compassionate communities** - We will work alongside our communities to support the development of compassionate communities with citizens who have a growing confidence and understanding about death, dying and loss.

PEOLC – Our progress to date

Key Successes in Delivery in 2023/2024

- Roll-out of the Universal Care Plan in South East London including integration into the majority of SEL clinical systems.
- Movement to an aligned Marie Curie contract within South East London (for 5/6 boroughs)
- Development of a specialist palliative care core offer by the Community Palliative Care Providers
- Piloting improvements to accessing palliative care medicines in the out of hours period
- Development of Palliative and End of Life Care Virtual Wards in some LCPs
- South East London Palliative and End of Life Care Network day with a focus on health inequalities
- Completion of a project to improve transitions from children to adults Palliative and End of Life Care services
- Development of shared SEL-wide outcomes for Palliative and End of Life Care

Key Challenges to Delivery in 2023/2024

- Lack of clarity around changes to the commissioning arrangements for Children and Young People's Palliative Care
- Ensuring the quality of Universal Care Plans and integration with the EPIC clinical system
- Challenging financial context across Palliative and End of Life Care
- Inefficient and fragmented out of hours support
- Recruitment and retention challenges across the workforce
- Variability in service offer and funding levels across LCPs
- Capacity available across the system to support planning, contracting and transformation

Learning and Implications for Future Delivery Plans

- Plans need to be better targeted to reflect capacity constraints
- Workforce development and retention needs to be a key priorities to support delivery

PEOLC priority action 1 – proactive and personalised care

Proactive and personalised care

Improving early identification of people approaching end of life and ensuring proactive, personalised care and support planning

How we will secure delivery

Actions for 24/25

- Funded place based projects to improve identification of patients in last year of life and increase use of advance care planning.
- Share learning from projects to agree standardization where appropriate
- Improve quality of records and utilisation of the Universal Care Plan
- Deliver integration of the Universal Care Plan with EPIC.
- Test approaches to integrate Palliative and End of Life Care provision into multiple Long Term Condition and Frailty integrated neighbourhood team models.
- Grow and improve MDT/ Gold Standard Framework meetings in LCNs with palliative care involvement

Actions for 25/26

- Test project ECHO (Extension of Community Healthcare Outcomes) model in SEL
- Mainstream integration of Palliative and End of Life Care planning within integrated neighbourhood teams
- Explore options for improved identification of people at end of life in hospital (find your third)

Intended outcomes in 5 years time

- Increased % of people identified as being in their last year of life on practice registers and Increased number of people with Personalised Care and Support Plan(PCSP)/UCP. (moving to England average of 1%)
- Increased % of people who die in their preferred place of death.
- A 10% reduction in the % of deaths with three or more emergency admissions in the last year of life
- Increased numbers of people referred to community SPC by 2027.
- Increase in time from referral to death in community SPC services by 2027.

PEOLC priority action 2 – improve our service offer

Name of priority action

Services which are accessible 24/7 for patients, carers and professionals in all settings that are rated as 'good' or above across all areas of SEL

How we will secure delivery

Actions for 24/25

- Complete gap analysis of current provision against the SEL specialist palliative care core offer.
- Review outputs of CYP transition pilot project against future commissioning plans.
- Complete a review of out of Hours services for people at EoL and identify opportunities for improvement
- Test further improvements to access to end of life care medications, particularly out of hours
- Ensure safe transition of Children's Palliative Care commissioning from NHS England, work with LCPs to establish approach for 25/26.

Actions for 25/26

- Mainstream improvements to access for end of life care medications, particularly out of hours
- Understanding and quantifying distance to travel to level up all provision to meet the core offers
- Review Children's Palliative Care provision and develop a core SEL offer
- Implement improvements to Out of Hours End of Life Care services (ensuring alignment with Integrated Urgent Care services)

Intended outcomes in 5 years time

- Delivery of core standards and outcomes across all specialist palliative care providers through the implementation of core offers
- Improved experience for children, families and carers transitioning from CYP to adult end of life care services.
- All patients (adults and children) to have access to palliative care support to optimise symptom control and relieve pain 24 hours a day, 7 days a week
- All patients, families, carers and professionals have access to specialist palliative care advice 24/7 days a week
- A single point of referral for specialist palliative care services is in place (at an appropriate geography) which provides triage, assessment and coordination of care needs
- All patients have access to hospice beds, acute and community specialist palliative care services, hospice at home services and ambulatory care services.
- Families have access to bereavement services and carer support services which meet local population need
- Good access to appropriate palliative care medicines in the community by working with community pharmacy to support peoples end of life care plans

PEOLC priority action 3 – improved access for marginalised groups

Improved access for marginalised groups

Identify groups who are marginalized and improve access for these groups

How we will secure delivery

Actions for 24/25

- Co-design pilots to improve end of life care for two underserved population groups for potential testing through health inequalities programme
- Review use of Universal Care Plan across inequalities groups and identify ways to better equalise access
- Targeted communications and engagement with underserved population groups to improve knowledge of services available

Actions for 25/26

- Work with the London Universal Care Plan programme on a plan to improve patient accessibility of the plan for all the population taking into account digital exclusion and language barriers etc
- Implementation of health inequalities pilots (subject to funding)
- Organise system-wide learning events to review missed opportunities for palliative and end of life care for patients who experienced 3 or more emergency admissions in the last three months of life

Intended outcomes in 5 years time

- Developed data in identifying areas of focus among underserved population
- Increase in fair and equal access to quality palliative care especially among underserved populations
- A reduction in variation in access to specialist end of life care services for patients from underserved populations
- A reduction in variation in patients identified as being in the last year of life from underserved populations
- A reduction in variation in the number of patients who have been offered a personalised care and support plan from underserved populations
- A reduction in variation in the % of patients who die in their preferred place of death across underserved populations
- A reduction in the number of patients from underserved populations who experience 3 or more emergency admissions in the last three months of life

PEOLC priority action 4 – workforce

Workforce

Support our workforce to have the confidence and skills they need to provide end of life care and work with the People programme to ensure that has End of Life Care is integrated into all health and care career pathways in SEL.

How we will secure delivery

Actions for 24/25

- Develop virtual training products to be made avaliable to all SEL practitioners, intially focussing on early identification of people at EoL.
- Implement a training scheme for band 5 nurses with an interest in EoLC to help them develop their palliative care knowledge and skills. This will aim to support 24 Band 5's from all settings.
- Consider opportunities via the NHS Long Term Workforce Plan to support further workforce initiatives across End of Life Care, engagement with the SEL People Programme.

Actions for 25/26

- Development of additional modules as part of the virtual training platform.
- Implementation of new recruitment and retention projects aligned to the NHS Long Term Workforce Plan.
- Explore joint recruitment/ rotation models across the Palliative and End of Life Care system

Intended outcomes in 5 years time

- Increase in confidence in the workforce with knowledge, skills and capability to deliver high quality PEoLC - number of staff trained in PEoLC
- Developed implementable SPC workforce plan across CYP/ adult
- Developed Education and Training Strategy which will include training and resources, prioritisation of staff groups/ topics and scoping for additional investment
- Improved confidence in managing end of life care staff reported as a result of training – via staff survey
- Alignment between capacity and demand for the specialist palliative care workforce

PEOLC priority action 5 – population health management approaches

Population health management approaches

We will use population health management approaches ensure that EoLC is integrated into the model of care for all population groups, starting with the frail elderly and those with long term conditions.

How we will secure delivery

Actions for 24/25

- Continue to implement whole system integration approaches in service provision - integrating EoL SME into LTC/ frailty management
- Develop a Palliative and End of Life Care dashboard based on the SEL outcomes framework
- Ensure SPC advice and guidance is integrated into the development of multi-disciplinary team approaches so that patients are supported holistically regardless of where they treatment is being managed.
- Share learning from initial End of Life Care virtual wards across SEL, and consider opportunities to further development the model.

Actions for 25/26

- Further development of Palliative and End of Life Care data tools, moving on to the development of new indicators where data is not readily available within the system (i.e patient and staff experience)
- Develop specification for the population health management tools required by front-line professionals and neighborhood teams to deliver the model of care
- Embed outcomes into SPC services and ensure reporting captures this

Intended outcomes in 5 years time

- As near to real time data flow between providers involved in the delivery of End of Life Care
- A detailed understanding of population segmentation within end of life care and the needs of those segments.
- Articulated and shared care pathways for all population segments
- A PEoLC dashboard is in place with timely activity and quality related data
- Patient and carer reported improvement in the integration and personalisation of care
- Staff reported improvement in feeling support to deliver the care that they wish to
- Improved symptom control and relief of pain
- Increase in the number of patients dying in their preferred place of death

PEOLC priority action 6 – develop compassionate communities

Develop compassionate communities

We will work alongside our communities to support the development of compassionate communities with citizens who have a growing confidence and understanding about death, dying and loss.

How we will secure delivery

Actions for 24/25

- Continue an events programme aligned to Dying Matters week to engage interested citizens in talking about death dying and loss
- Development of patient and carer stories to share with a) communities b) health and care professionals c) system leaders – what matters to me, what good eolc looks like.
- Development of a compassionate communities pilot in SEL to start in 2024/25 (rebalancing death and dying)
- Expand utilisation of patient-led access to the London Universal Care Plan
- Bid for funding to support Compassionate Community development in 25/26

Actions for 25/26

- Develop guides and resources on developing compassionate communities in South East London
- Work with, and map, community assets that can support communities outside of statutory services.
- Establish partnerships with key community institutions to develop a year of Compassionate Communities events

Intended outcomes in 5 years time

- Increase in people coming forward to share their story
- Increased understanding and empathy with EoLC experiences for a broad range of people
- Communities involved in co-production of services that meet their needs
- Increase in self referral

PELOC enabler requirements

Workforce

- Ongoing development of SEL PEoLC leadership team
- Clinical and Care Professional Leadership roles in each borough with sufficient resource and support to joint up professionals across boundaries.
- More joined up working between leadership roles across workstreams – cross working with other programmes
- Better utilization of additional role reimbursement scheme (ARRS) roles towards EoLC
- Support from the People Board and Programme to understand and act on future workforce, training and education needs for the EoLC workforce
- Access to a consistent training and education package around EoLC care, including advanced care planning, where uptake can be monitored
- Modelling and workforce planning tools
- Workforce Wellbeing for both NHS trust and non-NHS trusts staff
- Investment in care home staff training

Digital

- Investment to test remote monitoring and digital technologies to support workforce efficiency and improve patients care
- Seeing each other's records -as appropriate
- Development of webpage
- Remote monitoring kit for Virtual Wards and observations of people at home
- Improvements in IT equipment, in particular for domiciliary care – to enable measurement of outcomes
- Enabling digitally able community patients to self-report PROMs
- Ongoing renewing of kit
- Support to care homes, social care and children hospice providers to overcome barriers that are restricting access to the London Urgent Care Plan
- Videos for training

Estates

- Improvements to primary and community care estate to support the development of integrated neighbourhood teams for End of Life Care.
- Investment in WiFi infrastructure within our estate

Data

- Integrated data across primary, community, acute and social care providers
- Population health management dashboards for end of life care which meets the needs of front-line professionals, neighborhood teams, Local Care Partnerships and ICB teams
- Dashboard to monitor and track outcome measures and key performance indicators
- Regular, automated data flows relating to staff capacity, training and education
- UCP data
- Support to implement the community services dataset across our hospices

New ICB responsibilities - Delegation of Pharmacy, Optometry and Dentistry

- On the 1st April 2023 NHS England delegated responsibility for the planning and commissioning of pharmaceutical, general optometry and dental services (primary, secondary and community services) – known as PODs to all ICBs in England. This means that there is an agreement between NHS England and NHS South East London Integrated Care Board (SEL ICB) that enables the ICB to take on the responsibility for delivering these NHS England functions for our population.
- This decision was taken following a nation pre-delegation assessment process and the subsequent agreement of both the SEL ICB Board and NHS England to the planned 2023/24 delegation.
- The aim of the delegation was to provide ICBs with the responsibility and opportunity for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. It is hoped that, through delegation, ICBs will be able to support approaches to designing services and pathways of care that better meet local priorities. Delegation should also provide greater flexibility to integrate services across care pathways, ensuring continuity for patients, improved health outcomes for the local population and optimised use of resources.
- Certain functions were retained by NHS England such as national contract development and negotiations, performers list management, wider aspects of professional regulation and national transformation programmes.
- The delegation related to the following contracts and related budgets: 220 dental contracts with a value of £159m, 191 general ophthalmic contracts with a value of £15m and 326 community pharmacy contracts
- Due to the nature of the single regional team currently working across London to support PODs services commissioning, London's ICBs agreed to work collaboratively across their five systems to ensure the best use of this limited resource is secured through the retention of a single team for London. This team is hosted by NHS North East London ICB.
- The delegation arrangements are underpinned by signed agreements setting out respective roles and responsibilities between the SEL ICB and NHS England and across the five London ICBs.

Pharmacy, Optometry and Dentistry (PODs) (1)

23/24 Key Priorities/Deliverables

A safe landing - It was important that the ICBs secured a safe transition of the responsibilities from NHS England to SEL ICB during the first quarter of 23/24. This included retaining the expertise residing in the London PODs commissioning team through the establishment of a host and lead ICB arrangements, plus underpinning governance including a new London PODs Commissioning Oversight Group which coordinates the delivery of these delegated functions across the capital. This was successfully achieved, with minimal risk and disruption to the system.

Managing our community pharmacy, optometry and dentistry service portfolio - ICBs inherited a wide ranging service and contractual portfolio related to PODs from 1 April 2023 and a key year one focus was on ensuring the effective management of this service portfolio. This work continues into year 2 especially focusing on the opportunities that the dental recovery plan and Pharmacy First initiatives provide to the system.

Understanding the detail of the delegated services – During 23/24 we focused on understanding our POD service portfolio including contractual, quality and financial related requirements. This has included building on our knowledge and understanding through developing relationships with our PODs providers and their representative bodies. We will have also been working with our communities and patients to understand their perspectives to support the development of responsive, coproduced plans and approaches for the future.

A forward look – further opportunities in 24/25

Dental – In February 2024 the government published their Faster, Simpler and Fairer: Our plan to recover and reform NHS Dentistry. This 13 month plan gives the ICB a number of opportunities including working with public health colleagues on several initiatives and campaigns, working with local dental providers to maximise the opportunities to see and treat those people who have not seen a dentist for 2 years or over, and to utilise the ring-fenced funding for oral health services to meet the needs of those most in need. Whilst this is only a 13 month plan there is a commitment to consult on further reform of the dental contracts.

Community Pharmacy – in January 2024 a national Pharmacy First service was launched which enables people to access care for seven clinical conditions from their community pharmacy team, either by walk in or referral from general practice. We will support community pharmacy and general practice to work together to ensure that this, and other clinical services in community pharmacy such as blood pressure checks improve access to care and reduce health inequalities for our population. We will also continue to develop local services through community pharmacy such as vaccination and health and wellbeing checks. More detail is also outlined in the Transforming and Integrating Medicines Optimisation plan.

Population health and inequalities – we are developing our approach to utilising the data, information and insights that are available to us to shape our planning and commissioning of services to reduce inequalities across our diverse population.

Levering funding, contractual and service development opportunities – we have been developing our approach to lever available flexibilities and opportunities to secure a responsive service offer that enables us to build on our ambitions around integrated neighbourhood care, population health improvement and inequalities.

Pharmacy, Optometry and Dentistry (PODs)

Pharmacy, optometry and dental services are key components of general health and wellbeing, with deep rooted connections and synergies to prevention, primary care and community services – we hope to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff. Some key opportunities for further development are shown below.

Pharmacy	Community pharmacies are trusted and highly accessible sources of advice and care by their local communities. Our experience of working directly with pharmacies as part of an integrated vaccination offer has highlighted their reach into communities that are traditionally underserved by mainstream services. By promoting the range of national services (blood pressure checks, Pharmacy First, contraception, vaccination) on offer though pharmacy to our public and establishing partnerships and collaboration between community pharmacy and general practice, we aim to improve people's health and reduce health inequalities. Pathways are being tested for prescribing and referral in the community pharmacy setting which along with digital integration will enable community pharmacy to deliver more services for health and wellbeing (vital 5) and long-term conditions.
Optometry	Improving the utilisation of local optometry services for minor eye conditions to reduce demand on our urgent and emergency care and secondary care planned care services represents a further opportunity. Whilst minor eye condition services are already commissioned across South East London, delegation could support us in improving local relationships and links between optometry providers and our wider system and building optometry providers into work underway within our Local Care Partnerships to design integrated urgent care pathways as part of implementing Fuller Review.
Dentistry	There are evidenced links between tooth decay / poor dental health with broader physical health condition. We will be considering how to bring together work on healthy lives – including weight management, smoking cessation and alcohol use – with oral health promotion at a very local level, using a think family approach and Making Every Contract Count (MECC). By integrating our preventative approach and messaging and utilising the full range of health and care professionals across our system we hope to be able to increase our impact.

New ICB responsibilities - Delegation

Specialised services

- 'Specialised services' – a portfolio of 154 hugely varied services - have been commissioned by NHS England since 2012.
- Some of these services look after a handful of patients with rare conditions a year, while others, like radiotherapy or neurosurgery treat tens of thousands each year as part of wider pathways of care that also span primary, community and other secondary care services currently commissioned by ICBs.
- Within south east London, Guy's and St Thomas' and Kings College Hospital provide a wide range of specialised services, with geographic flows spanning south east London, London, Kent and beyond.
- Since 2018, NHS England has been working with local commissioners to develop more integrated planning for specialised services to maximise the opportunity for joined up, high quality and equal care for patients.
- The Health and Care Act 2022 formalised these approaches, by allowing ICBs to take on delegated responsibility, where appropriate, for the commissioning specialised services within a framework of continued national accountability, national standards, national service specifications and national clinical policies.
- This new legislative framework presents the opportunity for specialised services and patients to fully benefit from the focus of ICBs on local population health and ensure that the specialised elements of pathways are part of the integrated design and delivery of care to patients.
- It has been agreed nationally that commissioning responsibilities for an agreed sub-set of the specialised services portfolio will be delegated to ICBs from April 2024. A phased implementation of these new delegation arrangements will take place, with some Regions waiting until 2024/25 (April 2025) to take on delegation. This includes all five London ICBS.
- 2023/24 and 2024/25 therefore represents a transitional period as we gear up for taking on their new responsibilities.
- South east London, working with south west and other London ICB colleagues and NHS England London Region, has undertaken significant preparatory work during 2023/24, including as a national pathfinder to test the transactional elements of delegation, as well as progressing work on our future operating model and governance and pathway transformation pilots. Further work will take place over 2024/25.
- The specialised services portfolio covers mental health as well as acute services but mental health has been subject to earlier delegation from NHS England through lead provider arrangements – in south east London mental health providers have been working as part of the South London Partnership which has had delegated responsibility for a range of agreed specialised services for a number of years.

Specialised services

2023/24 development and preparatory work – what we achieved in 2023/24

Joint Working Arrangements – SEL has continued to work with London ICB and NHS England to secure joint oversight of specialist services. This includes being part of a joint London Committee across the five London ICBs and NHS England. The ICB has been a significant contributor to joint work across London to develop our proposed operating model focussed on future governance, ways of working and the development of the commissioning function.

Care pathway transformation pilots - South London has continued to develop and implement pilots to test opportunities and benefits around integration, financial and service benefit and reducing inequalities. These include:

- 2 year pilots that commenced in 2022/23 – neurology, cardiac and Blood Borne Virus testing. We continue to evaluate the impact of these pilots and ensure that learning informs both the future commissioning of these services but is also applied more generally to our future care pathway planning.
- Three new pilots developed during 2023/24 – specialist paediatrics, renal care and haemoglobinopathies (focussed on sickle cell disease), which whilst reflecting national and regional priorities also resonate from a local population perspective. SEL has secured national funding to support the development of our sickle cell services, with investment agreed to secure a new community services offer for SEL plus develop an acute A&E bypass model. We plan to supplement the national funding with targeted local investment to enable a core service offer to be secured consistently across SEL. We have also secured national funding to test a Multiple Morbidity Model of Care that enables integrated case management of a shared caseload between specialist teams and neighbourhood teams. The initial focus is integrated renal specialists, diabetes and cardiology specialities working as part of 7 neighbourhood teams across SEL.

Pathfinder pilot – working across South London to lead a national pathfinder programme. This programme tested some of the key processes around delegation, focussed on data and business intelligence, finance, contracting and payments arrangements, with a 'playbook' of processes and products for adoption by Regions and ICBs for full delegation from April 2024 generated because of the pilot and the learning derived from it. As well as the national benefit, the pathfinder programme provided key learning locally about what is needed to ensure safe delegation of services.

Pre-delegation assurance process – we participated in this national process during the summer/autumn of 2023, to test readiness for taking on these new delegation responsibilities. SEL was rated as green – ready for delegation. Further London wide preparatory work was however agreed for 2024/25, with delegation delayed until April 2025 to enable this to take place.

Specialised services - 24/25 priorities

London wide work – to support a safe and effective delegation

The SEL ICB is working jointly with other London ICBs and NHS England partners to further develop our plans and ways of working around the following four key areas:

Future operating model

- Work to define our **operating model for the NHS England specialised services function** across retained and delegated services, to support integration with ICBs whilst also retaining access to the subject matter expertise and resource that resides within NHS England. To do so we are considering options for developing commissioning hubs.
- Work to understand how we will collectively understand ICB/NHS England commissioning plans going forwards and ensure **effective multi ICB decision making** where services might be optimally planned on a population footprint bigger than a single ICB.

Quality and outcomes

- A comprehensive and systematic mapping of quality and outcomes across specialised services to ensure full visibility and collectively agreed approaches to managing any associated risks, via a **legacy risk log.**
- Building form this the development of a **strategic risk-based framework** for specialist services, where the development of more concrete proposals is required to address identified quality and outcome risks.

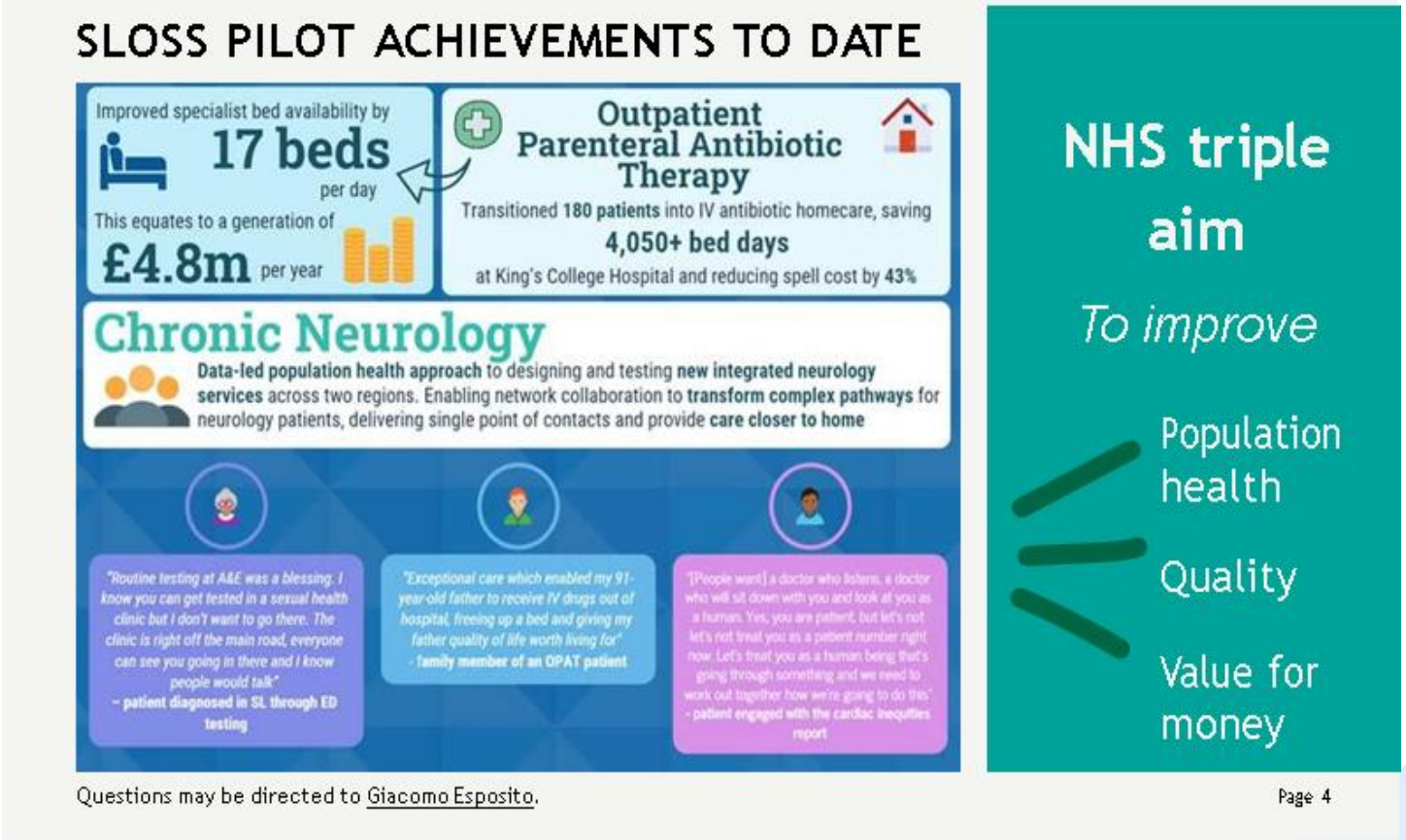
SEL specific work – to ensure benefits of delegation are optimised

The SEL ICB will work with partners as part of the South London specialised services programme on the following areas:

- Further development of our **care pathway transformation** pilots and learning from them, including applying this learning to secure a greater spread and scale, embedding approaches to improving productivity and efficiency and reducing our reliance on specialised services through prevention, earlier detection and interventions. Includes complimentary new **efficiency programme**.
- Building from the South London led delegation pathfinder pilot to ensure we embed and **further build our expertise across data, business intelligence, finance, contracts and payments**. To include work to understand the impact of national allocation changes to reflect population driven budgets.
- **Enhancing our collaborative working** with the London specialised services commissioning team to join up approaches with regards SEL providers, whilst also joining up acute and specialised services in our own ICB planning.
- Reviewing our South London **programme governance** to ensure fitness for purpose in the context of delegation and the development of an agreed London operating model.

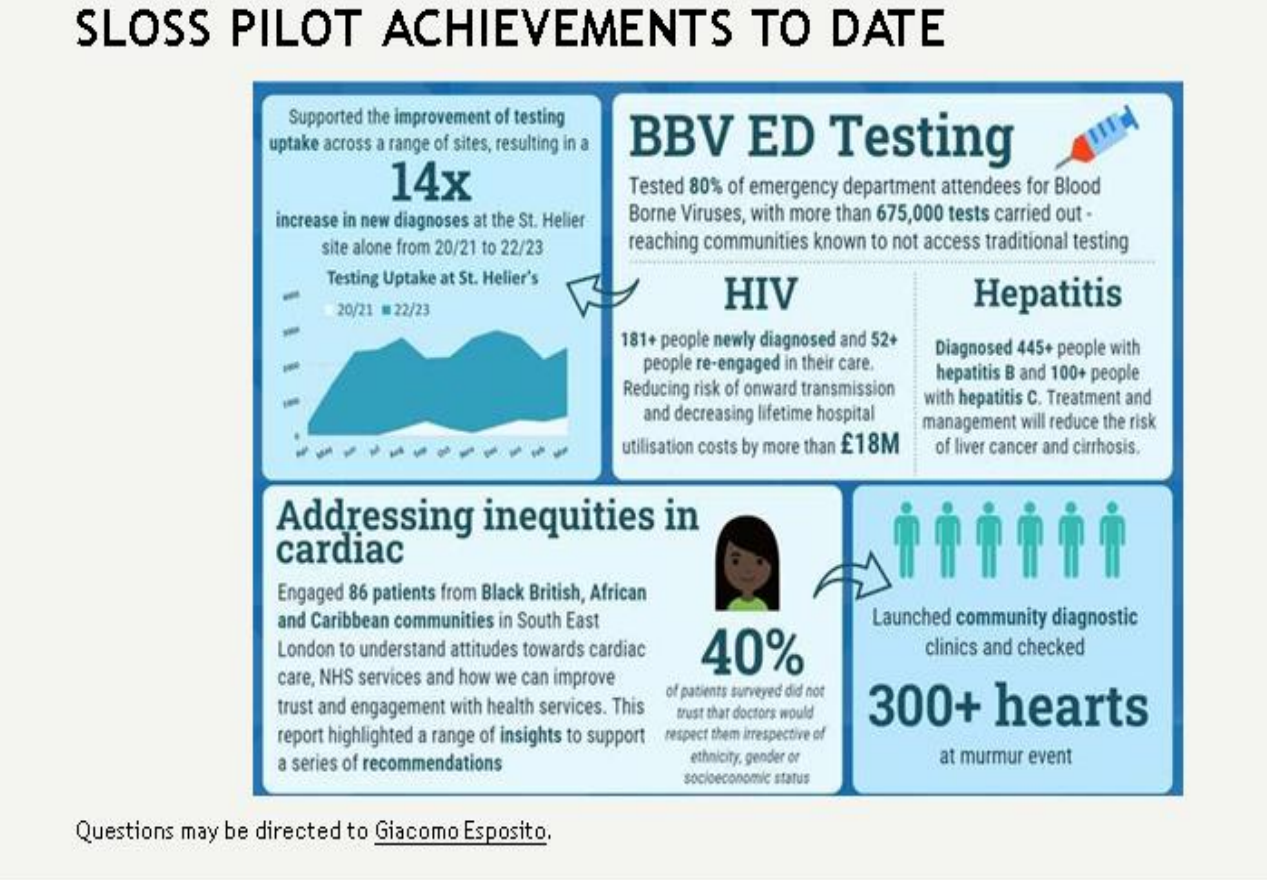
Specialised services - care pathway transformation pilots (1)

- South east London has participated in the south London transformation programme (SLOSS) which has been running a number of pilots over the last two years, focused on cardiac, testing in Emergency Departments for blood borne viruses and neurology.
- Pilots have been developed against an outcome objective that they demonstrably deliver benefits across the NHS triple aim.



- Key outcomes are shown over this and the next page.
- We will continue to progress these areas of transformation over 2024/25, including as part of our work a focus on care pathway efficiency.

Specialised services – care pathway transformation pilots (2)



- Our South London sponsored care pathway transformation pilots have enabled:
  - The fostering of collaborative working on a multi ICB footprint.
  - Clinically led and driven pathway improvement opportunities to be identified and implemented.
  - A focus on the benefits to be derived from specialised services delegation through a focus on end-to-end care pathways and tackling specialised services demand and inequalities through a focus on front end pathway prevention, dearly detection and intervention.
  - A systematic tracking of impact and benefit.
  - Valuable learning in terms of specialised services but also wider ICB approaches to care pathway redesign and transformation.

Specialised services - care pathway transformation pilots (3)

Sickle Cell

Achievements in 2023/24

- Secured funding for enhancements to community services across South East London and for testing of an ED bypass model at Lewisham and Greenwich NHS Trust
- Co-production of SEL hub and spoke multi-disiplinary team for sickle cell patients integrated with existing community nursing teams
- Development of partnerships with key voluntary and community sector providers to meet the holistic needs of sickle cell patients.

Areas of focus for 2024/25

- Full year operation of the enhanced MDT community model
- Transition of care plans for Sickle Cell patients to the Universal Care Plan ensuring all appropriate health and care professionals can deliver care in-line with the patient's personalised plan.
- Roll-out of ED bypass models for patients living with sickle cell across GSTT and KCH
- Evaluation of the enhanced MDT community model and ED bypass models to begin
- Development of pilots within primary care to reduce health inequalities for our population living with sickle cell

Multiple Morbidity Model of Care (Renal)

Achievements in 2023/34

- Identification of 7 neighbourhoods wishing to test a new integrated team approach for patients living with multiple long term conditions
- Co-production of an integrated model of care between specialist renal, cardiology and diabetes teams, GPs and other Health and Care Professionals working within neighbourhoods
- Continued roll-out of remote testing for CKD with 7000 more remote tests secured
- Development of an acute specialist team covering all specialities and all SEL acute sites to improve care for patients with complex cardiometabolic multi-morbidities.

Areas of focus for 2024/25

- Full year operation of pilots in all 7 neighbourhoods
- Implementation of a unified risk stratification approaches for the population cohort and a shared case management approach for higher risk patients to stabilise condition and reduce exacerbations
- Optimisation of treatment and medication protocols for patients at lower risk to support patients to remain healthy
- Improving the identification of, and advanced care planning support for patients with highest need who are facing choices over their treatment options and may be entering their last year of life.
- Evaluation of the model to begin

Specialised services – efficiency programme

- In 2023/24 the spend on specialised services for South London trusts was approximately £1.9 billion - of which £1.5 billion will be delegated to ICBs.
- With ever-increasing pressures across the system (cost and inflationary pressures, demand and capacity, population health and ability to meet performance standards), there is a real priority attached to delivering care in the most efficient and effective way possible.
- There is a recognised need for transformative work that reconfigures pathways and delivers care in new ways to deliver more efficient services whilst improving patient outcomes.
- There is consequently a strong appetite across the South East London (SEL) and South West London (SWL) systems for a multi-year efficiency programme to run through 2024/25 and beyond.

In response we are collating further opportunities for transformation and financial and efficiency impact, to help to deliver the triple aim whilst evidencing impact over activity. Work includes:

- Procurement – opportunities for savings in the procurement of cardiac devices within the upcoming renewal of contracts.
- Renal – agreement of five proxy measures that would serve as a first step towards quantifying financial impact of renal projects in future, such as the annual cost per dialysis patient.
- Neurology - Moving care into the community with IVIG and early access to specialist care
- Cardiac – Focus on reducing repeat heart attacks using integrated prevention clinics.
- High cost drugs – development of proposals for savings in this significant budget.
- Workforce - long term planning to ensure capacity for transformation changes, such as community care.

South East London Integrated Care System

Enabler programmes

Enablers - introduction

- The previous sections of our Joint Forward Plan set out the key objectives and priority actions of our local care partnerships and our care pathway programmes.
- Successful delivery of these objectives is reliant on some key enablers namely workforce, digital and data, estates and finance
- There are other overarching programmes of work which will support delivery of the SEL Joint Forward Plan, and these are also set out in this section including; how we will continue our system development, our approach to population health management, our approach to sustainability and delivering the commitments of the green agenda, how we will support wider social and economic development in SEL through our plans, and the link between our plan and the performance and quality targets we are required to meet as a system.

Workforce Programme

Overview

Ensuring adequate workforce supply to meet future service needs is central to our vision for excellence in care. The Workforce Programme aims to address national and local priorities across Health and Care, by strategically supporting the retention and growth of our “one workforce” (health, care, voluntary and charity) across SEL to make a tangible difference for our population.

Strengths / opportunities

- The SEL ICS People Strategy was published in April 2023: selondonics.org/people-strategy. This sets our mandate to deliver against the ICB Vision and direct priorities for investment.
- The National Long Term Workforce Plan (LTWP) published in June 23 which set out ambitious targets which will be delivered over the next 15 years, supported by National funding of £2.4B over a 5 year period. Workforce growth is to be supported by the priorities to train, retain and reform the workforce.
- Our SEL People Strategy is aligned to the LTWP.
- Actions to support workforce growth and transformation are being fulfilled through collaboration, and aim to deliver a coherent and co-ordinated approach to fulfil our commitments across the full patient pathway.
- The People Strategy has been co-designed and is a “LIVE” document allowing for ongoing co-production and engagement across the system to maximise impact.
- This Strategy responds to our “case for change”, a document that details the current financial pressures, increases in service demand and the differences across SEL boroughs. Regular bi-annual reporting to our People Board is now in place.
- The ICS People Programme continues to build on established collaboration, partnerships and steer from senior leaders working through a strong governance set up to deliver against the ICB vision (see slide below).
- We will build on our work in progress and expand it to meet ongoing challenges, unsolved problems and future requirements
- The workforce programme team has been expanded to deliver against this strategy which focuses on 5 key priorities (see slide 223).
- Commissioning strategically and investment in workforce development and training will continue dependent on Regional budgets and other sources

Challenges

- Delivery plan, targets and budget linked to the National NHS Long Term Workforce Plan are currently unknown, and will impact delivery
- Workforce shortages are an ongoing challenge with increased demand for services due to an aging population and advances in medical technology.
- Workforce challenges are now further exacerbated by the need to manage service recovery post-COVID whilst supporting an over stretched workforce.
- Our financial deficit and the need to focus on productivity remains a challenge
- A system wide narrative on productivity in line with the LTWP is required, including quantitative analysis or pilot work that supports identifying improvements
- Whilst investment in education, piloting new roles and transformation are ongoing; opportunities to spread and scale remain, and the challenge is to address these by appropriate prioritisation and resource commitment.
- Enabling innovation through increased use of AI and digital features in our People Strategy but this is new work that comes with the challenges of start-up and the requirement to forge new collaborations.
- We recognise “gaps” within the programme i.e. areas that we have not previously focussed on in any detail eg CYP, LD and digital. However, expansion of our team and foundations being set will enable us to undertake new work.
- The Workforce Programme team remains relatively small in relation to the breadth of work that needs to be covered. We will be relying on continued collaborations and time commitment from our partners; this can be a challenge where partners are stretched between organisation specific and ICS priorities.
- The workforce team will be working across a mixed portfolio of work and some priorities will need time to scope and plan in detail to ensure deliverables meet our system level needs.

Workforce – Delivering the Strategy

We will deliver against our "Live" People Strategy by working through our governance and partnerships

SEL ICB

People Board

SEL ICS Workforce Programme

SEL Formal Workforce Programme Governance	Collaboratives	Informal Workforce Supply Advisory Groups	Linked Networks
ICB Planning Team	APC	Workforce Collaborative Education Collaborative OD & Leadership Collaborative Nursing Expansion Board Widening Participation Network Apprenticeship group Anchor Alliance Population Health Equalities/ VCSE Network Communications Network Jobs Hub Steering Group	DASS Group / SC
SEL ICS HRDs Network	Community		Mental Health
APC CPO (EAG)	Mental Health		Communications Network
Staff Health and Wellbeing Committee	PC Exec Group		
Equality, Diversity and Inclusion Committee			

Local Care Partnership Committees – Place Based

Regional / National Priorities

Delivery against this strategy will be based on prioritisation against 4 tests:

- The size of the opportunity
- The need for collaboration
- Feasibility
- Strategic coherence.

This strategy will be delivered by:

1) Collaboration - Aggregation of assets and potential for driving economies of scale across partner organisations.
2) Convening - Bringing people together across the sector Create a dynamic for unusual pairings and for working across boundaries in new ways
3) Capability - Building expertise such as workforce planning and transformation inc new roles, education, leadership development at all levels and talent management.
4) Capacity - Establish the right level of resource to enable and support the clinical programmes and partner organisations to deliver on their priorities and transformation agenda.
5) Commissioning - Provide funding to deliver on certain requirements and commission expertise from within our SEL assets or from other organisations.
6) Change - Delivery of consistent approach to planning to drive change. This will enable the sustainable adoption of new care models; ways of working and ways of being.

Workforce - Our vision and objectives

Our vision

Where are we trying to get to? What would good look like in 5 years time?

- We want South East London to be a diverse, joyful and vibrant place where our skilled “one workforce” are supported to live healthy working lives and empowered and encouraged to collaborate across our partners making a difference to the lives of people our communities.
- We are committed to show a measurable difference in workforce supply, staff retention and transition to new ways of working across boundaries to support population health
- Work will be delivered through the Workforce Programme team working with system partners; working together effectively across teams will be critical to delivery against our

Our key objectives – what we want to achieve over the next five years

People strategy 2023-2028: Delivering new and integrated models of care will impact on how we recruit, develop and retain our people. Our People Strategy outlines our commitment to supporting transformation and retention of our “One workforce” for the South East London Integrated Care System, looking across health and care.
To achieve this, five interlinked priorities are set out, recognising the value of activity undertaken at every level, including across the system, within partnerships and by organisations; these are:

- Strategic workforce planning to\ grow the workforce for the future, with integrated system planning to support transformation, driven by data analytics.
- Driving strategic training and education to develop our people and manage talent, with targeted investment in workforce development and up-skilling to meet our strategic vision.
- Promoting south east London as a great place to work, with good jobs for local people which support broader social and economic development.
- Embedding a culture of inclusion and wellbeing and creating a great experience for staff.
- Enabling innovation by leading workforce transformation and new ways of working.

Place level planning and partnership working is central to our People Strategy. Priorities for workforce planning and transformation at place level relates to our system response to the Fuller Review and the development of integrated MDTs (harnessing the NHS, local authority and voluntary and community sector workforce), working to support the needs of our population, with the neighbourhood driven focus enabling us to target resources to best meet need and reduce inequalities. Our planned investment in community-based care will further support the development of an integrated workforce to drive the agreed integrated care strategy and Joint Forward View priorities, all of which link back to our understanding of population health need and inequalities in access, experience and outcome. Each Local Care Partnership is developing a Delivery Plan that will include key steps to addressing these objectives
As a workforce programme we are committed to avoid duplication, ensure value for money and work in collaboration. A named team member will forge a link to each Borough. Specific actions against workforce programme priorities will be set against the 4 tests set out within the ICP strategy namely: The size of the opportunity, need for collaboration, feasibility and strategic coherence. In addition, actions will also be linked to National requirements, regional collaboration and the requirement to support operational pressures. A key priority is to support financial recovery work across the system.

Workforce - Our priority actions

Our priority actions – what we will do

1. **Strategic Workforce Planning**
   Growing the workforce for the future, and enabling adequate workforce supply
   To ensure evidence based decision making supports investment in workforce growth and transformation

2. **Driving Education and Training**
   Educating, training and developing people, and managing talent
   To strategically plan education to address future workforce gaps and requirements of new roles and ways of working

3. **Promoting SEL as a great place to work**
   To support recruitment and retention of staff by promoting SEL as the best place to work

4. **Embedding a Culture of Inclusion and Well-being**
   To provide staff health and well being and inclusivity support to our 'one workforce' across all sectors in SEL

5. **Enabling Innovation**
   Leading workforce transformation and new ways of working

Workforce priority action 1 – Strategic Workforce Planning

Strategic Workforce Planning

- Growing the workforce for the future, and enabling adequate workforce supply
- To ensure evidence based decision making supports investment in workforce growth and transformation

How we will secure delivery

Actions for 24/25

- Develop our reporting and risk mitigation to secure workforce supply. A bi-annual plan will continue to be delivered.
- Supporting all provider collaboratives (Acute, Community, Mental Health and Primary Care)
- A multi-stranded approach to workforce Planning. Setting foundations for data sharing and progressing towards automated digital solutions aligned to National data sets, supporting one version of the truth
- Continual focus on the triangulation of workforce, service activity and finance
- To assess productivity metrics in line with National guidance and develop options for supporting providers to make improvements as needed
- Learn from funded integrated workforce planning pilots in Primary Care, the Acute Provider Collaborative and others as they emerge.

Actions for 25/26

- To work towards integrated planning approaches that will have long term benefit and align to national sources.
- To develop consistent methodology in collecting and reporting workforce data, with regional and national benchmarking
- Delivery of workforce intelligence to identify and address workforce gaps across Primary Care, Acute Care and Social Care
- Develop long term skills-based planning supporting new roles

Intended outcomes in 5 years time

- Integrated workforce planning across Health and Care delivering accurate data and analytics to drive investment, report on workforce supply risks and develop mitigation plans.
- All sectors will be covered
- Workforce gaps will be viewed by integrated care pathways

Workforce priority action 2 – Driving education and training

Driving Education and Training

- Educating, training and developing people, and managing talent
- To strategically plan education to address future workforce gaps and requirements of new roles and ways of working

How we will secure delivery

Actions for 24/25

- To deliver against a comprehensive, co-designed education strategy and start implementation; setting the foundations for supporting the LTWP
- Work with educational institutions, local councils and place leads to develop and expand training and placement opportunities. To deliver specific educational and training material to support recruitment of local people into “good work” (paid at London Living wage) through the Health and Care Jobs Hub
- Educational support required to develop community and neighbourhood-based teams to be further explored and developed working with partners to respond to needs of Primary Care, Mental Health and Place based leads.
- Continue strategic investment in workforce development funding connected to the LTWP if received from NHSE and others and active engagement to secure further regional resource.

Actions for 25/26

- Continuation of work to support delivery against LTWP targets
- Targeted action plans by profession and Multidisciplinary teams with a focus on National shortage professions and new ways of working
- Support action on medical education to address known changes to the pipeline and the need to support non-traditional training routes and widening participation
- Increasing accessibility to shared educational resources with a particular focus on smaller organisations, Social Care and Voluntary sector
- Design and delivery of new education offers to support priorities and new roles

Intended outcomes in 5 years time

- All our “one workforce” have a development plan and opportunities for access to multi-disciplinary training offers. Integrated care is embedded within everyone’s career planning

Workforce priority action 3 – promoting SEL as a great place to work

Promoting SEL as a great place to work

- Creating good jobs for local people supporting broader social and economic development
- To support recruitment and retention of staff by promoting SEL as the best place to work
- Deliver against the Anchor agenda and commitment to support social value

How we will secure delivery

Actions for 24/25

- To ensure promotion of SEL forms part of a robust recruitment and retention strategy underpinned by data and intelligence highlighting workforce gaps
- Implementation of the "Health and Care Jobs Hub " with funding secured from the Greater London Authority (GLA) which will support the following:
  - Delivering a SEL marketing strategy with a co-ordinated recruitment campaign with a specific focus on smaller organisations
  - Community engagement to understand and address barriers to employment
  - Actively supporting widening participation
  - Focussed work on activities that can be sustained beyond the GLA contract, that support the pledges made as an Anchor Alliance on access to work.
- Increase utilisation of Apprenticeships supported through the newly established Apprenticeship Steering Group
- Mental Health Competency framework previously developed to be promoted on the ICS website and support for utilisation continued
- Targeted actions supporting Place, with a strategic commitment to levelling up and support to establish Place workforce fora linked to the ICS People Board
- Delivery of SEL wide Employee Value Proposition with collaboration from partners and organisations across the system

25/26

- Expansion of all of the above
- Secure new investment to extend the Health and Care Jobs Hub further to evaluation (Funding from GLA ceases in 2025)

Intended outcomes in 5 years time

- Our integrated vacancy rate stabilises with annual improvements set by profession; and with an increased number of staff are recruited from our local communities
- Vacancy rates will be reduced by up to 1% for all professions
- Staff are actively recruited from our local communities or under-represented groups (the definition of underrepresented groups will vary by sector and staff group) utilising improved recruitment practices based on learnings from the SEL Health and Care Jobs Hub

Workforce priority action 4 – Embedding a culture of inclusion and well-being

Embedding a Culture of Inclusion and Well-being

- Delivery of a staff retention strategy
- Supporting inclusion and belonging for all, and creating a great experience for staff
- To provide staff health and well-being and inclusivity support to our 'one workforce' across SEL workforce

How we will secure delivery

Actions for 24/25

- SEL are a People Promise Exemplar site and are taking action to improve staff retention through supporting flexible working, career progression and reward and recognition. 4 out of 5 SEL NHS Trusts are now exemplar sites and will continue oversight of Provider level activity which will enable planning future actions.
- Complete pilot in progress for SEL trusts and work through recommendations for flexible working and implementation of new rosters demonstrating staff satisfaction and efficiency savings
- Implement recommendations from engagement exercise to establish SHWB offer in primary care and social care workforce in SEL. This includes delivery of pilot to extend EAP services these areas, and creating a repository of wellbeing resources for all to access.
- Gather and share impact and learning from investments to reduce violence, abuse and aggression towards staff, including Violence Reduction Officer roles.
- Delivery of refreshed SEL EDI priorities, agreed by the Senior Responsible Officer (SRO) and revived SEL EDI committee, with a focus on creating an engaged community across our diverse SEL workforce, motivated and inspired to drive change.
- Delivery of priorities established by newly created SEL OD collaborative, including a SEL wide line management development offer and defining SEL wide approaches and framework for talent management, ensuring inclusion and wellbeing principles are considered in building capability of managers and leaders
- To work with the Anchor Alliance to better understand barriers to employment and actively engage with the Voluntary sector to support local recruitment; funding has been secured though NHSE for project work where the Workforce Programme will contribute as partners.

25/26

- Embedding culture of compassionate leadership
- To support leadership and expanding collaboration across boundaries

Intended outcomes in 5 years time

- Our integrated retention rate stabilises with an improvement of 2% by 2025 aligned to national targets; noting that staff turnover is high in London c. 17%
- Our diverse population profile is represented at all levels
- The workforce is more representative of the community it serves

Workforce priority action 5 – enabling innovation

Enabling Innovation

- Leading workforce transformation and new ways of working
- To embed innovation throughout our system workforce plans and work with Partners to deliver dynamic services and create future focused employment opportunities

How we will secure delivery

Actions for 24/25

- Deliver an Innovation plan spanning productivity, new roles, ways of working, digital & automation, aligned to reform theme of the LTWFP
- Complete our EAP at scale commissioning and phase 1 of the OH services collaboration to move towards a SEL model (initially APC Trusts, ICB and BHC)
- Promote and support adoption of new roles and new ways of working with a focus on community-based roles and linked the AHP Council and Community Provider Network
- Continue to deliver support, retention and upskilling activities to enable Virtual Ward (VW) implementation and expansion across SEL. Develop medium term solutions to workforce implications of VW as integrated part of community and social care workforce priorities and plans.
- Support operationalising hybrid working across Health and Care
- Complete phase 1 of the Acute Provider project to reduce the demand for Agency Registered Mental Health Nurses (RMN) with solutions to optimise patient care.
- Identify and develop additional workforce productivity interventions and transformation (e.g. linked to Bank and Agency demand) , informed by further exploration of system productivity opportunities.
- Support the collation of digital, data and technology workforce census data working in collaboration with the ICB Digital lead as a new area of strategic workforce planning.
- Form new partnerships and create new investment opportunities by working with external private sector organisations and charities in areas linked to key ICS workforce risks

Intended outcomes in 5 years time

- Spread and scale of high impact actions supporting integrated care, closer to home.
- Investments in AI and digital solutions to address workforce gaps and support workforce productivity
- The People Strategy is aligned to the digital strategy with action taken to support digital upskilling and capability across the system for the current and future workforce and in collaboration with key partners including Kings Health Partners, NHSE, ICB, HIN and providers.

Actions for 25/26

- To support system readiness for operational change e.g. anticipatory medicine
- Develop an approach to enhance workforce capability for prevention and population health promotion
- Support the expansion of technology enabled care and digital solutions with a focus on the workforce opportunities and implications.

Workforce - Supporting programme and place delivery

Acute care

Workforce programme are working with the Acute Provider Collaborative (APC) through the formal governance of the APC CPO group (executive advisory group). A work programme is set to ensure APC service priorities are supported by CPO led high impact actions on things like bank and agency rates, job planning and staff movement across Trusts. In addition, this group will direct further work required to drive workforce transformation. Workforce planning is also being further developed to identify gaps and mitigate against risks to workforce supply.

Community care

Care in the community utilising our "one workforce" across Health and Care is fundamental to our People Strategy. Our case for change points to inequalities that exist across SEL boroughs and the key priority for care close to home.
We are engaging with partners that form our "Community Collaborative" to support system and place level action to address key challenges such as shortages in community specialist nurses and AHPs. Social Care is a high priority and investment has been made in planning support for the Home Care workforce and also in education to support discharge. Plans to sustain the SEL Social Care Nursing Workforce lead roles established in 23/24 in consideration.

MH/LDA

Baseline work was conducted to understand community Mental Health services and a mental health competency framework was developed to support recruitment and career progression for staff working in mental health services. Work is now in progress to communicate this competency framework on the ICB website and the digital portal being set up to support recruitment.
Bespoke, dedicated support to one of our two mental health providers in underway to enable the development of a 5 year workforce plan. It is well understood that further work is required to dedicate support and investment to address all Mental Health services and integrated teams within *each borough.*

Primary care

Our People Strategy acknowledges the fundamental need to support Primary Care, with limited workforce growth in traditional roles, and the need for focussed action on neighbourhood based teams and the vision set out in the Fuller Report. Strategic planning for Primary Care and effective utilisation of AARS and other new roles will be explored. Practical ways of enhancing recruitment and retention of AARS roles is a priority. The implementation plan for the Health and Care Jobs Hub features actions directed at Primary Care. It is also a priority to support smaller organisations, neighbourhood based integrated teams and engage with voluntary sector.

Key pathway transformation programmes

Borough based transformation programmes will be further developed through engagement and joint working with Borough Leads. Initial review of LCPs was conducted in 2023 and an investment of £90K made across 6 boroughs to contribute to work already planned to support the workforce agenda. This review concluded that there is the need for on-going engagement through the set governance, allowing a response to borough based need that adds to existing strategies and work in progress. The People Strategy is committed to focussed action on levelling up across SEL. Team resource from the Workforce Programme has been aligned to each Borough to support collaborative working and will support the newly established Neighbourhood based Care Board. Place based and led workforce networks are being established, strengthening links to the ICS People Board.

Digital and Data: Our vision and objectives

Our vision

To improve the health of our population and the quality and efficiency of our health and care system through the use of digital technology, data-driven intelligence, and innovation.

Our key objectives – what we want to achieve over the next five years

- People are empowered to manage their health and wellbeing through access to their information and insights about their health and wellbeing, as well as the ability to engage with the health and care system.
- The care record is available to care providers at the point of care to support decision-making.
- Information collected is used to generate data-driven insights in population health, proactive care and research, with the aim of improving decision-making, reducing inequities in health and care provision, improving health outcomes, and making use of finite resources.
- Service transformation is supported by innovative digital and data products, and existing capabilities well-supported and continuously improved.

Underpinned by our ICS approach to digital

- Taking action where it makes sense to do so at ICS level (for example involving interoperable digital architecture, or where we could benefit from economies of scale)
- Taking a lead to test or de-risk an initiative, or to research different options or to bid for national funds to help our work
- Taking ownership of issues where the responsibility for addressing them is either unclear or does not sit with individual organisations
- Bringing system-wide coherence and consistency through shared goals, targets or standards that our constituent organisations will then deliver
- Bringing organisations together where there are multiple interests to be managed, and potential trade-offs to be agreed regarding ICS-wide investment priorities

Priority Areas

1. **Empower people to manage their health and care**: providing and promoting digital tools to people in our community to support them to be active partners in their own health and care, and taking action to ensure that tools available do not result in digital exclusion.
2. **Digital Solutions for Connected Care:** aiming to capture all interactions, events and decisions digitally so that we are able to join up information across our health and care system, and ensuring those records are available to the health and care team to support decisions about care provision.
3. **Deliver Data-Driven Insights:** joining up data across our system and delivering data-driven insights to support direct care, care planning, population health management, commissioning, public health and approved research as well as innovation.
4. **Ensure System Resilience, Data Integrity and Cyber Security:** taking action to ensure our critical systems are always available, and also ensuring the integrity of the data in our systems, and that its use aligns with information governance and data protection requirements.
5. **Drive Continuous Improvement and Innovation:** ensuring that we always look for ways to improve our digital and data solutions to ensure they continue to provide what is needed for a contemporary health service into the future, and look for innovative ways to do things better.
6. **Undertaken workforce planning to support our digital, data and analytics activities**: taking action to develop digital, data and analytics professions, ensuring that south east London is able to attract and retain the staff we need now and into the future, as well as ensuring the broader workforce has the skills needed to engage with digital and data.

Empower people through digital and data

Many people in our community are able to actively participate in their own health and care if given the right tools and if supported by the right team. We want to increase people's ability to interact with the health and care system in ways that are easy for them. We also want to break down barriers to that access through providing easy-to-use digital tools which can remove barriers such as relating to language, vision and mobility.

TARGET 1: Digital tools to the community

Provide people in our community the insights and tools to improve their health.

TARGET 2: Supporting access to care

Assist people in our community to identify the right care for them based on their individual needs.

TARGET 3: Digital inclusion

Taking action to support everyone in our community to use digital tools.

Achievements in 2023/24:

- Recruited a digital inclusion lead to map the current people facing digital services
- Collated existing consultation and engagement feedback to ensure that our planning is based on what people want not our perception of what they want.
- Undertook a campaign to increase access people have to their health records via the NHS App.
- Started our review of existing work to tackle digital exclusion and consider whether any action is required to tackle this at an ICS level.

Priorities for 2024/25:

- Integrate our health and care systems and patient portals with the NHS App to ensure that people have a single entry point into patient engagement tools, and promote uptake of the NHS App.
- Support digital inclusion by developing a register of patient-facing digital tools and identifying and removing barriers to accessing those tools.
- Deliver GP online consultation and video consultation, messaging, appointment booking and health review questionnaire tools to enable people to access healthcare more easily.
- Increase digitisation of virtual wards to keep people out of hospitals unless necessary and providing people with assistive technology to support living at home.

Digital Solutions for Connected Care

Many of our health and care providers have multiple systems for collecting and displaying information on people's health and care. These are often not joined up betweeen organisations. To move toward a data-driven health and care system, we need to ensure information is collected at the point of care and shared with the health and care team, with people responsible for planning and research.

TARGET 1: Digital interactions

Clinical and care provision interactions are recorded digitally in real-time.

TARGET 2: Access to information

Information required for decision-making about care is shared with the health and care team.

TARGET 3: Shared care teams

Teams across organisations are able to contribute to a shared record for a person.

Achievements in 2023/24:

- Supported the implementation of the Epic electronic patient record for Guys and St Thomas and Kings NHS Foundation Trusts.
- Supported the implementation of a new general practice ordering and communication solutions for radiology and pathology.
- Expanded the London Care Record to social care and commenced projects to expand access to care homes and community pharmacy so that they have access to information needed to support their care of people in our community.

Priorities for 2024/25:

- Support the transition to a single ordering system for pathology and radiology for general practice.
- Support the procurement of contemporary electronic patient records including for Lewisham and Greenwich Trust and South London and Maudsley Trust.
- Expand access of clinical tools to community pharmacies including the London Care Record and an integrated primary care referral system to support their safe and efficient provision of care.
- Support digitisation of care homes as well as access to the London Care Record to support their role in the care of people in the community.
- Work with London region to support plans to expand the Universal Care Plan to support cross-organisational care delivery.
- Support the Continuing Healthcare operating model review as relevant to digital systems.
- Identify the approach for digital documentation of support provided by learning, disability and autism key workers.

Deliver Data-Driven Insights

We need to make the most of the information collected and held across the health and care system locally and regionally, supplemented with information about the environment where people live, by providing actionable insights and intelligence that support direct and proactive patient care, system and service planning and research and innovation.

TARGET 1 Proactive Care

Insights are embedded into systems used by health and care providers so that they can use them when making decisions.

TARGET 2 System and service planning

Tools are available to support demand and capacity modelling, identify inequalities and system and service planning.

TARGET 3 Research and Innovation

Research and innovation is supported and encouraged through the adoption of innovative analytical techniques (AI/ML) and modern business intelligence solutions, that enable us to continue to learn as a health and care system

Achievements in 2023/24:

- Developed tools to support Population Health Management and identify health inequalities which are available to ICS partners through a SharePoint reporting portal.
- Piloted the re-platforming of the ICB data warehouse into a modern cloud-based solution that will enable more advanced analytics e.g. Machine Learning/AI and make it possible to expand access to wider ICS analytical teams.
- Piloted the adoption of a patient segmentation tool to generate further insights into the needs and outcomes of the South East London diabetic population.
- Partnered in the work to develop the London Health Data Strategy, London Data Service and regional research capabilities.
- Implemented a digital tool to support the System Coordination Centre, which aims to provide real time operational management information for healthcare providers across South East London.

Priorities for 2024/25:

- Apply the lessons learnt through the ICB data warehouse pilot to complete the full migration of the current ICB data warehouse into a modern cloud-based solution that will enable more advanced analytics.
- Explore ways to improve and expand access to the ICB data repository to other analytical teams across the South East London Integrated Care System.
- Continue to partner in the development and delivery of the London Health Data Strategy.

Ensure System Resilience and Cyber Security

Our health and care system is reliant on digital technology and data to provide safe care and to support the flow of people and services through our system. This means it is critical that our core systems are available and that the public trusts that the information they hold is only accessed by those that need it to support care planning, delivery and innovation in the way care is provided.

TARGET 1: System resilience

Critical systems will always be available to support care delivery and business continuity and disaster recovery arrangements will be enacted should this fail

TARGET 2: Cyber security, data integrity and information governance

Systems and data flows implemented comply with clinical safety protocols and data protection protocols.

TARGET 3: Access to systems

More staff time is available to focus on care rather than on complicated access and IT issues.

Achievements in 2023/24:

- Collected information to inform a cyber and resilience maturity assessment
- Participated in ICB Board cyber training
- Allocation of national funding to target areas of greatest risk to Trusts

Priorities for 2024/25:

- Recruit a Chief Information Security Officer for the ICB.
- Complete the cyber and resilience maturity assessment.
- Develop of a cyber strategy for the ICS taking into consideration the outputs of the maturity assessment.
- Develop of a community of practice of cyber subject matter expertise.
- Support improvements to information sharing and data flows by continuing to support health and care providers operate safely and in alignment with information sharing legislation and protocols.
- Scope a review of technical and support infrastructure to identify if there are opportunities to standardise and rationalise infrastructure across the system.

Drive Continuous Improvement and Innovation

It is important that as a system, we continually improve on our existing capabilities so that they remain contemporary, and also that we remain flexible so that we can take advantage of emerging opportunities.

TARGET 1: Artificial intelligence and machine learning

Optimise the use of artificial intelligence into clinical workflows as well as demand modelling and service planning.

TARGET 2: Digital maturity and continuous improvement

Annually assess digital maturity and ensure improvement activities are targeted to the areas of greatest need.

TARGET 3: Diagnostic capabilities and capacity

Improve diagnostic capabilities and capacity through digital innovation

This is a new priority in 2024/25

Priorities for 2024/25:

- Complete the 2024/25 NHSE digital maturity assessment.
- Analyse barriers to effective transitions of care between providers including identifying if there are opportunities to improve digital enablement of referrals.
- Partner with SWL ICB and the Health Innovation Network to host an innovation day.
- Identify opportunities for the deployment of AI models into demand modelling, planning and clinical workflows, including by using Cogstack and Medcat models, and for radiology - AIDE (AI Deployment Engine) as led by the AI Centre for Value Based Healthcare.
- Work with Kings Health Partners, the Health Innovation Network, the Centre for Innovation and Transformation and the AI Centre for Value Based Healthcare, the Centre for Translational Informatics and other key partners in our region to ensure our health and care services are able to appropriately engage with innovative products and services including by partnering with SWL and the Health Innovation Network to host an innovation day. .
- Progress projects to improve digital connectivity infrastructure including the Gigabit programme for GPs.
- Identify further opportunities for process automation including in primary care.
- Assist all GP practices across SEL to implement cloud-based telephony solutions
- Implement automated patient registration solutions to support practices to quickly and easily register new patients enabling faster access to primary care services
- Digitise an additional 130,000 patients' Lloyd George records across 17 GP practices

Undertake Workforce Planning to Support our Digital, Data and Analytics Activities

As technology advances, so does the skills and experience needed to harness the benefits of that technology. We will work to build our workforce so that we have the right people to deliver the needs of our health and care system now and into the future. We will also identify the support that our broader workforce needs to be able to engage with digital tools and understand and use data and insights to inform their practice.

TARGET 1: Competency framework

Staff know the competencies required and are assessed against these, with actions undertaken to fill gaps in skills and knowledge

TARGET 2: Workforce plan

A workforce plan will outline the workforce requirements for the digital, data and analytics workforce now and into the future and how we will secure this.

TARGET 3: Digital and data literacy

Staff will have the skills to engage with digital and data tools and insights.

This is a new priority in 2024/25

Priorities for 2024/25:

- Submit information required in the national census of the Digital, Data and Analytics workforce.
- Work with London region to progress development of workforce plans for the Digital, Data and Analytics workforce.
- Commence development of strategies to retain existing skilled staff through skills and career development opportunities - a network of excellence in analytics and data science being established, including career development pathways.
- Consider the value of implementing national competency frameworks and professional accreditation for digital, data and analytics specialists.
- Commence development of a talent pipeline and route into a career in digital data analytics, building on programmes already underway for data and analytics apprenticeship (Multiverse) and KHP data science training available for free to SEL NHS staff.
- Identify and promote opportunities to develop digital and data literacy among end-users of digital systems and consumers of data and analytics.

Estates Enabler programme

Overview

In SEL, it is important that our estate is good quality, offers flexible accommodation, in the right place, to enable delivery of health and social care services to our communities. We need to understand local, regional and national priorities, and seek external funding where possible to facilitate and continually improve this. We need to plan for the future and have published our ICB estates and infrastructure strategy which sets out our estate ambition in SEL. We have refreshed our local priorities, and our programme and project plans to ensure our SEL estate is in the right place.

Strengths / opportunities

In SEL we have strong established estates partnerships working across health and local government. We have forums where we come together and share estates plans and work together on opportunities to review priorities, rationalise, transform, collaborate, and co locate where it make sense to do so.

There is significant property development, particularly housing growth, in our boroughs and we are financially supported with Community Infrastructure Levy (CIL), s106, One Public Estate (OPE), Brownfield Land Release Funds (BLRF), and central NHS capital.

We are developing our knowledge and implementing a SEL estate database, sensor and utilisation intelligence and a portal for promoting void and bookable space. This will enable us to mange our estate more effectively.

Challenges

- Lack of capital and revenue
- Increasing construction costs and constrained rents
- CDEL restrictions
- Lack of skilled property and estates professionals
- Lack of investment in digital and digitization of records
- We have some poor quality estate that should be either exited, redeveloped or re provided.

Estates: Our vision and objectives

Our vision

The NHS estate in South East London plays a **key role as an enabler** through the provision of good quality buildings in the right place to improve access, tackle inequalities, improve outcomes, enhance productivity and value for money to support broader social and economic development.

We continually encourage all key acute, community, primary care, mental health social care, local government, voluntary, and third sector to come together to share estates plans and strive to work together to promote integration, collaboration, and transformation.

Our key objectives – what we want to achieve over the next five years

The ICB will not manage partners' business as usual activities, but where it makes sense, we will provide support and **work as a system and in partnership** to deliver an estate that is efficient and supports the delivery of the ICB Forward View Plan and our own estates and infrastructure plan. Our key estate objectives are:

- Maintain an estate that is fit for purpose
- Create a net zero estate by 2040
- Work as a system to maximise value from the SEL estate
- Support modern clinical care
- Support the delivery of place based care
- Making smart use of our estate
- Enable the wider ICS Partner Strategies
- Ensure value for money and affordability of health care facilities

Estates: Our priority actions

Our priority actions – what we will do

Objectives of the estates work:
We strive to work with all of our public partners to share property plans, to ensure our services are easily accessible in good condition, well managed and where possible in community settings.

1

Working Together:
Our partners come together to share and develop joint estates plans in two important groups, the Local Estate Forums and ICS estates leads group. These groups specifically review assets alongside need and population health and need to ensure that not only core services can be provided but also specific locality needs are catered for. Place Based and Local Care Partnerships are also here to facilitate.
These groups contributed to our estates and infrastructure strategy.
Part of working together is also sharing strategic business cases, applying for and obtaining external sources of funding such as OPE, BFLRF, s106, CIL and other NHS Capital and sharing resources.
We will jointly procure across SEL where it is sensible to do so.

2

We will **manage the delivery of national and regional supported projects** such as CDC, Out of Hospital, Midwifery/Better Births and all PCN plans, prioritise them with place based teams and establish a programme of prioritised money and delivery

3

We will strive to have an efficient estate: and continue to address voids and underutilisation, install sensors, create a SEL data base for property, and provide infrastructure to enable the shared use of estate.
We will continue to consolidate our corporate office in all of our property and support the development of new ways of working.
Our estate should be fit for purpose and in good condition.

Estates priority action 1: working together

Working together

Working Together:
There are so many benefits to work collaboratively in SEL with all of our partners.
When plans and strategies are shared, we can spot opportunities to rationalise, co locate, jointly fund, avoid duplication and most important understand the specific needs and pressures in each locality and how we can support each other with estates planning. By working together we can also ensure that the provision of estates for health and care is financially sustainable.

1

How we will secure delivery: - Actions completed in 23/24
SEL estates and infrastructure strategy published
Sharing thinking, proposals and plans around the development of health and care estate at an early stage, including any plans for disposal, lease exits, redevelopments and refurbishment, so that it can inform and align with system wide developments
Providing on-going support for the partners with estate planning and decision making
Ensuring that estate planning takes into account wider strategic aims for health and care and supports the transformation, improvement and delivery of both acute, primary and community based care and the delivery of new models of care
Seek opportunities to improve the use of our estates by working more closely together and sharing estates information
Ensuring our estate is fit for purpose, flexible and accessible, contributes to a positive health and care experience for residents and a positive working experience for staff.

2

Actions for 24/25
Apply for external sources of funding when they are announced
Track all planning applications so that appropriate applications for CIL and OPE can be made.
Keep in touch with our LGA and Cabinet office partners to continue to apply for OPE and BLRF
Keep in touch with our regional and national colleague to bid for national NHS monies when available
Establish a central function for procurement and jointly procure where it is appropriate to do so.

3

Intended outcomes in 5 years time:
We have a clear SEL ICS estates an infrastructure strategy with clear next steps and therefore the next 5 years is about prioritisation and delivery
We will have an up to date SEL capital plan
Continue our Local Estates Forums and SEL Estates Leads Group to keep up to date
Get various project business case ready so that when further local, regional and national funds are released our schemes are business case ready.

Estates priority action 2: delivery of national, regional and local schemes

Delivery of Nationally, Regionally and Locally supported schemes

ICBs received various sources of funding to deliver either nationally or regionally supported such as Community Diagnostic Centres (CDCs)/Out of Hospital, Better Births Initiative, Primary Care Network plans and progressing schemes that have been supported by OPE, BLRF, S106 and CIL.

1

How will we secure delivery: - Actions completed 23/24

Programmes and projects are appropriately resourced
Responded to all opportunities and applied for external funds
Priority schemes are business case ready
Innovate to find ways to enable projects and avoid duplication

2

Actions for 24/25

Continued delivery of all priority projects
Improve the utilisation and efficiency of the health and care estate in SEL, releasing land for development where appropriate
Identify joint opportunities to share estate between health and care
Bringing forward health and local government land to provide affordable housing for residents and staff where possible as well as health and care facilities.

3

Intended outcome in 5 years

Better Births: The implementation of the hub strategy for our providers in SEL noting some of this work is complete or underway.
CDC
There will be a CDC in Eltham in August 24, with activity starting in March April 23.
The business cases for potentially another CDC at Queen Mary's Sidcup will continue to be developed.
PCNs: The primary care network estates and infrastructure plans are complete, summarised and the capital investment asks will be prioritised and where possible various projects will commence.

Estates priority action 3: efficient estate

Efficient Estate

The management and planning around estates is complex and the ICB will continue to work with colleagues elsewhere to help us achieve our aims for the use and development of our estates. These other partners include our providers of acute and community services, our landlords NHS Property Services and Community Health Partnerships, One Public Estate, HUDU and LEDU. Working with our Local Government partners in housing and regeneration, we are also committed to achieving the goals of the Government's One Public Estate initiative to stimulate economic growth; provide integrated and customer-focused services; generate capital receipts; and reduce estates and facilities running costs.

1

How will we secure delivery: - Actions for 23/24

Install Sensors in all CHP and NHSPS estate
Establish a SEL property database
Develop a portal to promote available health estate – void/bookable and property that can be shared to public and private end users
Joint mapping of estates in all boroughs – all public sector partners

2

Actions for 24/25

Move sensors to other buildings in SEL as and when needed, as appropriate
Continue to monitor opportunities that are presented
Create a more efficient estate
Appropriately resource the priority programmes and projects
Create a more sustainable estate and strive towards net zero

3

Intended outcome in 5 years

Alignment of estates plans with clinical strategies and early identification of estates requirements within programme and delivery plans.
Improve the utilisation and efficiency of the health and care estate in SEL releasing land for development where appropriate. Good quality data about utilisation, property events and voids.
Provision of incentives to encourage services into underutilised but modern facilities. Support each other to exist accommodation that is not fit for purpose.
Buildings which enable smarter and efficient working practices, including digital infrastructure, and which contribute to patient/resident experience and satisfaction.
Support to manage facilities costs and accommodate flexible use (both clinical, partners, back office, and Voluntary, community and social enterprise sector groups). Reduce running costs by addressing high maintenance and poor quality buildings
Reinvest disposal proceeds into the local health and care systems
Identify joint opportunities to share estate between health and care
Estate mapping with our Local Authorities to bring forward both affordable housing for residents and staff where possible as well as health and care facilities.

Supporting programme and place delivery

These are the current strategic workstreams coming out of the 23/24 estates strategy. The strategy highlights the work to do and future priorities where we will work together to promote integration, collaboration, and transformation.

Acute care

- Continued investment in technology and new ways of working :
- maintaining good community presence :
- outpatient modernisation:
- improving research and education :acute specialist functions expansion + infrastructure and sustainable place making and better patient experience.
- Addressing beds and theatres capacity:
- Ensure that only what is needed (as practically possible) is on an acute setting.

Community care

- De-compressing busy acute settings to create other opportunities:
- Prioritise services that can relocate to other community areas care closer to home

Mental Health/LDA

- Improved quality of accommodation for the benefit of staff and patients:
- Maximise space for clinical activity vs office space:
- Reduce estates costs to reinvest in frontline services:
- Monitored and bookable, rather than owned and protected:
- Disposals to re-invest:
- Creating living well centres/hubs

Primary care

- Prioritise the infrastructure plans and providing the support to the new ARRs roles:
- Support with modernising ways of working and
- Supporting the need for investment in primary care.

Key pathway transformation programmes

- Each provider will have their own redevelopment/strategy delivery board however the ICB will use the 2 important groups, LEF and ICB Estates Leads who drive forward system projects.

Medium term financial strategy - key objectives (1)

1. OUR AMBITION

Over the next 5 years we aim to secure two key objectives:

- To make a **tangible difference in reducing health inequalities and improving health outcomes through significant annual targeted investment funding to 2027/28** (target of £135m recurrently invested by this date) to support prevention and inequalities focussed action across our system.
- To **deliver sustainable financial balance across our system by the end of the 2027/28**, to provide a stable financial environment to support continued improvement and investment in healthcare and outcomes.

While the NHS financial framework remains uncertain, our commitment is that health inequalities and prevention investment will be at the core of our plans with a funding commitment that is ambitious, realistic, achievable and sufficient to deliver real change. The commitment to financial sustainability will also be vital to ensuring a robust and effective ICB delivering on its core responsibilities, secured through approaches that demonstrably improve productivity, efficiency and value through making the best possible use of the money we have available. Our 2023/24 financial outturn and the pressures we are facing means securing both these objectives over the next three years looks increasingly challenging – we will be reviewing our recovery glide path in 2024/25.

2. ADDRESSING INEQUALITIES IN INVESTMENT

Total healthcare spend at 5 of our 6 boroughs is broadly aligned, with the ICB being over target in terms of spend relative to need. At an expenditure area level, however there are larger variations in spend, particularly for community and mental health services. **Our focus on any rebalancing of investment will therefore primarily be within boroughs**, with a targeted **forward investment plan that addresses known areas of inequity e.g. inequalities, prevention, mental health and children and young people.**

3. MAXIMISING OUR RETURN ON INVESTMENT

We will need to be more rigorous in the tests we apply to both existing and additional investment – with a specific focus on **return on investment and benefits realisation,** including reducing health inequalities and improving health outcomes and improving quality and outcomes. We will also need to ensure we are **optimising productivity and efficiency opportunities and reducing our current cost base across all service areas.**

Medium term financial strategy - key objectives (2)

4. ONGOING FOCUS ON THE DELIVERY OF EFFICIENCIES ACROSS THE SYSTEM

Our acute sector particularly will continue to be under **significant financial and service pressure** resulting from underlying deficits, convergence requirements and demand and capacity imbalances but also with **significant opportunities** associated with the post covid period productivity gap and wider efficiency opportunities. We will work collaboratively across the system to secure collective approaches, ensure the best possible use of available capacity and resource, address variation and improve productivity and efficiency. We may also need to consider more radical actions across site and service configurations that will reduce out cost base and enable us to live within the resources made available to us.

We will apply an **equivalent rigour to community-based care and other out of hospital services**, to ensure demonstrable improvements in productivity and efficiency across all parts of the system. In doing so we will be asking our Local Care Partnerships to proactively take forward integration opportunities to secure demonstrable best value and reduce duplication, help reduce secondary care demand and support improved acute productivity.

5. USING OUR MEDIUM-TERM FINANCIAL STRATEGY TO FACILITATE AND INCENTIVISE DELIVERY

We need to ensure that our **MTFS facilitates the delivery of our wider population and service ambitions**, to reduce health inequalities and to provide operational and financial stability. Prevention and targeted investment should reduce demand pressures over time and thereby aid financial recovery. We recognise however that there will be **timing issues** as it is likely that the savings/efficiency requirements will exceed a realistic pace of delivery around population and pathway improvement. We will therefore need to recognise a realistic but ambitious **pace of change** to ensure we are not leaving parts of our system exposed in terms of financial viability whilst also ensuring we are able to invest for the future, stay true to and not jeopardise our planned strategic investments.

6. INFLUENCING NATIONAL POLICY

As a system we will continue to work through national allocation approaches, question and challenge where appropriate, specifically convergence, shifts to population-based budgets and the pace of change, to seek to **influence national policy and draw attention to the consequences**, in the context of the overall NHS financial framework, including budgets we will take on from NHS England associated with delegation.

Our ambition - where do we want to be in 5 years?

Our Integrated Care Board and Integrated Care Partnership has endorsed a set of clear system wide ambitions around our Medium-Term Financial Strategy. Our MTFS will need to be align to the ICS's and national strategic frameworks and priorities, which continue to be developed in line with our Integrated Care Strategy, this NHS Joint Forward Plan and overall national policy approaches and imperatives. Notwithstanding this our agreed ambitions are:

- **FINANCIAL BALANCE**
  - To secure a **financially balanced ICB** that has eliminated its recurrent underlying deficit and established a sustainable forward financial position that enables us to respond to the needs of our population effectively.
  - To secure the **financial health of the key provider organisations within SE London** that provide care to local residents and wider populations.
  - To **meet our annual financial targets** through operational plans that are demonstrably delivered inclusive of a clear **annual improvement in our underlying position**.
  - Aim to deliver a system financial position that is in the **top-quartile** nationally, inclusive of key productivity and efficiency metrics.

- **SECURING STRATEGIC, REBALANCED INVESTMENT**
  - To look at all of our resources, including existing spend, to ensure targeted action within core budgets that **identify and address health inequalities**.
  - Ensuring that our investment moves over time to a position where we have **rebalanced spend between sectors and places** to meet the needs of our population, with a core focus on continuing to **increase our relative investment in mental health services to align investment to weighted population need.**
  - Demonstrably shifting the balance of investment across prevention, early detection and intervention and managing ill health, underpinned by ring fenced investment for prevention and inequalities.
  - Ensuring a minimum proportionate level of investment across services for **children and young people** and adults
  - To **shift resource and care along the care pathway** to support community-based care, invested in prevention, early detection and intervention and reducing inequalities.
  - Targeting our investment to **maximise and demonstrate a clear return on investments.**

- **DRIVING AND INCENTIVISING CHANGE**
  Utilising the opportunities of our ICB, Collaboratives and Places to lever, **drive and incentivise change, innovation, value, productivity and efficiency.**

Financial context

- **Up to 2019/20, before the pandemic, the SEL system faced significant financial challenges** and the second highest ICB deficit in London of £252m. The position by provider was differential but with underlying recurrent challenges evidence and building across the system. As a result, SEL was in receipt of significant levels of national support funding from the Provider Sustainability Fund (PSF) and the Financial Recovery Fund (FRF).

- Over the period **since the pandemic the NHS financial regime has changed significantly** marked by significant short term **Covid funding** support, a shift away from **Payment by Results** contractual and payment forms, new recovery incentive arrangements through the **Elective Recovery Fund** and the replacement of national support funding arrangements with **system top-ups**. Furthermore, **convergence adjustments** have been introduced for those systems spending more than their fair shares, to reduce systems' reliance on national support and bring their allocations into line with weighted population need. Increased **collaborative planning arrangements** have accompanied these changes, with closer working within and across systems to deliver common strategic and financial objectives at a system (ICS) level.

- **In 2023/24 the SEL ICB agreed a balanced financial plan** , with a very significant inbuilt challenge around planned efficiencies, income risks, the Elective Recovery Fund (ERF), and inflationary pressures. In year the NHS has seen significant financial impact from Industrial Action and other inflationary pressures with some additional funding allocated nationally to compensate for the associated cost pressures. This has improved our position, but we have, despite the delivery of material cost improvement plan savings and the use of non-recurrent flexibilities, been unable to secure a breakeven year end position and also come in to 2024/25 with an increased underlying financial deficit.

- For **2024/25 we will be seeking to improve our underlying financial position** and to secure an ambitious in year savings programme with a focus on recurrent cost out and significantly improved productivity and efficiency, as a year 1 contribution to the delivery of our five-year ambition. We hope as part of our plan to be able to continue to target investment in inequalities and prevention, alongside the other allocative commitments made in our MTFS.

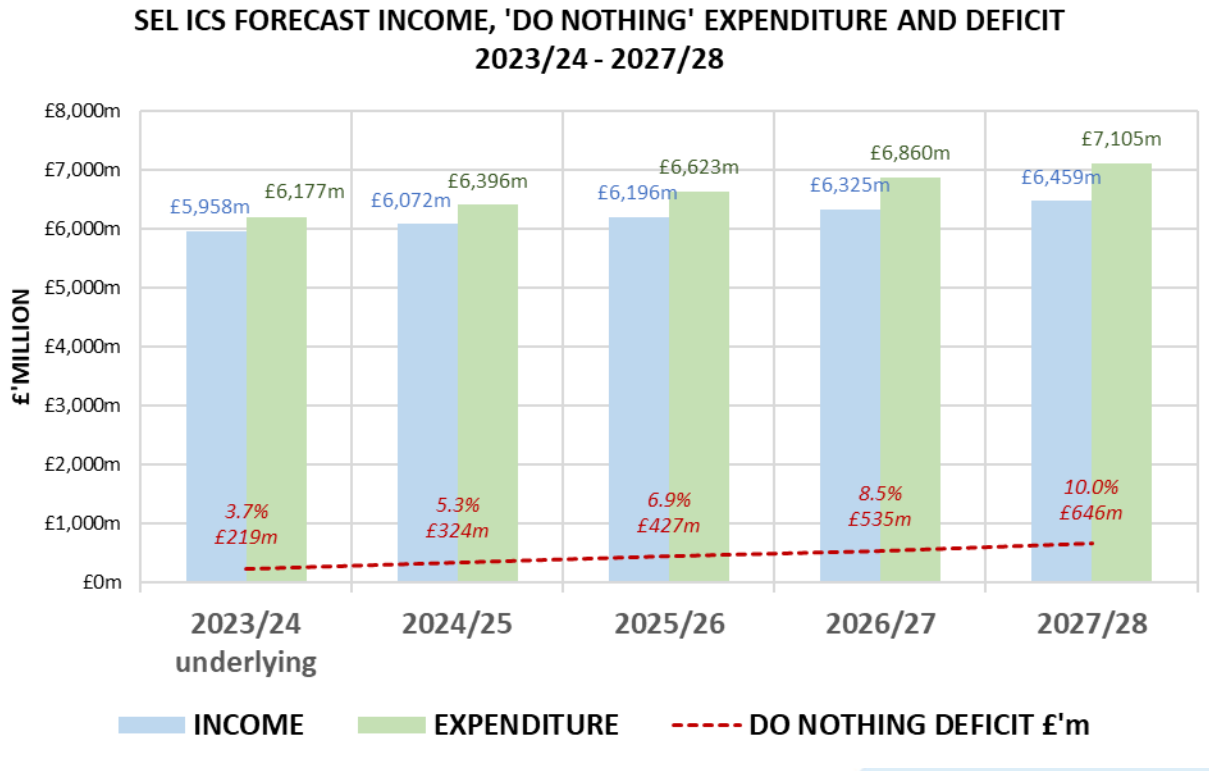
- Looking ahead, there are continuing **significant changes to the NHS financial framework** particularly in relation to the **delegation of specialised commissioning** to ICBs, accompanied by a shift to **population rather than host provider-based funding**. These are expected to increase SEL ICB's allocation by approximately 20% but with a reduced level of funding compared to current spend reflective of population need. The funding outlook for specialised services is challenging due to the complexities associated with disaggregating national spend to populations and the expected funding shifts away from London ICBs and providers, so the increased allocation masks a material carry forward uncertainty and a likely financial challenge.

- The medium-term financial outlook for the NHS remains uncertain, but we can expect the **continued shift to a lower growth environment** and with **continued convergence adjustments**. As more information is made available, we will need to **flex our plans** accordingly to address changing assumptions, requirements and priorities.

- Fundamentally **we need to secure a shift in focus across our system to one of productivity improvement and cost base reduction rather than income growth.**

What happens if we do nothing?

- As a system we are committed to the delivery of a sustainable recurrently balanced financial position over the medium term.
- A **'do-nothing' scenario** has been modelled which shows that without the delivery of efficiencies and savings, we will have very large **unmitigated system deficits that rise over the next few years.**
- This will require significant mitigations including efficiencies associated with tariff uplifts, managing demographic growth, plus savings to offset convergence, covid funding reductions and cost pressures, plus demand management to support us meeting population needs within a needs-based funding formula.
- We have been working to assess actual expenditure and are undertaking further work around forecast expenditure, savings and productivity and efficiency opportunities that will underpin our 2024/25 plans and forward MTFS.



- In support of this wider MTFS we have undertaken work to understand and quantify future financial recovery and opportunities. This work has identified some examples of cost variation and efficiency improvement opportunities, including the **covid period productivity gap and opportunities associated with Workforce; Urgent & Emergency Care; Clinical productivity; Estates; Procurement; Mental Health; Commercial income.** We are taking forward these opportunities via system wide groups and the opportunities will be embedded within our forward plans.
- The likely scale of required efficiencies going forward means however that we are going to need to identify more ambitious and far-reaching savings opportunities to those identified through our work to date, with the need for the ICB to focus on cost out rather than income in.

Our allocative approaches

Our MTFS has been built on a set of assumptions guided by previous national indications, where available, and local priorities and approaches. These will need to be updated annually as allocations are provided to systems and as our strategic objectives and recovery plans are further developed. Our allocative approach is set our below.

- **ICB INCOME ASSUMPIONS**:
    - **Core allocation growth** in line with published allocations for 2023/24 and 2024/25 and 3.4% per annum thereafter.
    - **Reduction in Covid income** from £100m in 2022/13 to £22m in 2023/24, £21m in 2024/55 and zero thereafter.
    - Retained **elective recovery fund budget at** 2023/24 levels
    - Reductions in the allocation each year recurrently associated with **convergence savings,** by £217m over the 5 years from 2023/24
- **ICB INVESTMENT ASSUMPTIONS:**
    - We have assumed that **national guidance will continue to set prescribed uplifts** linked to ICB overall allocation growth for many areas of ICB spend, including mental health, and delegated primary care.
    - We have assumed a minimum uplift of tariff uplifts + 0.5% for community services, primary care prescribing and continuing care.
    - We have earmarked recurrent resources each year to allow further **investment in health inequalities prevention** – we will aim to secure a **recurrent investment budget of approximately £135m by 2027/28**. This will feed through into investment across our providers and budgets, noting we will need to keep under review the pace and scale of ambition in the light of the overall financial position and context.
    - We will target our investment to align with our approaches to **levelling up and addressing variation in spend when compared to weighted population need,** noting this may result in disproportionate investment in a particular area or place e.g. for mental health.
    - Forward investments will be subject to **rigorous assessments of return on investments**, highlighting in particular a **focus on reducing health inequalities, delivery of measurable benefits and delivery timelines** alongside the application of value for money and reprioritisation approaches across core budgets. **Post investment review processes** will be initiated. We will also seek to secure more rigorous approaches to understanding and improving the efficacy of existing spend.
    - All areas of ICB spend will be expected to contribute towards the delivery of **convergence savings** to help bring the system to financial balance on a sustainable basis.
    - **Reduction in Covid spend**, in line with expected reductions in our allocation.
    - The balance of investment is applied to acute services, after funding national prescribed uplifts and local priorities, as set out above. **Acute sector funding will fall over the period**, particularly because of reductions in Covid funding and the impact of convergence savings on acute providers.
    - The **impact of excess inflation has been excluded** from our assessments - our assumption is that additional expenditure will be matched by ICB income increases in this area.

Financial recovery and sustainability

South East London Integrated Care System

We are adopting a tiered approach to financial recovery planning and delivery, with shift from levels 1/2 to 3/4

Increasing need to share ideas / opportunities

Level	Description	Examples
Level 4 **System Change**	**System-led Strategic & Structural change Initiatives** The configuration of services across the System is changed to create a lower cost of supply, whilst continuing to meet an agreed level of demand.	*Service Reconfiguration* *Service Rationalisation* *Pathway redesign* *Shared Back Office*
Level 3 **System Collaboration**	**Improvement that requires System Partners to collaborate** System partners agree to consolidate purchasing power, agree standardisation and consolidate across multiple providers. Share a single staff bank for SEL, set rates and agree exceptions at System-level.	*Procurement collaboration* *Single Staff Bank* *Single Rate Card* *Common Formulary*
Level 2 **Provider Collaboration**	**Common improvement initiatives, productivity improvement.** Multiple organisations doing the same change share & agree a standard approach, share lessons to minimise duplication of effort; delivery is done individually.	*Theatre Optimisation* *OP modernisation* *UEC Pathways / LoS*
Level 1 **Local CIPs**	**Local Divisional/Organisational Cost Improvement Schemes** Savings plans specific to individual organisations, identified and delivered locally. No collaboration or external involvement is required.	*Establishment reduction* *Lower cost contracts* *Income margin generation*

Increasing complexity, risk and uncertainty level

2024/25 priorities & approach

- Optimising levels 1 & 2 - priority focus on addressing the implied productivity gap we currently have in terms of spend, workforce (WTEs) and activity, plus driving remaining quick win efficiency opportunities identified by our work on transactional and care pathway savings opportunities.
- Developing (by end Q2) our plans for levels 3 and 4 - system collaboration and system change – as the key areas of focus for years 2-5, alongside the continued implementation of local and provider collaborative cost improvement plans on a full year effective and remaining opportunity basis.
- Continued investment in agreed strategic priorities – prevention and inequalities, mental health, children and young people and community-based care - with a renewed emphasis on return on investment and improved value/productivity within these services.

Meeting our ambition – enablers

In order to secure our financial and strategic objectives, **our approach will need to evolve** over the planning period:

- **A short-term focus on provider and provider collaborative cost improvement approaches that target productivity improvement** (with associated cost base reductions) plus targeted savings around identified transactional and care pathway opportunities.

    - It is clear that the **acute sector particularly will continue to be under significant financial and service pressure** resulting from underlying deficits, convergence requirements and demand & capacity imbalances but with **significant opportunities associated with the covid period productivity gap**. As a result, there will **need to be collaboration across the acute sector,** for example around managing capacity on a system basis to drive efficiency and best use of available capacity, taking coordinated and systematic action to address variation and improve productivity and efficiency - we will be working to ensure a set of consistently applied improvement plans and expectations across our acute sector.
    - Whilst our **mental health sector will continue to receive investment through the mental health investment standard, but we will need to maximise productivity and care pathway improvement opportunities across these services**, including ensuring that the development of community services (supported by significant transformation investment) and crisis alternatives help reduce pressure and cost within our acute sector, plus within mental health on bed demand and out of area placements.
    - We will need to **maximise opportunities at place level** including operating at scale, working at neighbourhood rather than practice level, refocusing core spending, working at scale to deliver efficiencies, breaking down barriers between funding sources (e.g. pooled budgets) and developing integrated multi-disciplinary neighbourhood teams that break down organisational barriers and reduce duplication and drive forward integration opportunities. The objective will be to maximise return on investment and impact of community-based care, to support acute cost base reductions whilst also improving population health and outcomes, including demand management and containment, admission avoidance and supported discharge.

- A **medium-term focus on more fundamental change**, looking at less transactional and more fundamental collaboration opportunities and potential system changes with **regards service provision, models of care, site and services configuration**. We will be undertaking the work to focus on these areas during 2024/25.
-
- We will work to a set of **financial principles** to secure the ways of working and approaches required to underpin our ambition including:

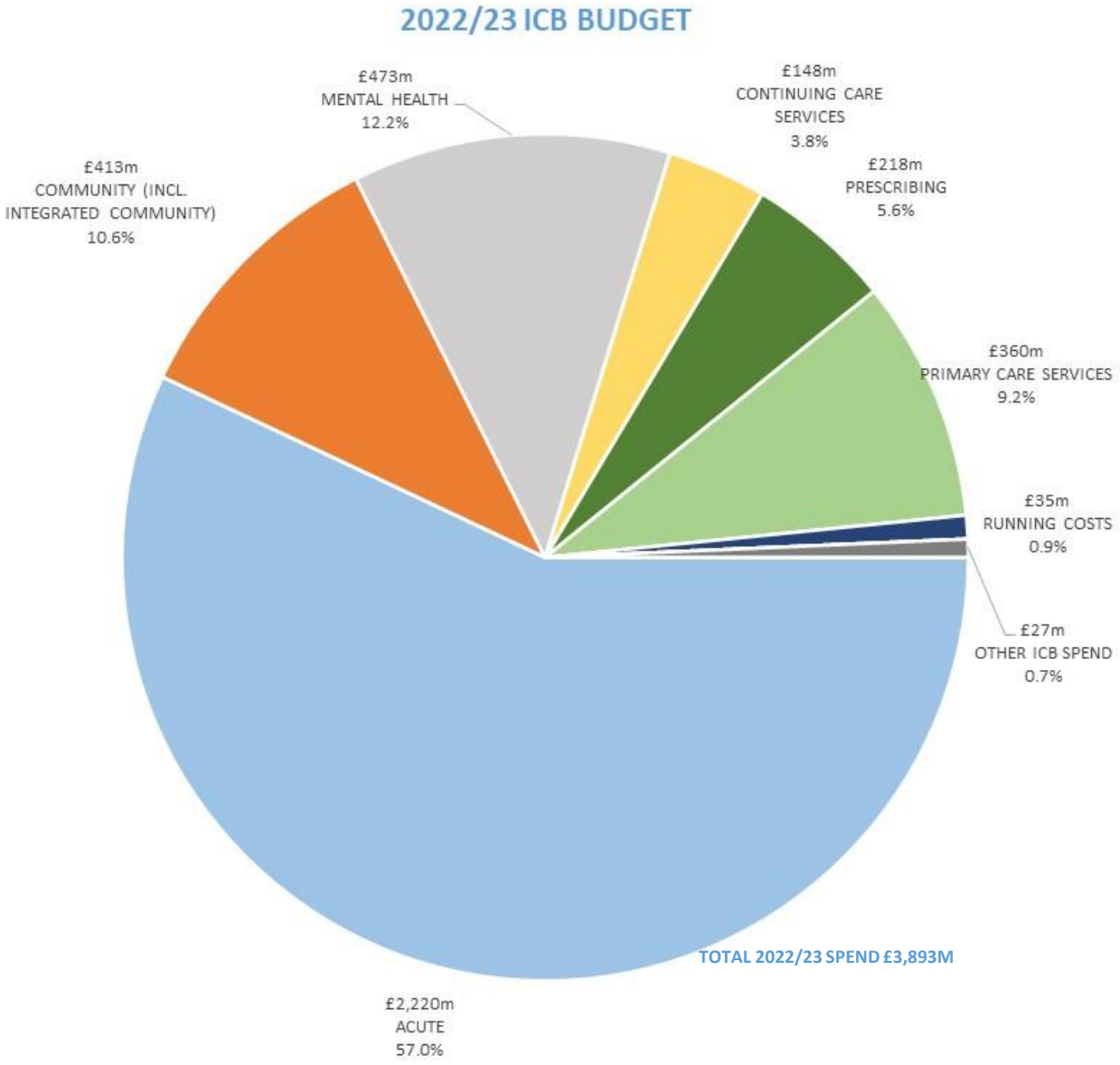
    - Openness, transparency and peer challenge,
    - Demonstrating return on investments linked to improved outcomes and linkage to our strategic priorities, in particular addressing health inequalities.
    - A minimum efficiency expectation of 3% per annum and more in some years as required
    - Collaborative approaches to investment across the ICS
    - The sharing of financial management capacity and resources across organisations to help leverage the improvements required

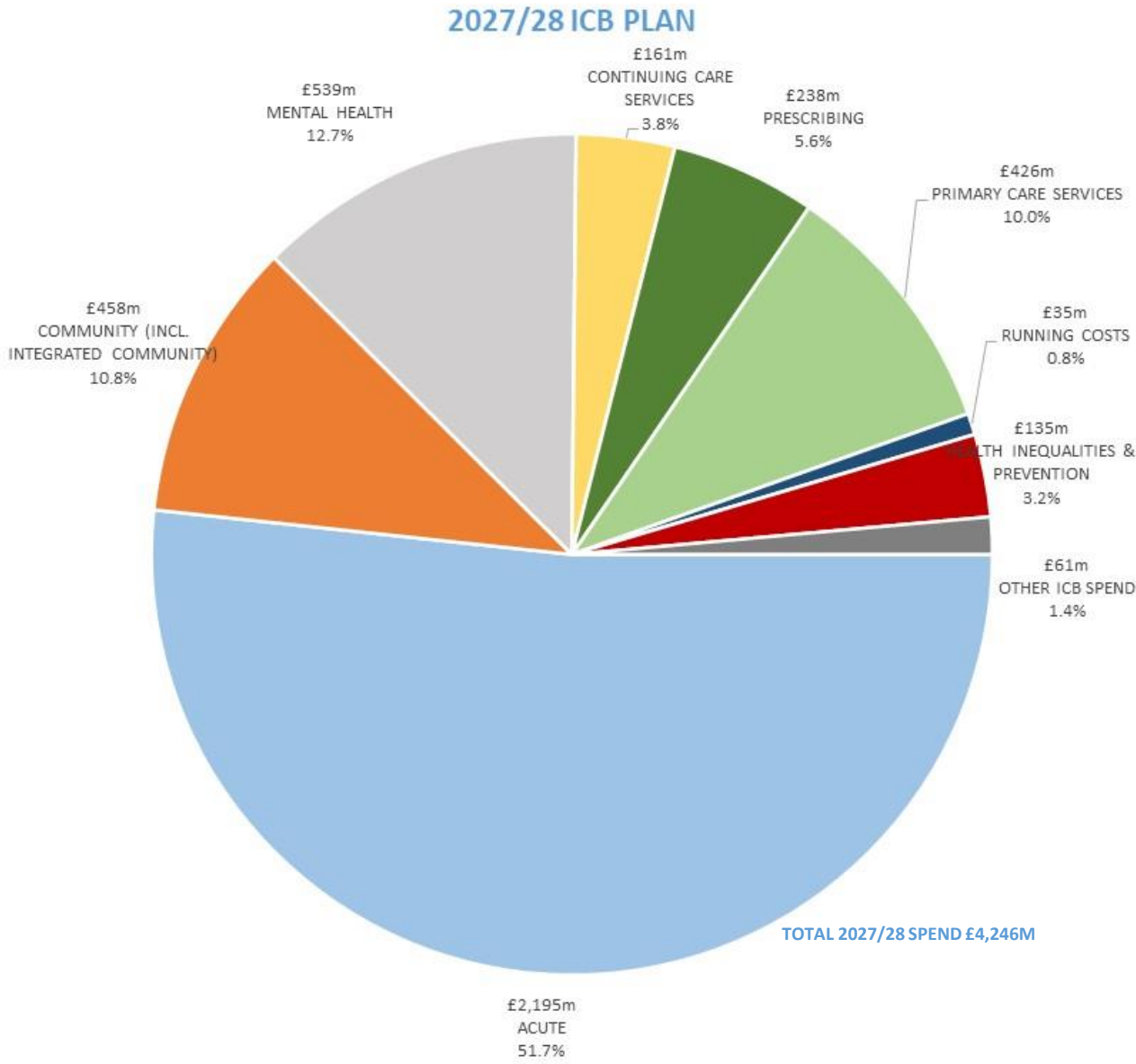
- Alongside **enhanced system wide governance and enabling architecture** for managing and monitoring agreed improvement plans. As a system we will also consider whether **alternative funding and payment mechanisms** can incentivise collaborative working.

South East London Integrated Care System

How will our spend change by 2027/28?

NHS South East London





ICS system development

Since the establishment of the SEL ICB in July 2022, far-reaching changes have been made as to how the system works. These changes recognise the reality of working as a system-of-systems and seeks to establish the skills, capabilities and infrastructure needed to transform health and care.

Three principles have been agreed to support delivery within this complex environment:

- **Partnership**: The ICS is a partnership of sovereign bodies coming together to achieve something greater than the sum of the partners.
- **Subsidiarity**: This means issues and decisions should be dealt at the most local level consistent with their effective resolution.
- **Accountability**: The ICS places value on partners both supporting each other and being held to account by each other and wider partners.

Six areas have been identified in which the conditions for change must be created (see next page):

- Working together as a system,
- Allocating resources,
- Developing leadership and workforce,
- Working in partnership with local communities,
- Innovation and service transformation, and
- Developing analytical and digital capability and estates.

We will be continuing to work as a system to secure these conditions for change as part of our enabling approach to securing our overall strategic and outcome improvement objectives.

Structure of the South East London ICS

System development: creating the conditions for change

Working together as a system	There is a focus on introducing more effective ways of working as a health and care system, with the ICB acting to oversee the effectiveness of the system as a whole, bringing partners together to tackle cross-system challenges, and supporting the redesign of services across organisational boundaries. OD and professional support continues to be invested to embed new ways of partnership working, including the sharing of responsibility in line with the principles of partnership, subsidiarity and accountability.
Allocating resources	The ICB has been given greater flexibility to choose how to allocate resources across the system, with a medium-term financial strategy which was launched in June 2023 and reflects local and national priorities. Recognising the ongoing financial pressures, there is a continued focus on efficiencies and ensuring a sustainable financial plan for the system whilst enabling transformation, innovation and improvement.
Developing leadership and workforce	The People Strategy is a key enabler to the Integrated Care Strategy, with new ways of working across boundaries and new roles an ongoing priority. Creating the conditions for change, addressing workforce gaps, and ensuring the right leadership at every level are fundamental to success. Connections across workforce, digital and estates are being made regularly in service delivery.
Working in partnership with local communities	The 'Working with People and Communities' strategy sets out the ambitions of the SEL system to shift its delivery model to one of partnership with local people and communities, supported by appropriate investment. This includes within the context of design and delivery as well as oversight of the system.
Innovation and service transformation	The Integrated Care Strategy sets out five priorities, through which a new approach to major cross-system projects in improvement, innovation and service redesign will be tested. Implementation plans for the five priorities will be developed, drawing on the expertise present in the system, including within our Boroughs and NHS Trusts, the Health Innovation Network (the Academic Health Science Network for south London), King's Health Partners (our Academic Health Sciences Centre) and the voluntary, community and social enterprise sector (VCSE).
Developing analytical and digital capability and estates	SEL ICS is committed to developing the skills, technology, data and digital systems required to improve services and make better use of resources. This includes the 'population health management' programme which will generate more detailed information on the health of people in south east London to allow for more targeted services and support. In parallel, the use of buildings and facilities continues to be developed to support joint working across services and more person-centric care.

Population Health Management (PHM)

South East London is a diverse place, made up of lots of different neighbourhoods, communities and cultures with varied health needs and different preferences for accessing and receiving care. What works for people in Sidcup does not necessarily work for people in Streatham. Health and Wellbeing Plans and Joint Strategic Needs Assessment provide insight into the variability of need that exists across our ICS.

Population Health Management (PHM) is a way of working that further supports us to ensure the care we delivery is tailored to the needs of our diverse population, supported by a data-driven methodology. PHM enables us to generate and use population specific data to influence care planning, resource allocation and delivery of care, shifting our way of planning and delivering health and care from a reactive approach to a proactive approach and improving our ability to predict, prepare for and manage the health of our populations at all levels. It is as much about evidence as it is about cultural change and ways of working. It requires a system-wide change away from care being structured around organisations to care being structured around populations. As part of this shift, PHM can increase our focus on the wider determinants of health, through the strengthening of relationships across our local care partnerships.

Our vision is to build our population health management capacity and capability as an ICS across all partners, programmes and places to enable care to be tailored for individuals with early support and prevention, resulting in improved outcomes and a reduction in health inequalities for our population.

- PHM is an enabler for change, and is not something which can or should be taken forward in isolation. We believe that developing a systematic approach to embedding PHM as a way of working across all partners, places and programmes will bring significant opportunities for our patients in South East London.
- We are not starting from scratch. There is a rich history of using population data to drive the development of solutions and interventions, such as use of public health intelligence within Local Care Partnerships.

Within South East London this will be supported through a **PHM Framework** which sets out how we will develop our PHM capability and capacity across 4 key domains:

- **Population segmentation and unified outcome measures**, enable us to use a single language as a system to underpin our understanding of our population and what we are trying to achieve
- **Big data**, which links data from across our system and drives bespoke, accessible and user-friendly analytics for individual practitioners, teams, places and systems
- **Alignment of incentives**, ensuring investment and capacity is aligned to population segments and outcomes, with effective sharing of risk and reward across partners
- **Cultural change**, partnership working and integration driven through organisationally-agnostic system leadership with ownership and accountability for delivering integrated care. This will be supported by a reflective understanding of current ways of working and how these either support or act as barriers to the delivery of effective, population-based care.

Our **key priorities** over the next two years will be to:

- To develop a **core understanding of population health management** across the ICB, Local Care Partnerships, providers of health and care services as well as front line clinicians and practitioners.
- To **build population health management capacity and capability** across our partners, places and programmes
- To support the delivery of **tailored, person-centred care** where teams are able to use a data driven approach to pro-actively manage individuals and focus on prevention.

Sustainability and ICS Green Plan Delivery

Overview

In October 2020 the NHS became the first national health system in the world to commit to being 'net zero', setting two key national targets:

- For the emissions we control directly we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The NHS accounts for c.4% of the country's carbon emissions, so it has an essential role to play in meeting the net zero targets set under the Climate Change Act.

To support the co-ordination of carbon reduction efforts across the NHS, since 2021/22 Trusts have been required to develop Green Plans to detail their approaches to reducing their emissions in line with the national trajectories. In 2022, given the pivotal role that integrated care systems (ICSs) play, this was expanded to include the expectation that each system develops its own Green Plan.

The SEL ICS Green Plan was published in April 2022 and details a number of sustainability objectives across 11 areas of focus *(see slide 2)*. The plan is delivered through a collaborative, system level, Executive-led programme which includes input from Trusts, Primary Care and the Integrated Care Board (ICB); for which Chief of Staff Tosca Fairchild leads the programme as Senior Responsible Officer (SRO).

Strengths / opportunities

- The ICS Sustainability Programme has an established governance structure, supported by Executive-level and Sustainability Lead/subject matter expert input – and has continued to deliver in year 2, with 79% of our combined year 1 + 2 objectives delivered partially/fully
- There remains abundant opportunities for delivery of net zero, through the 11 areas of focus detailed in the Green Plan
- Routes to collaborative working across health and social care not yet fully realised; will provide wealth of additional initiatives and opportunities
- Supporting the environment and reducing the ICS carbon footprint helps our residents to live longer and healthier lives
- Residents who are more disadvantaged are often the people who suffer the effects of climate change most acutely. Our mission – to protect and improve our residents' health and reduce health inequalities is supported by this work

Challenges

- Constraints in dedicated sustainability resource across system
- Many initiatives going on outside of the Green Plan/central programme; meaning the totality of all sustainability activity is not identified, recorded and reported
- Measurement of emissions reduction is complex and imperfect and there is no agreed unified reporting on this across the programme
- Primary Care does not have the same experience as Trusts on sustainability and delivery; increased support (or a different support structure) and subject matter expertise may benefit delivery in primary care
- The links between health and social care have not yet been realised. This is improving with Boroughs developing greater autonomy but opportunities for collaboration have not yet been fully explored
- Employee engagement and embedding sustainability as BAU: showing staff how to embed sustainability in everyday delivery without putting the onus directly on them

Our vision and objectives

Our vision

NHS South East London Integrated Care Board will lead a sector-wide programme that will deliver a demonstrable impact on reduction of greenhouse gas emissions through delivery of the objectives set out in the ICS Green Plan. We will work collaboratively with, listen to and learn from our Trusts and from Primary Care colleagues and we will to develop our programme to full maturity; delivering upon multiple Green Plan objectives to support the NHS-wide ambition to be the world's first healthcare system to reach net zero.

Our key objectives – what we want to achieve over the remaining two years of the Green Plan, and beyond

- We will deliver on our sustainability commitments, which are made across 11 areas of focus in the ICS Green Plan:
  - We will embed carbon reduction and sustainability in our core business
  - We will work collaboratively across the ICS to improve air quality in South East London
  - We will reduce and decarbonise our travel and transport while supporting safe and active travel of staff, patients, and visitors
  - We will optimise our resource use and reduce emissions from our estate in line with the national target of 80% reduction by 2032
  - We will review our existing and develop new models of care which will simultaneously improve patient care and community wellbeing while tackling climate change
  - We will use digital transformation to improve the sustainability of healthcare without compromising the quality of our care or exacerbating inequalities in access to care
  - We will reduce the environmental impact of our medicines through optimisation of prescribing, use of low-carbon alternatives, and appropriate disposal
  - We will use our supplies more efficiently, consider low-carbon alternatives, and collaborate on the decarbonisation of our suppliers
  - We will ensure all our inpatients have access to sustainable healthy food, and for food waste to landfill to be eradicated
  - We will mitigate the risks of climate change and ensure climate change does not impact on the ICS's ability to deliver core services and manage population health
  - We will contribute to the improvement of and equal access to South East London's green and blue spaces
- We will deliver the above by continuing to enable all contributor organisations in SEL ICS to work together in a non-hierarchical way, and also by ensuring the provision of mutual support – a structure which allows for identification and escalation of risks, issues and obstacles and also enables sharing of learning, approaches, connections and resources so that delivery is maintained
- Recognising the sustainability/climate change work that Local Authority have been doing for several years, our Place teams are now taking opportunities to work collaboratively with across health and social care through Delivery Partner networks, which are now beginning to develop.

Our priority actions

Our priority actions – what we will do

1

Continued delivery of the ICS Green Plan

Years one and two (combined) of the ICS Green Plan set 85 objectives for delivery; 67 of which (79%) we are delivering against. We will:

- Continue – and build upon - delivery of existing objectives
- Continue to develop implementation plans for the 18 objectives not yet in delivery
- Take collaborative, whole-system approaches towards planning and implementation of the additional 37 objectives which become live in year three of the Green Plan

We will assure continued delivery of the NHS England "minimum foundation"; a set of seven interventions from the NHS Standard Contract, Planning Guidance and *Delivering a net zero National Health Service*, which are to be delivered by each contributor organisation and reported to the London Region Greener NHS Team quarterly.

2

Meet our priority of taking action to improve air quality in South East London

In March 2022, representatives from the ICB (then CCG), the five trusts, the six local authorities and general practice came together in the first ever 'Sustainability Summit' in South East London and agreed that a key Area of Focus for health and social care in South East London to collaborate on should be Air Quality. Year one of the ICS Green Plan has focussed on installation of air quality monitoring nodes and the collection/interpretation of the data gathered by these nodes. Years two and three will move us into identifying and delivering interventions based on findings.

3

Ensure the Primary Care Green Plan is supported to be delivered, with consideration of Borough-level approaches

Multiple arising priorities in primary care have been a recurrent barrier to delivery of the Primary Care Green Plan. There are many sustainability initiatives being delivered in Boroughs and practices but not led by – or in full alignment with – the central ICS Sustainability Programme. For 2024/25 we will:

- Review what is required to create sustained delivery of Green Plan objectives in primary care
- Harness the excellent sustainability work happening in our practices and Boroughs. We will explore establishing and supporting Borough-based plans (moving away from the centralised programme model to allow for differentiation and innovation) which will also provide greater opportunity for collaboration with social care

Sustainability: priority action #1

Continued delivery of the ICS Green Plan

- We will continue – and build upon - delivery of existing Green Plan objectives, and develop implementation plans for current year objectives not yet in delivery
- We will take collaborative, whole-system approaches towards the additional 37 objectives which become live in year three of the Green Plan
- We will assure continued delivery of the NHS England “minimum foundation”; a set of seven interventions to be delivered by each SEL contributor organisation

How we will secure delivery

Actions for 24/25

- Undertake a review of Green Plan delivery at the end of year 2; note the progress made and consider our ability to accelerate agreed actions and the resource required
- Use the oversight and network structures within our programme governance to record delivery progress and to mitigate/remove risks and barriers to delivery
- Undertake review of programme workstream leadership for optimal delivery
- Develop our programme reporting to fulfil our bi-annual assurance requirement
- Develop close working with regional and national Greener NHS and Net Zero teams; using their intelligence and London-wide reach to:
  - stay appraised of priorities and assurance requirements for next business year and embed them in SEL planning for 2024/25
  - be involved in London-wide initiatives that offer greater economies of scale and collaboration opportunities
  - Understand and use the reporting and carbon footprint tools made available

Actions for 25/26

- Formal retrospective review of delivery of Green Plan over 3-year life and refresh of ICS Green Plan, with consideration of guidance anticipated to be issued towards the end of 2024.

Intended outcomes at end of 3-year Green Plan

- Quantifiable reduction in greenhouse gas emissions/carbon footprints; contribution towards NHS net zero targets and reduction of health inequalities
- Delivery across all Green Plan objectives/actions, supported by quantifiable carbon reductions at objective/area of focus level.
- Sustainability initiatives embedded and established in a way that they are sustainable and continue to contribute to net zero
- Fully functioning programme structure with subject matter expertise resource within each programme workstream, and with links to existing internal and external support structures/groups
- Opportunities for collaborative working across health and social care realised
- Sustainability embedded in core business at sector and organisation levels; especially as part of service reviews, reconfiguration, system transformation, capital estates projects and ICB Board discussions
- SEL workforce educated in importance of sustainability practices at home and in the workplace, and with the confidence to suggest practices to our organisations
- Foundation laid for refresh of Green Plan for in 2025.

Sustainability: priority action #2

Improving air quality in South East London

At a South East London Sustainability Summit held in March 2022 it was agreed that a key Area of Focus for health and social care in South East London to collaborate on should be Air Quality. Year one (2022/23) of the ICS Green Plan has focussed on installation of air quality monitoring nodes and the collection/interpretation of the data gathered by these nodes. Years two and three will move us into identifying and delivering interventions based on findings.

How we will secure delivery

Actions for 24/25

- Establish Air Quality workstream/working group for SEL
- Consideration of hosting a Clinical Fellow to provide additional leadership and expertise around Air Quality.
- Data from air quality nodes to be reviewed and interpreted; compare baseline air quality with air quality guideline levels and identifying appropriate delivery actions
- Develop relationship with Breathe London (Imperial College London) for subject matter expertise and data interpretation support
- Recognise interdependencies with travel and transport, estates and facilities and green/blue space and biodiversity workstreams and adapt plans to capture collaborative opportunities
- Focus on anti-idling initiatives at major locations
- Seek opportunities for collaborative working i.e. with local authorities, GLA, TfL etc. and use their projects and learning to inform local plans
- Join pan-London active travel workstreams to learn about/adopt London-wide initiatives that contribute to air quality improvements

Actions for 25/26

- Formal retrospective review of delivery against Green Plan air quality objectives over 3-year life and refresh of objectives in ICS Green Plan, with consideration of guidance anticipated to be issued towards the end of 2024.

Intended outcomes at end of 3-year Green Plan

- Quantifiable improvement in air quality/reduction of air pollutants and thereby contribution towards NHS net zero targets, reduction of health inequalities
- Foundation for reduction of asthma, lung cancers, strokes, cases of CHD and deaths attributed to air pollution
- Contribution to achievement of air quality objectives in respect of the Air Quality Management Areas (AQMA) declared across all SEL Boroughs (areas within all Boroughs for Nox, all expect Bromley and Lewisham for particulate matter, the whole of Lambeth and Lewisham)
- Delivery reported across all Green Plan air quality objectives/actions, including elimination of vehicle idling at major locations
- Increased uptake of active travel, physical activity and use of green/blue spaces in connection with improved air quality

Sustainability: priority action #3

Primary Care Green Plan delivery

- We need to review what is required to create sustained delivery of Green Plan objectives in primary care, with a particular view to how we embed sustainability when there are consistently multiple priorities in primary care.
- We must also harness the excellent sustainability work happening in our practices and Boroughs. We will explore establishing and supporting Borough-based sustainability plans; which will also provide greater opportunity for collaboration with social care.

How we will secure delivery

Actions for 24/25

- Undertake review of Primary Care Green Plan delivery across years 1&2; note the progress made and consider our ability to accelerate current actions, our options to re-cast priorities and objectives and the resource required for ongoing delivery
- Consider means to expand resource dedicated to delivery Primary Care Green Plan objectives, which may include (but is not limited to) clinical input via Fellowship programmes
- Consider the ICS Sustainability Programme governance structure and how it may be adapted and/or enhanced to provide greater focus on and support to delivery of Primary Care Green Plan objectives
- Exploration of Borough-led initiatives and potential for delegating green planning to Boroughs; may significantly enhance opportunities for partnership working and will more effectively harness the breadth of initiatives already established within Boroughs (outside of the Green Plan and therefore not captured by existing programme reporting)

Actions for 25/26

- Formal retrospective review of delivery against Primary Care Green Plan objectives over 3-year life; establishment of forward plan for 2025/26 and beyond, in consultation with primary care Sustainability Leads and with consideration of guidance.

Intended outcomes at end of 3-year Green Plan

- Delivery across all Primary Care Green Plan objectives/actions
- Sustainability initiatives embedded and established in a way that they are sustainable and continue to contribute to net zero
- Opportunities for collaborative working across health and social care realised
- Opportunities for collaborative working with Trust colleagues realised
- Sustainability embedded in core business across primary care
- Primary care workforce educated in importance of sustainability practices at home and in the workplace, and with the confidence to suggest practices for adoption in their practices and PCNs. Leads to a network for Sustainability Champions across primary care.
- Foundation laid for development of Primary Care Green Plan (or equivalent) for 2025/26 and beyond

Focused Green Plan delivery requirements

Programme/system-wide requirements

- Board-level leads at all SEL contributor organisations – supported by subject matter expert operational leads – to drive the ICS Sustainability Programme and the organisational net zero agenda
- Continuation and development of the SEL Sustainability Network to share best practice and to provide inter-organisational support, especially with barriers and risks to delivery
- Growth of dedicated sustainability resource (notably Sustainability Leads and technical/subject matter experts) over time, in order to deliver the ICS Green Plan in full
- Continued identification of opportunities for clinical fellowships, to support the implementation of the Primary Care Green Plan and sustainable quality improvement (SusQI)
- Review and full establishment of the required programme structure; to drive overall delivery and to ensure that every Green Plan area of focus has dedicated time and collaborative effort
- Continued facilitation of collaborative and/or matrix working opportunities:
    - between primary care, ICB, Trusts and other health partners
    - between health and social care
    - with external organisations (NHS and otherwise, including community groups and third sector)
- Continued support from regional and national NHSE Greener NHS/Net Zero teams, to help identify and share changes in policy and process, assurance requirements and to facilitate involvement in pan-London initiatives and opportunities
- Membership of peer-support groups for sharing of good practice in London and beyond i.e. Greener Practice (primary care sustainability group)
- Continued ability to identify external funding/bid opportunities as and when they arise
- Establishment of realistic and achievable local assurance process unified reporting across contributor organisations
- Development of local process for periodic (annual) review and refresh of the Green Plan and its objectives
- Continual review of our programme model and practices and the opportunity to adapt the model for optimal delivery
- Development of a sustainability communication strategy
- Development of a suite of staff engagement tools/means, including (but not limited to) staff Sustainability Champions, staff forums, comms built around key sustainability events/dates, visible leadership and role-modelling, etc.
- Continued provision of workforce training and education; prior to now focus has been on training Board-level leads – expansion or cascade would further support Green Plan delivery
- Continued input from supporting/interdependent/enabler workstreams i.e. Estates & Facilities, ICT/Digital transformation, Medicines Management – and any external organisation whose support has been purchased i.e. Breathe London (air quality), Turner & Townsend (estates).

Supporting wider social and economic development (1)

The South East London ICS collectively employs more than 100,000 staff, many from our local communities; it is also one of the largest purchasers, property owners and investors across the six Boroughs. There is a collective ambition to adapt how the ICS's economic power and resources are deployed to create economic opportunity and better environments for deprived communities and, in doing so, directly tackle the economic and social inequalities that contribute to poor health.

Aligned to the Anchor agenda, many of the organisations that make up our Integrated Care System are already doing good work in this area. Together we have set a strong expectation within our system that we should work together as a partnership through our ICS Anchor System Programme to accelerate progress and maximise the impact of the work ongoing within individual organisations.

SEL system-wide approach to maximising social value:

Sharing and celebrating best practice

A myriad of programmes are ongoing, both cross-system (see next page) and within the Anchor organisations. An Anchor Alliance has been formed, bringing together representatives from across the ICS to share and celebrate best practice, both from within south east London and from other UK systems. The Anchor Alliance also provides an opportunity for partners to identify opportunities to work together in value-adding cross-system projects (see below).

Listening to our people and communities

Building on the success of South London Listens, between June and September 2023 a south east London-wide listening campaign was undertaken, led by delivery partner Citizens UK with support from Anchor Institutions and VCSE partners. Over 2,500 people across southeast London took part in the campaign, leading to the development of five pledges in the areas of: becoming a Living Wage system, championing English as a Second Language (ESoL) support, supporting those furthest from the workforce into employment, making physical spaces available to VCSE partners, and developing an action plan for better housing. These pledges were publicly committed to through an Accountability Assembly in November 2023 at which leaders from across the ICS came together with leaders from community organisations and members of the public.

Community-based cross-system projects

Following commitment to the five pledges, work programmes are being developed for community-based delivery based on the principle of co-development with our people and communities. In addition, relevant opportunities are being explored as they arise. For example, following a successful bid for £250k of Health Education England funding, the Anchor System Programme is working with the ICS People Strategy implementation team and the SEL VCSE Strategic Alliance to deliver projects designed to support local people into health and care employment, with the SEL VCSE Strategic Alliance leading the process of recruiting VCSE partners for the collaboration. These projects will be complementary to those ongoing within SEL Anchor Institutions and other SEL programmes (see next page).

Supporting wider social and economic development (2)

Maximising our social value across the five Anchor pillars:

Using buildings and spaces to support communities	The Estates strategy recognises the need to use the buildings and spaces available to the system in new ways which allow for integrated working, support local communities and ensure the system is environmentally sustainable. This includes creating vibrant community hubs and destinations that serve the specific needs of south east London people and communities.	See 'Estates'
Reducing the environmental impact	Delivering the ICS Green Plan supports carbon reduction efforts across the NHS in South East London, in line with NHS national net zero targets. Making a meaningful contribution to net zero supports the ICB's mission to protect and improve population health, reduce health inequalities and build a more resilient healthcare system – whilst reducing financial impacts in the longer term.	See 'Sustainability'
Widening access to quality work	Our People Strategy sets out key actions for promoting SEL as a great place to work, supporting widening participation and the broader Anchor agenda. All 5 SEL NHS Trusts are now accredited as London Living Wage (LLW) employers alongside other organisations; this work continues. The SEL Health and Care Jobs Hub is supporting local people into employment with specific targets set for education, work experience and apprenticeships. The Jobs Hub aims to address structural barriers to engagement, recruitment and retention. Piloting new work and building collaborations are central to investing strategically and planning for sustainability	See 'Workforce'
Purchasing more locally and for social benefit	NHS London Procurement Partnership (NHS LPP) have created a pan-London tool kit to maximise social value by strengthening communities through collaborative working across the public, private, and community and voluntary sectors to create the biggest impact. This was created using a place-based approach to understand social inequalities.	More information is available through NHS LPP
Working more closely with local partners	The South East London ICS is structured under a 'system of systems' model, building on strong existing relationships using the principles of partnership, subsidiarity and accountability. Relationships, collaboration and investment in the VCSE sector continue to develop and strengthen, including through the creation of a Director of Voluntary Sector Collaboration and Partnerships role. We have co-developed and publicly signed our SEL VCSE Charter which outlines our system's commitments to positioning the VCSE sector as key strategic partner, shifting our approach towards equitable collaboration and investing in the sector's capacity and sustainability to ensure sustained positive impact for the diverse communities of SEL.	See 'System development'

Quality & Patient Safety

Overview of our current system

The ICB has overarching quality responsibilities: to ensure the fundamental standards of quality are delivered – including managing quality and safety risks, addressing inequalities, reducing communicable infections, assuring that the ICB is meeting its statutory responsibilities for Safeguarding, Adults and Children, Children Looked After, Children with Special Educational Needs and those with a Learning Disability and Autism, and to reduce variation and to continually improve the quality of services, in a way that makes a real difference to the people using them. This is currently carried out by strengthening collaboration and working in partnership across health, social and care providers to improve quality outcomes for patients and provide a common definition and vision of quality to ensure high quality care as being safe, effective and providing a positive experience with greater emphasis on population health and health inequalities.

Strengths / opportunities

- Patient safety, IPC and safeguarding clearly defined national priority areas/statutory functions
- Have a clear evidence base and demonstrable positive outcomes
- Strong partnership working collaboratively across the system including regulators, Local Care Partnerships and NHSE
- Quality framework for primary care including delegated services from April 23
- Strong partnership with local authorities and potential for much more e.g. around quality in care homes
- Strong relationships with partners with good collaboration, information and intelligence sharing through the System Quality Group (SQG) and borough based Safeguarding Boards
- Integration of patient safety partners representing the patient view
- Open relationships with HealthWatch partners allowing challenge and community view
- Integration with our partners across the safeguarding landscape.
- Collaborative approach and strong relationships forged through the CHC strategic group.

Challenges

- Changing behaviours, ways of working that have been in place for a considerable amount of time
- Availability, sharing and lack of standardisation of data collection and collation
- Competent interrogation, analysis and interpretation of data
- Embedding a robust safety culture across SEL
- Ensuring learning is shared and embedded across SEL to effect change and encourage quality improvement and patient outcomes and experience
- Disintegration of structures e.g. Laboratory changes has had a negative impact on close working relationships and can lead to delayed diagnosis
- Large number of primary care providers (with more contracts delegated in 2024 community pharmacy, dentistry and opticians) to engage with
- Workforce challenges across health and social care with high vacancy rates and turnover
- Disparate CHC/CYPCC digital information systems and increasing national data demand
- Communication and information flow regarding quality, safety and safeguarding

What we've heard from the public

Through our Patient Safety Partners, ContactUs colleagues, insight from local people, and strong links with Healthwatch, we know that patients are concerned about access to primary care services, long waits for hospital care, poor communication and not being listened to when things go wrong.

Quality & Patient Safety - our vision and objectives

Our vision

To work in partnership to drive high quality care and patient safety across our ICS to promote a culture of continuous learning and improvement.

We aspire to build a seamless, collaborative and productive way of working with all our partners that will further improve patient outcomes and experiences whilst reducing health inequalities across our population.

Our key objectives – what we want to achieve over the next five years

Over the next five years, we want to develop a shared single view of patient safety and quality which means:

- Development of joint quality priorities and quality improvements across the system which reflect and are informed by the patient voice through Patient Safety Partners across the ICS.
- Foster an embedded learning culture which improves patient safety across infection control, safeguarding and quality.
- Reduce repetitive patient safety incidents and preventable communicable diseases.
- Improved communication and engagement with all stakeholders to ensure embedding and sustainability of national and local obligations.
- Encourage and promote an open and inclusive culture for staff, patients and system partners which will enable those to speak up and challenge without fear.
- Drive forward the national All Age Continuing Care (AACC) programme to ensure local policy change and reform: Everyone being assessed for NHS Continuing Healthcare and NHS-funded Nursing Care and Children and Young People's Continuing Care receive an equitable, transparent, person-centred experience of a consistent high standard.
- Develop all digital systems to facilitate effective communication and information flow to improve quality, safety and safeguarding.

Quality & Patient Safety - our priority actions

Our priority actions – what we will do

1. **Implementation and embedding of the national Patient Safety Strategy:** Working with system, independent, primary & social care and regulatory partners to establish ways to engage the ICS to ensure clear oversight and challenge around quality failure, that fundamental standards of quality are delivered, including managing risks, learning from deaths and national reviews to promote a robust patient safety culture leading to a consistent approach to address concerns which are managed effectively and learning is achieved that is shared across the ICS.

2. **Communication and Engagement:** Through various networks and collaborations increase the knowledge of stakeholders to support the delivery of quality at Place with engagement with communities and their representatives to enable them to embed and sustain the implementation of the National Patient Strategy, reduce the spread of preventable infectious diseases and ensure the patient voice is heard.

3. **All Age Continuing Care (AACC):** To have an optimised sustainable and resilient AACC workforce with professionals undergoing standardised training that supports appropriate competencies and consistency/ compliance of processes. Develop AACC digital systems to facilitate effective communication and information flow to improve quality, safety and safeguarding and meet national data demand.

4. **Learning and Development**: Working with Health & Social Care Partners to embed learning using triangulation of key quality measures/indicators and professional insight to inform improvements and monitor progress. Work with our system and statutory partners through the ICS System Quality Group and borough based Safeguarding Boards.

5. **Reduce the occurrence of preventable infections:** Working collaboratively with partners to reduce healthcare associated infection, reduce antimicrobial resistance using standardised tools and ways of working and to develop common objectives to achieve reduction.

6. **Safeguarding and Special Educational Needs (SEND):** Working collaboratively with all partners across SEL to seek common solutions to the changing landscape of safeguarding and SEND enabled by a governance structure that supports delivery of the NHS Long Term Plan and identifies opportunities within safeguarding and SEND for improving outcomes for the population of SEL.

Quality priority action 1 – Implementation of the Patient Safety Strategy

Implementation of the Patient Safety Strategy

Working with system and regulatory partners ensure learning is shared and patient and service outcomes are improved.

How we will secure delivery

Actions for 24/25

- Collaborative working with Local Care Partnerships, primary and secondary care providers, local authorities, regional and internal stakeholders to develop ways of working to ensure clear and concise sharing of intelligence and outcomes .
- Understand the needs of each Borough and identify system blockages and develop an approach to address these
- Conduct a training needs analysis across SEL in relation to PSIRF and LFPSE and facilitate workshops as required.
- Use of data to identify services with poorer patient outcomes that will benefit from a Quality Improvement Project or adjustment to delivery.
- Engagement with the Patient Safety Partners to ensure inclusion of the patient/community voice
- Implement data gathering to support reporting on patient safety events and incidents
- Establishment of a patient safety group and mortality, morbidity group to review incidents, deaths and outcomes

Actions for 25/26

- Implementing patient engagement plans including sustainable ways of building in patient involvement in service design
- Implement processes to ensure early risk identification, detection and intervention and proactive planned care support particularly where these are identified as part of Core20
- Provide education resources and training for health professionals in SEL

Intended outcomes in 5 years time

- Established reporting methods that will demonstrate improvement in patient outcomes
- Seamless working between Place Based and SEL partners
- An embedded safety and learning culture
- Reduction of repetitive themes and trends.
- Improved data collection, interrogation and intelligence sharing
- As near as possible, real-time reporting

Quality priority action 2 – Communication and Engagement

Communication and Engagement

Through various network and collaborations increase the knowledge of stakeholders to support the delivery of quality at place with engagement with community and a representative to enable them to embed and sustain implementation of the National patient safety strategy and ensure the patient's voice is heard

How we will secure delivery

Actions for 24/25

- Strengthen the communications plan across SEL that informs stakeholders about the patient safety strategy and its requirements for implementation
- Facilitation of stakeholder workshops to communicate the patient safety strategy
- Facilitations of safeguarding workshops to communicate the safeguarding strategy
- Design a method of communication that provides an update against progress.
- Develop a concise method of communication that uses data to enable reporting on themes, trends and investigation outcomes.
- Facilitation of learning events

Actions for 25/26

- Continued review of communication and engagement and identification of lessons learnt to improve collaboration and information sharing

Intended outcomes in 5 years time

- The National patient safety strategy is fully embedded
- All staff are aware of their responsibilities against strategy and how their concerns or issues will be addressed.
- Learning from safeguarding incidents and safeguarding statutory reviews are shared and embedded throughout the ICB/ICS.

Quality priority action 3 – Embed All Age Continuing Care

Embed All Age Continuing Care

AACC: To have an optimised sustainable and resilient AACC workforce with professionals undergoing standardised training that supports appropriate competencies and consistency/ compliance of processes. Develop AACC digital systems to facilitate effective communication and information flow to improve quality, safety and safeguarding and address increasing national data demand.

How we will secure delivery

Actions for 24/25

- Develop an AACC strategy and transformation action plan
- Optimse links with key stakeholders ensuring interface with other Children policy reform including Safeguarding and SEND supported by an Engagement and Communication Management Plan
- Harmonise local CHC/CYPCC policies and processes via the CHC/CYPCC Oversight Group
- Understand the needs of each Borough and identify system blockages and develop an approach to address these

Actions for 25/26

- Actions for 24/25 will be determined through the National AACC Collaborative and the SEL AACC strategy and action plan.

Intended outcomes in 5 years time

- Embed the All Age Continuing Care (AACC) programme to ensure local policy change and reform: Everyone being assessed for NHS Continuing Healthcare and NHS-funded Nursing Care and Children and Young People's Continuing Care receive an equitable, transparent, person-centred experience of a consistent high standard.

Quality priority action 4 – Learning and Development

Learning and Development

Working with health and social care partners to develop a method to measure learning using key triangulation measures/indicators and professional insight to inform improvements and monitor progress

How we will secure delivery

Actions for 24/25

- Working with system partners conduct a training needs analysis to identify gaps in learning and sharing lessons
- Working with system partners develop a rolling programme of education related to patient safety and outcomes
- Participate and contribute to existing training delivery programmes to increase and embed learning
- Develop technological skills and abilities to enable interpretation, interrogation and analysis of data
- Work with the ICB and through borough based Safeguarding Partnerships to learn from safeguarding reviews and ensure this learning is shared

Actions for 25/26

- Continuation of above

Intended outcomes in 5 years time

- Robust programme of learning from patient safety events, incidents, national reviews which reduces and mitigates against recurrence of repetitive themes
- Oversight of quality improvement initiatives
- Quality is embedded within all ICS contracts and service review workstreams
- Triangulation of data and information is collated, collected and presented in a cohesive way.
- Increased reporting on the LFPSE platform which will allow identification of repetitive and key themes in SEL allowing for national, regional and local comparison.
- To build on the identified areas within safeguarding Training Needs Analysis-in line with statutory guidance

Quality priority action 5 – Reduce the occurrence of preventable infections

Reduce the occurrence of preventable infections

To work with the system to reduce the occurrence of preventable infections: Working collaboratively with partners to reduce healthcare associated infection, reduce antimicrobial resistance using standardised tools and ways of working and to develop common objectives to achieve reduction.

How we will secure delivery

Actions for 24/25

- Codesign and agree shared IPC priorities with system partners to address identified gaps, themes and trends that affect SEL.
- To ensure that a programme of IPC training is in place across all SEL ICS settings.
- Monitor HCAI infection rates and benchmark against SEL targets/London/national rates and identify areas with higher than expected incidence.
- Work with key partners to develop integrated workstreams to reduce infection where there is higher than expected incidence.
- Support borough based primary care teams to achieve GP practice CQC requirements relating to IPC through a programme of audit.
- Facilitate appropriate antimicrobial use and stewardship to optimise patient outcomes and prevent antimicrobial resistance.
- Develop a system for sharing information on infections for prompt follow-up to prevent further spread and share lessons learnt.

Actions for 25/26

Continued codesign of quality priorities as being 23/24

- Monitor and review the IPC training programme across SEL ICS.
- Continue monitoring HCAI infection rates and benchmark against SEL targets.
- Strengthen working relationships with key partners to fine tune integrated workstreams to reduce infection.
- Maintain the programme of IPC audit in primary care to support continuous improvement.
- Ensure that infections are identified promptly and appropriate treatment provided to reduce the risk of cross infection.
- Support services to ensure lessons are learnt and best practice embedded.

Intended outcomes in 5 years time

- Reduction in NHSE mandated reportable healthcare associated infections across all settings.
- Improvements in antimicrobial stewardship resulting in a reduction in prescribing and overuse of antimicrobials in all SEL settings.
- Seamless work programmes across SEL settings to prevent infections, outbreaks and ensure patient safety and public health protection.
- Ongoing comprehensive IPC training for SEL ICS which provides staff with core/basic IPC knowledge and skills.
- All GP practices would have had a baseline IPC audit with ongoing support for improvements.

Quality priority action 6 – Safeguarding and Special Educational Needs (SEND)

Improve outcomes within Safeguarding and SEND

To support the work of Place Based Teams and System Partners to seek opportunities and common solutions to the changing context of Safeguarding and SEND: Ensure effective systems and processes are in place to support evidence-based practice and implementation of shared learning across the system and that ICB governance arrangements are consistent with NHS England Safeguarding requirements.

How we will secure delivery

Actions for 24/25

- Review and agree ICB safeguarding and SEND governance arrangements that ensure the ICB is fully compliant with the Safeguarding Commissiong Assurance Toolkit (S-CAT) and Safeguarding Accountability and Assurance Framework (SAAF).
- Hold a series of engagements workshops across ICB safeguarding teams to identify challenges and opportunities for shared learning and working that supports delivery of both Place based Plans and the development of a SEL shared development plan.
- As part of the above, and recognising that Place based plans are already live, set up a safeguarding development programme to support delivery of NHS England Priorities, Place Based and SEL priorities on a shared learning basis including: Child Protection Information System (CP-IS) –Female Genital Mutilation, Prevent Programme, Domestic Abuse, Mental Capacity Act and Deprivation of Liberty, Serious Violence Duty, Modern Slavery, Child Sexual Abuse, Improving outcomes for Children Looked After, care leavers Covenant, safeguarding dashboard and Working Together 2023(Statutory guidance). To ensure local priorities are shared to identify any system issues and learning.
- Programme of work to review data requirements for reporting and improved analysis of data to better inform areas for development and need including Population Health.
- Set up a SEL Safeguarding workforce group to develop career pathways for Safeguarding professionals. Reduce variation across SEL and develop succession plans. Commissioning of a safeguarding review
- Increase in the reporting of all types of abuse, a reduction in serious violence.
- Continue to work with the Child Sexual Abuse Working Group to develop to reprocure emotional support and advocacy service.

Actions for 25/26

- Continue to develop the maturity of ICB SEL working and shared learning processes across our system with a continued focus on the priorities and development programme set out for 23/24.

Intended outcomes in 5 years time

- SEL Wide Governance framework will be strengthened that supports the delivery of improved health outcomes from safeguarding, Children Looked After, and SEND at Place.
- Process SEL wide for learning from statutory safeguarding reviews and rapid reviews embedded to continually inform and develop practice with a greater focus on prevention.
- The voice of people with lived experience is embedded in all areas of safeguarding practice.
- Safeguarding pathways in place across SEL ICB to reduce variation in delivery of care.
- Consistent use and analysis of data across SEL safeguarding programmes that informs practice, identifies areas for development and is used to track improvement.
- Children & Young People with special educational needs and disabilities (SEND) are identified early, reducing the need for escalation to more specialist services and are supported to access education in their borough.
- SEL wide Mortality Group well established that takes learning from all death reviews to support an increased focus on prevention with a stronger interface with CDOP and the child death process.
- Professional career development and progression pathways established for those in safeguarding, Children Looked After and SEND services and for those wishing to enter these specialisms.
- Delivery of bespoke leadership training for those developing in safeguarding to progress to be system leaders
- Increase in the reporting of all types of abuse, support a reduction in serious violence.

Quality & Patient Safety - enabler requirements

Workforce

- Training and support for staff across the ICS to ensure knowledge and familiarity with the patient safety strategy and implementation, including PSIRF, LFPSE and quality improvement
- Training and support for staff across the ICB to ensure compliance with statutory guidance and safeguarding strategies.

Digital

- Integration of systems where possible to reduce repetition of input and human error inputting data
- Robust data sharing agreements and access for GPs and ME's to allow for review of information as and when required
- Patient access for booking GP /Primary Care appointments

Estates

- Improved estate across the system to reduce infection risk, improve the monitoring of patients waiting to be seen, and initiatives such as reducing ligature risks across our estate.

Data

- Data that provides quality outcomes rather than purely performance
- Access to data to support targeted population approaches to support reduction in inequalities, early risk identification, detection and intervention and proactive support
- Development of key data sets to support quality oversight and early identification of quality failure
- Development of a health safeguarding dashboard which is consistent across the ICS.

Transforming and Integrating Medicines Optimisation

Overview

Medicines are the most common therapeutic intervention in the NHS, with a critical place ("golden thread") in therapy in virtually every care pathway. Medicines optimisation is a systematic approach aimed at ensuring that people receive the most appropriate and effective medications for their specific health conditions, maximising the benefits of medicines while minimising any potential risks or harm. NHS South East London spends £800m annually on medicines and pharmacy is the 3rd largest profession after medicines and nursing so the impact is high. The goal is to improve patient outcomes and enhance the quality of care using a personalised care and shared decision-making approach.

Strengths / opportunities

Strengths:

- Strong pharmacist-prescriber relationships across sectors and partnerships.
- Well established cross sector ICS Integrated Medicines Optimisation Committee and Integrated Pharmacy Stakeholder Group.
- Collaborative leadership, shared objectives, data & incentives drive quality improvement
- Consideration of subsidiarity guides efforts to reduce inequalities and unwarranted variation in care.
- Engagement with academic health science networks and higher education institutes to facilitate research and innovation.

Opportunities:

- Pharmacy can contribute more to population health and reducing inequalities.
- "One pharmacy team " workforce model has been developed to
- Commissioning and provision of new national clinical services for community pharmacy
- Digital tools to enhance productivity.
- Pharmacy professional education and legislative changes empower them to prescribe and take on leadership roles in health and social care
- Collaborative approach between community pharmacy and other primary care teams.
- Collaboration with local authorities and work with the voluntary sector to deliver on common goals such as reducing waste medicines, sustainability and health inequalities
- Substantial work delivered, including patient engagement on overprescribing.

Challenges

- Medicines shortages and supply problems
- Pharmacy professional and support staff workforce gaps, esp. band 6 and 7.
- Rising prices of medicines, including generic medicines and increased National Institute for Health and Care Excellence Technology Appraisals pose challenges for prescribing budgets.
- Frequent updates in treatment guidelines, new medications, and changing indications mean challenges in keeping up with the latest evidence and incorporating it into treatment pathways.
- Infectious diseases and capacity constraints further impact routine care.
- Lack of externally funded organisational development, leadership development and infrastructure support for community pharmacy to implement new models of care
- Engaging patients in shared decision-making, promoting adherence, and addressing patient concerns and expectations require effective communication and tailored approaches.
- Increasing complexities and pressure on time and resources to deliver tailored and person centred care to optimise medicines in an ageing and multi-morbid population
- Ongoing urgent demands which delay progress on collaborative priorities between acute, mental health and primary care.

South East London Integrated Care System

Our vision and key objectives

NHS South East London

Our vision

Our vision is that medicines optimisation and the development of the pharmacy workforce will support Long Term Plan goals, deliver net zero targets, and reduce health inequalities. We will respond positively to changing roles and ever-increasing demand for pharmacy professionals to work in multidisciplinary teams, and create innovative, inclusive solutions and shared workforce models to solve recruitment and retention challenges. We will strengthen our cross-sector pharmacy systems leadership approach to foster common purpose at all levels and develop neighborhood pharmacy leadership. We will have personalised care and shared decision-making at the heart of our work.

Our key objectives – what we want to achieve over the next five years

1. Developing our **ways of working strategic approach, governance and network**, through our **"one pharmacy"** team model, focusing on the development of independent prescribing roles, developing roles of pharmacy technicians and prescribing pathways in community pharmacy. Build collaborative working between pharmacy teams across health and care systems to support people's health and wellbeing and develop shared workforce models.

2. Delivering **medicines value** as ICS partners through the SEL Integrated Medicines Optimisation Committee (IMOC) and Integrated Pharmacy Stakeholder Group (IPSG), delivering on priority national medicines optimisation opportunities. Work with others on shared priorities and adopt **digital** innovations to improve efficiency and improve experience of care.

3. Our medicines pathways and pharmacy workforce will support our **long term conditions** programme, reducing inequalities and improving outcomes. We will explore the potential of **genomics** to delivering personalised care and medicines safety as part of the south east genomics network.

4. We will significantly reduce the **carbon impact** of medicines through using lower carbon products, reducing waste, reducing packaging and recycling schemes. We will continue to make progress as an ICS partnership on reducing **overprescribing**, focussing on groups experiencing inequalities. We will embed personalised care and shared decision making at all stages of prescribing and acknowledge the role of the person as experts in their own care.

5. We will continue to develop our **South East London Forum for Antimicrobial Stewardship (SEL FAS)** working alongside partners from the ICS .
   The **medicines safety network** will continue to deliver our shared priorities.

6. We will develop the **community pharmacy sector** to unlock its potential to improve population health and reduce inequalities.

Our priority actions- what we will do

Our priority actions

1. **Ways of Working.** Develop supervision roles for trainee pharmacists who will qualify as independent prescribers in 2026. Develop pathways for community pharmacists to prescribe as part of Integrated Neighbourhood Teams (INTs) in line with competency frameworks. Develop shared workforce arrangements, training and career paths for pharmacy professionals to work in INTs and deliver personalised care e.g. working with social prescribers.

2. **Medicines Value**. Agree collaborative cross sector plans to deliver the highest impact medicines value and reduce waste, focusing on delivery of our selected priorities from the national medicines optimisation opportunities. Plans will be delivered at organisation and place level, also responding to local needs. Measure impact using multiple data sources to track medicines use across sectors. Maximise the use of **digital** and IT enablers to support more accessible care and best use of clinical time.

3. **Long Term Conditions & Genomics**. Work alongside Clinical Effectiveness Southeast London to implement evidence informed guidelines and pathways to improve outcomes and reduce health inequalities. Use prescribing data, linked to broader data sets (long term conditions measures, CORE20PLUS5) to identify unwarranted variation in medicines access or optimisation, support improvement and measure impact on health inequalities and outcomes. Improve digital interoperability between care sectors to support best use of medicines. Agree a plan for delivering the opportunities in genomics and pharmacogenomics.

4. **Sustainability and Overprescribing.** Implement a cross sector inhaler recycling scheme and optimise the use of inhalers in respiratory conditions. Reduce overordering of repeat medicines and reduce medicines waste and packaging. Mainstream and roll out successful pilots from the overprescribing programme including peer support, education, training and work with South London HIN to run communities of practice to support prescribers to tackle overprescribing. Reduce the numbers of people over 65 years old who are inappropriately prescribed 10 or more medicines and reduce medicines errors when people transfer between care settings.

5. **Antimicrobial stewardship**. Use data, decision support tools and a single prescribing guideline for primary care to improve stewardship and reduce duplication. Implement the national common ailments service including community pharmacist management of simple UTIs **Medicines safety.** Build relationships with medicines safety officers to develop a medicines safety network which can oversee cross system work such as sodium valproate in women of childbearing age and opioid stewardship.

6. **Community Pharmacy integration.** A community pharmacy integration group has been established to provide the leadership and governance for our community pharmacy integration and transformation work. This will develop our community pharmacy neighbourhood leads programme, oversight of the community pharmacy performance dashboard and work with the SEL pharmacy alliance to improve consistency of access and quality of new clinical services through community pharmacy. Oversight of a proof of concept for a community pharmacy childhood immunisation service as part of a place immunisation strategy.

Medicines Optimisation : Our progress to date

Key Successes in Delivery in 2023/2024

- Community pharmacy integration group established to provide the oversight and engagement
- A community pharmacy neighbourhood leads programme launched to develop clinical and professional leadership and increase the impact of new clinical services in community pharmacy.
- ICS medicines value group established to develop cross sector plans including delivery of the national medicines optimisation opportunities.
- A cross sector overprescribing programme worked collaboratively to deliver integrated projects to reduce the impact of overprescribing on vulnerable patient groups and engage with our public.
- Pharmacy workforce transformation projects delivered including a “one pharmacy” workforce model and action plan and models to deliver designated prescribing practitioner supervision explored.
- Joint working with CESEL and the acute provider collaborative to improve clinical pathways of care and outcomes.
- A sustainability clinical fellow was recruited to lead on the medicines net zero plan including reducing the environmental impact of inhalers and an inhaler recycling scheme.
- Multi-professional ICS antimicrobial stewardship group established which will oversee a harmonised SEL primary care antimicrobial prescribing guideline promoted through an electronic web-based platform (Microguide).
- Community pharmacy health and wellbeing service delivered over 3000 population vital 5 checks across 24 pharmacies placed in prioritised CORE2-PLUS5 areas across SEL.
- Continued the SEL ICS Medicines Safety Network which has oversight of local implementation across secondary and primary care to improve patient care and deliver safer systems

Learning and Implications for Future Delivery Plans

- There is a significant degree of overlap between medicines optimisation and other functions, as well as collaboration needed between Places in delivering the extent of change required in areas such as overprescribing, personalised care and community pharmacy transformation.

Key Challenges to Delivery in 2023/2024

- Workforce shortages, strikes and capacity in the system.
- Medicines shortages impacting on pharmacy team workload, patient care and implementation of cost-effective prescribing initiatives.
- Limited interoperability between different healthcare information systems and lack of financial investment can hinder the sharing of patient data, including medication histories and allergy information. This lack of comprehensive data can lead to medication errors and duplication of therapy.
- Fragmentation between primary and secondary care, as well as between healthcare providers and community pharmacies, can impede seamless medicines management and coordination of care.
- Delivery of personalised care and shared decision making is challenging. Ensuring patient understanding of their medicines takes time with language barriers, health literacy issues, and cultural factors all contributing to non-adherence, which can compromise treatment effectiveness and patient outcomes.
- People with multiple chronic conditions are often prescribed numerous medications (polypharmacy) and overprescribing presents a significant challenge, leading to adverse effects, waste and hospital admission.
- Implementing and embedding new processes for EPIC, the new electronic patient administration system impacting on resources and prescribing data.
- The challenges associated with rising cost of living, tackling health inequalities and financial pressures on budgets.

Priority action – ways of working

Name of priority action

Ways of Working. We have developed a "one pharmacy" workforce model for Southeast London to share one approach to attracting, training, retaining and reforming a flexible and satisfied pharmacy workforce across our sector. The model identifies recommendations for a range of universal, targeted, and integrated intervention approaches across all pharmacy-related working environments in healthcare which we will implement in coming years. To build trust with the public, we will continue our co-production approach and incorporate the public feedback into our overprescribing action plan. Pharmacy teams will work at their full potential, considering skill mix, utilising training opportunities and new prescribing skills to work as part of multidisciplinary teams delivering high quality care.

How we will secure delivery

Actions for 24/25

- Create a strategic ways of working group across SELICS to harness collective leadership, develop a shared vision, and create communication and governance structure.
- Develop a collaborative pharmacy network with representation from all levels of pharmacy to create a plan for how the One Pharmacy Workforce Model will be implemented.
- Agreed processes and shared accountability for creating environments for rotational and joint roles including trainee cross sector placements.
- Develop supervision roles for trainee pharmacists who will qualify as independent prescribers in 2026.
- Deliver the independent prescribing pathfinder in collaboration with North Southwark PCN and community pharmacy
- Engage with general practice to optimise the role of pharmacy professionals and increase the number of training sites.

Actions for 25/26

- Develop shared workforce roles, training and career paths for pharmacy professionals to work in neighbourhood teams and deliver personalised care.
- Support preparation for community pharmacy independent prescribing, using the learning from the pathfinder sites.
- Evaluate and mainstream community pharmacy neighbourhood leads

Intended outcomes in 5 years time

- Improved recruitment and retention of pharmacy professionals, focussing initially on junior pharmacists and pharmacy technicians.
- A broader pharmacy workforce in general practice, incorporating appropriate use of pharmacy technicians, foundation pharmacists.
- A pharmacy workforce with a better understanding of care delivery in all care settings.
- A training programme to ensure trainee pharmacy technicians and foundation pharmacists are working safely and competently, with supportive training programmes and advanced roles to progress to.
- Pharmacist prescribers skilled to deliver personalised care and shared decision making, ensuring the right medicine is prescribed at the right time and reducing inequalities.
- Increased access to care from pharmacy teams in a way which works for people.
- Pharmacy teams working to their full potential

Priority action – Medicines Value

Name of priority action

Medicines value and long-term conditions. Medicines value refers to the overall benefit and worth derived from the use of medications in healthcare. It encompasses various aspects, including clinical effectiveness, patient outcomes, safety, cost-effectiveness, and patient and clinician experience. We will agree high impact changes to deliver medicines value, considering the balance between the clinical benefits achieved and the associated costs, ensuring the best use of healthcare resources while prioritising patient well-being and population health. This will include benchmarking Southeast London ICS against the national medicines optimisation opportunities, delivering improvements on priority areas for SEL. We will do this in partnership so that people have access to best value medicines in the most appropriate setting and we work to reduce inequalities.

How we will secure delivery

Actions for 24/25

- Benchmark SEL with other ICS areas on any new national medicines optimisation opportunities
- Deliver on plans to improve in the 7 national medicines optimisation opportunities selected by SEL : Obtaining **secondary care medicines** in line with NHSE commercial medicines framework agreements, using best value **biologic medicines**, appropriate prescribing and supply **of blood glucose and ketone meters and testing strips**, identifying patients with **atrial fibrillation** and using best **value anticoagulants**, addressing problematic **polypharmacy**, reducing course length of **antimicrobial prescribing**, improving **respiratory outcomes** while reducing the **carbon emissions** from inhalers.
- Horizon scan to plan for new medicines and new indications in 24/25.
- Continue to address low priority prescribing and promote self care.
- Review individual borough self care pharmacy first (plus) schemes for harmonising and mainstreaming.

Actions for 25/26

- Identify a broader range of health inequalities and health and care data to stratify priority cohorts for review, linking medicines and outcomes.
- Implement digital tools to identify patients who need medicines or long term conditions reviews.

Intended outcomes in 5 years time

- People will have equitable and timely access to NICE approved, cost-effective medicines .
- People get care from pharmacy teams in a way that suits them using innovations in patient-facing digital technology, digital intra-operability , remote monitoring and artificial intelligence
- Our population have equal access to high value medicines which deliver best outcomes and their personalised goals.
- High impact collaborative investment and savings plans for medicines deliver best use of collective resources and NHS funds.
- Improve our management of medicines shortages through collaborative planning and working.
- Promote self care, signposting to non-pharmacological support.

Priority action – Long Term Conditions and Genomics

Name of priority action

Long-term conditions and genomics. People living with major health conditions such as cancer, CVD, stroke diabetes, respiratory disease, learning disability and autism and mental health problems will benefit from pharmacy professionals working in cross sector healthcare teams to provide gold standard care, enabling effective self-care, delaying and preventing complications. This approach will also benefit people living with rarer conditions where we will work alongside specialised commissioners and partner ICBs to improve the pathway of care. We will work with the South East genomic medicine service alliance in developing a consistent and equitable genetic and genomic testing approach for medicines use as these are approved for the NHS.

How we will secure delivery

Actions for 24/25

- Improve communication and digital intra-operability between sectors to share episodes of care in the comprehensive primary care patient record.
- Incentives to drive identification and management of people with atrial fibrillation cross sector, using best value direct oral anticoagulants where indicated.
- Increase detection of hypertension and percentage of patients with hypertension and lipid lowering therapies treated to target.
- Develop and test a new psychosis pathway, including use of long-acting injectable antipsychotic medicines to avoid risk of relapse and providing choice for people to access ongoing treatment.
- Use prescribing data, linked to broader data sets (long term conditions measures, CORE20PLUS5) to identify unwarranted variation in medicines access or optimisation, support improvement and measure impact on health inequalities and outcomes.

Actions for 25/26

- Implement digital tools to identify patients for medicines or LTC review.
- Explore the opportunities of pharmacogenomics to deliver personalised care. Explore the need for pathway changes to improve medicines access for young people transitioning into adult services.

Intended outcomes in 5 years time

- Development of pharmacy services which are tailored to meet needs of our residents and delivered in locations or targeted to population groups where there are the greatest inequalities and opportunity
- People get care from pharmacy teams in a way that suits them using innovations in patient-facing digital technology, digital intra-operability , remote monitoring and artificial intelligence
- Prevention of ill health and improving outcomes for people living with long term conditions and mental health.
- Pharmacy professionals will provide tailored treatments with assistance of intuitive decision tools for example point of care testing.
- People will have access to genomic interventions to improve early detection, disease management and overall population health.
- Patient focused pathways in place for young people transitioning into adult services.

Priority action – Sustainability and Overprescribing

Name of priority action

Sustainability and Overprescribing. Around 25% of NHS carbon emissions are from medicines. Evidence shows that the number of items dispensed by primary care providers has doubled in recent years although a recent report estimated that at least 10% of prescriptions in primary care need not have been issued. Adverse effects of medicines account for 6.5% of hospital admissions. We will reduce the carbon footprint of medicines, reduce waste and reduce overprescribing so that people in South East London are only prescribed medicines when there are no non-medicines alternatives, and the medicines are appropriate for their circumstances and wishes. Overprescribing is everyone's business so we will work with others and our population, focusing on older people, BAME groups and those with learning disabilities and autism who are particularly affected.

How we will secure delivery

Actions for 24/25

- Reduce the numbers of people over 65 years inappropriately prescribed 10 or more medicines, scale and spread of successful pilots.
- Incorporate medicines adherence into clinical reviews and measure the impact, considering a focus on priority groups such as CORE20PLUS5 communities.
- Make it easier for people to book a medicines review with their general practice, communicating this to our public.
- Provide training on new inhalers, and treatment pathways for chronic obstructive pulmonary disease, working with Clinical Effectiveness Southeast London.
- Implement the cross sector inhaler recycling programme
- Implement a community pharmacy scheme to reduce over-ordering of medicines.
- Continue to engage and communicate with our public on overprescribing and the sustainability medicines programme.
- Explore recruitment of another a Chief Sustainability Officer clinical fellow.
- Implement the national repeat prescribing improvement toolkit.

Actions for 25/26

- Reduce medicines errors when people transfer between care settings.
- Deliver medicines waste amnesties, engaging with our public on overprescribing and medicines waste.
- Implement a programme of antidepressant review and potential deprescribing where individuals are not gaining benefit from their current treatment.

Intended outcomes in 5 years time

- The carbon impact of medicines including inhalers will be significantly reduced – as measured by carbon emissions by inhaler type and formulation
- More people with respiratory conditions will have accurate and confirmed diagnoses
- Reduced waste and better adherence to medicines, particularly through patient empowerment
- Reduced inappropriate polypharmacy especially in those with 10 or more medicines
- Culturally competent clinicians prescribing and reviewing medication, trained and informed by our patient voice, taking a shared decision-making approach.
- Fewer medicine related admissions/harms.
- Increased collaboration with voluntary sector and patient groups enabling community initiatives to deliver net zero targets.
- Reducing cost for the NHS (both in less admissions and less medicine use).
- Quality medicines reconciliation and transfer of information about medicines during care transitions is standardised across SEL Trusts.
- South East London guidelines and pathways incorporate shared decision making alongside prescribing recommendations to reduce the number of medicines which people don't want or need.

Priority action – Antimicrobial stewardship, medicines safety

Name of priority action

Antimicrobial stewardship and Medicines safety. Work with medicines safety officers to develop a medicines safety network to co-ordinate a plan to address any identified gaps in medicines safety across the system, learning from patient safety incidents or near misses and interface or transfer of care issues. Develop a culture of mutual support and a blame free approach. Continue to build and develop the South East London Forum for Antimicrobial Stewardship to ensure antimicrobial stewardship to protect vital antibiotics, respond to infectious disease outbreaks and reduce antimicrobial resistance.

How we will secure delivery

Actions for 24/25

- Deliver on the SEL action plan to implement the recommendations of the national patient safety alert NatPSA/2023/013/MHRA on sodium valproate.
- Continue the work on safe use of high-risk medicines, including anticoagulants, liquid medicine in children and methotrexate.
- Develop and deliver interventions to improve opioid stewardship and reduce use of ineffective medicines for chronic pain.
- Learn from patient safety incidents in medicines by looking for trends including cross sector, sharing widely and acting on them to reduce the risk of reoccurrence
- Create one South East London primary care antimicrobial guideline including electronic format to include reducing the course length of amoxycillin.
- Develop the antimicrobial stewardship dashboard, training packages and use of antimicrobials in other settings eg virtual wards, dental surgeries.

Actions for 25/26

- Work with people to reduce the long-term use of potentially addictive medicines and reducing access to medicines as a means of suicide.
- Explore joint communications sector wide on medicines safety
- Review acute and mental health antimicrobial guidelines, harmonise where feasible, and make readily available in an electronic format (Microguide), including and switching intravenous antibiotics to oral where appropriate.

Intended outcomes in 5 years time

- South East London is a safe place to take medicines, with better and more consistent reporting and clear analysis of near misses for all to learn from.
- Collaborative working supports people to understand the benefits and harms of their medicines and know where to get help with medicines when they need it.
- To reduce the number of pregnancies which continue to be exposed to sodium valproate.
- Reduce the use of opiates in long term chronic pain, considering non-pharmacological interventions to help people's wellbeing and self management.
- The pharmacy workforce can respond to ongoing and new infectious disease outbreaks, delivering vaccination programmes and antiviral or antimicrobial medicines as part of timely and equitable services.
- More people fully understand the medicines they take and the side effects, in order to avert potential medication harms

Priority action – community pharmacy integration and transformation

Name of priority action

Community Pharmacy integration. Collaborative working on a common goal between health and social care teams working in community settings, general practice and community pharmacy will enhance accessible services, reduce health inequalities, and improve population health. Community pharmacy can work with social prescribers, integrated care teams, and the voluntary sector to deliver personalised care. . This includes developing new workforce models and community pharmacy neighborhood leadership. Through our partnership approach we can maximise the opportunities of pharmacy, optometry, and dentistry contracts delegation to the ICB.

How we will secure delivery

Actions for 24/25

- Deliver the community pharmacy neighborhood leads development programme.
- Pilot a community pharmacy Place-based childhood immunisation service.
- Continue to develop and use the community pharmacy benchmarking dashboard to drive clinical service uptake and quality.
- Expand access of clinical tools to community pharmacies including the London Care Record and a referral system to support their safe and efficient provision of care.
- Continue to work with Community Pharmacy colleagues to increase the impact and quality of new nationally and locally commissioned clinical services including Pharmacy First.
- Implement the recommendations of the vital 5 health and wellbeing service evaluation.
- Explore electronic transfer of prescriptions from hospital to community pharmacy to reduce journeys to deliver medicines and convenience.
- Deliver a SEL pathfinder pilot to explore community pharmacy independent prescribing.

Actions for 25/26

- Mainstream the community pharmacy vital 5 health and wellbeing service.
- Test independent prescribing models in community pharmacy following local and national pathfinder projects.

Intended outcomes in 5 years time

- Community pharmacies will consistently offer a broader range of clinical services, tailored to local needs.
- Community pharmacy will play a crucial role in health promotion, providing interventions, vaccinations, and screening to reduce health inequalities.
- Partnerships between pharmacies, general practice, mental health and integrated services will be strengthened and common goals agreed.
- Digital intra-operability will facilitate the sharing of care episodes and reduce medication errors.
- Independent prescribing pharmacists in the community will collaborate with the multidisciplinary team to care for people with long term conditions, including ongoing prescribing. This will start with blood pressure, mental health, and respiratory care
- This will lead to reduced medication waste and increased public knowledge to help people get the most from their medicines.
- More people empowered to self care; seeking advice and where to go for non-pharmacological support

Enabler and programme requirements : Transforming and Integrating Medicines Optimisation.

Workforce

- Support to implement the “one pharmacy” workforce model and recommendations developed through consultation with pharmacy teams in Southeast London. This includes system, organisational, team and individual actions with the aim of improvements to train, retain and reform.
- Community pharmacy workforce will need transformation support to deliver new clinical services, develop leadership capability and reduce inequalities.
- Changes in pharmacy training and development of independent prescribing for the pharmacy profession will require development and management of cross sector pharmacy training and placement programmes.
- Development of integrated pharmacy roles to deliver more holistic pharmacy care across care settings will need support to develop shared workforce models between providers.

Digital

- Expand access of clinical tools to community pharmacies including the London Care Record and a referral system to support their safe and efficient provision of care.
- Support Community Pharmacy independent prescribing including smart card access, electronic prescribing and access of patient records.
- Implementation of EPIC may over time provide opportunities to make medicines safer during transfer of care and collect data on outcomes from medicines.
- Test and expand trust electronic prescribing to community pharmacy to provide more opportunities for patient choice and ongoing care.
- Develop intra-operability of systems between community pharmacy, general practice and acute/mental health trusts to communicate changes in episodes of care for medicines and long term conditions.

Acute, primary community and mental health/LDA care

Work together to develop:

- Shared roles across primary /secondary care
- Support overprescribing system workplans and older adults medicines optimisation e.g. care homes
- Work with the mental health transformation programme to embed specialist pharmacists into multidisciplinary team staying well services.
- Work with specialist clinicians and primary care to optimise care in medicines and deliver pharmacist prescribing supervision and models
- Promote collaboration across community pharmacy and all sectors
- Work with councils and the voluntary sector on medicines optimisation priorities

Data

- Continue developing BI dashboards for medicines optimisation and community pharmacy integration.
- Explore the use of the PrescQipp ICS dashboard as part of our planning and monitoring of medicines use across the different sectors of our system.
- Support from HEIs to evaluate our “proof of concept” tests and contribute to research in pharmacy practice and medicines optimisation.

Supporting research and innovation in South East London

South East London aims to be a place where research and innovation is embedded in everything we do, where research informs service design and delivery, where innovation drives progress and where we use the extensive expertise in our partner organisations to build a learning health and social care system.

The challenges current faced by our health and care system and the inequalities of outcomes experienced by our population, coupled with a financially constrained environment, mean that now more than ever we need to think differently, bring creativity and imagination to the problems we face, and apply learning more systematically to address the unwarranted variation in outcomes that exist for our population.

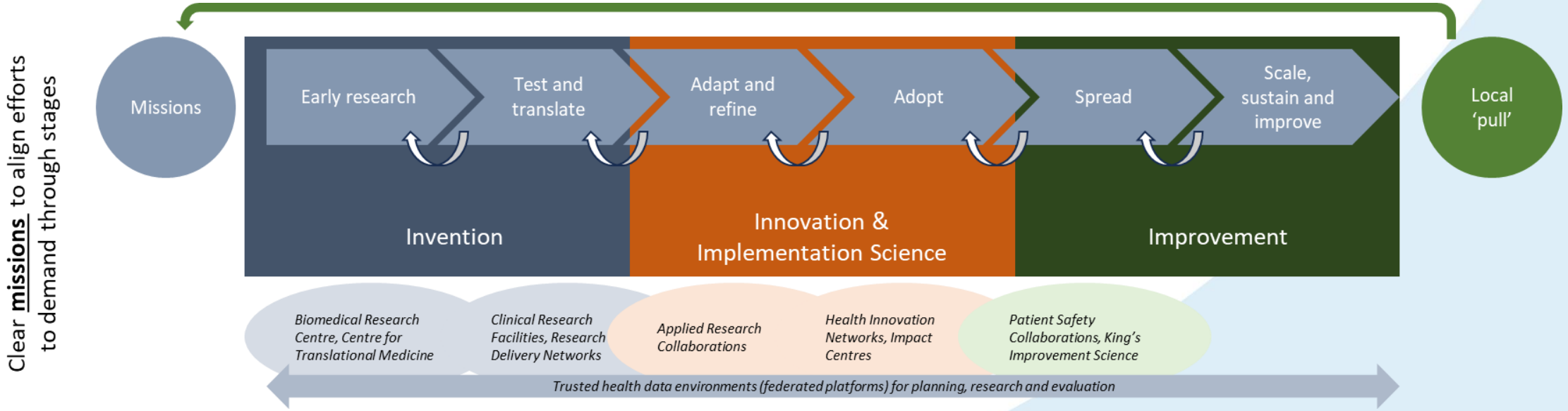
The physical and mental health needs and inequalities within our population in south east London will be best met if we utilise our collective resources with vision, focus, collaboration and strong leadership. We are working with our partner organisations to ensure we:

- Increase visibility of, and access to, research expertise and opportunities for our extended workforce and communities
- Increase research activity in primary care, social care and the voluntary, community and social enterprise (VCSE) sector
- Use research and best evidence to inform evidence based-practice and service design
- Understand priorities for research based on priorities outlines by our places based on robust data and population health management approaches
- Build a shared understanding of what outcomes we are trying to achieve, including those that matter most to our patients
- Better understand the value and impact of all that we do

Supporting research and innovation in South East London

Innovation is the adoption/deployment and scale-up into widespread practice of proven ideas that result in improved outcomes at a patient, pathway and/or population health level. These might be 'new or improved' health policies, practices, systems, products and technologies, services or delivery methods. This may also include validation work, and the establishment of innovation test-beds. Innovation (or adoption/deployment) activities will bring about most impact for the population, and the ICS, when there are some clear signals of what the ICS wants to focus effort on solving.

Across our Acute, community and mental health Trusts there are partners focused on supporting teams to bring innovations into care as well as our AHSN/Health Innovation Network. We will start to align our research, innovation, and improvement capabilities in a way that optimises impact, as illustrated in the current change model described by AHSNs across London:



Research and innovation- our objectives

Our key objectives – what we want to achieve over the next five years

Over the next five years we will achieve our ambitions to become a system where research and innovation is embedded in all that we do by:

- Working with our system partners to build a learning system where all those working in health and social care have access to the world-class expertise offered by our system partners. These include, but are not limited to: Kings Health Partners,, King's Improvement Science, the Health Innovation Network, Ask the Institute, the Applied Research Collaborative and the Clinical Research Network. We will also seek to develop partnerships with academic, public sector and VCSE organisations in SEL, particularly those who have relationships with our diverse communities.
- Creating a research-embedded system that will ensure that those delivering and designing services have access to the best available evidence, understanding of where there are gaps and opportunities to build an evidence base
- Attracting innovators from the public and private sectors to a system which celebrates innovation and the testing of new ideas and technologies tt the benefit of our patients and communities
- Focusing research and innovation activity on the population health needs of the communities we serve whilst also considering national health priorities and those areas which may attract funding and investment. A particular area of focus will be the priorities of our ICS Strategy.
- Making the best use of data, including that delivered by our data strategy and the London Data Services Blueprint to maximise the impact of research and innovation in our system.
- Working with improvement and transformation teams as well as patient and community organisations in our boroughs and partner provider organisations to deliver innovative and transformational local and system-wide changes to service delivery which address inequalities, improve the outcomes most important to patients and enhance cost-effectiveness
- Training our staff and broader health and social care community in research and improvement methodologies which support them in delivering high quality services into which continuous improvement is hard-wired

Our priorities for 2024-25

Embedding research into the ICB's activities and governance	We will establish a multidisciplinary senior leadership group with the authority to create greater strategic alignment between the ICS and research and innovation partners; commit on behalf of the ICS to a small number of priorities that reflect opportunities to benefit our population; and influence the development of key enabling condition. In the first instance we will establish a research board. This Research and Innovation Board will influence R&I activities by providing research teams and organisations with clear descriptions of the needs of the population in SE London and the priority areas of ICS
Build a learning health and social care system	Working with key system partners we will establish a framework for evaluation, ongoing learning and sharing of best practice. We will agree an approach with clear signposting to the most appropriate expertise and support. This will include problem definition, evidence review, identification of KPIs and outcome measures. We will seek to take a pragmatic approach to developing an outcome framework which represents the needs of our population and within which key metrics are shared across our system. We will test/pilot this framework in one of the ICB's major work programmes.
Maximising impact of our quality improvement resources	We will create closer collaborations between improvement and transformation teams to encourage a shared understanding of approach through our Quality Improvement Collaborative. We will seek to create conditions in which we can create a shared and systematic approach, underpinned by the principles of NHS IMPACT including shared purpose and vision, investment in our people, developing leadership behaviours, improving capability and embedding improvement methodology into management processes
Developing our people	We will continue to build on the success of the South East London Leadership Academy to develop a culture which supports and encourages improvement, transformation and research. We will reflect on the successes of our spread and scale programme, Create, to understand how we can maximise the impact of teams who are seeking to deliver innovative service transformation. As we refresh our clinical and care professional leadership (CCPL) community we will ensure that key enablers of innovation and data-driven improvement including population health management are developed and accessible, with particular emphasis on addressing health inequalities in our communities
Celebrating success, learning from failure	It is essential that we create forums where learning is shared and success is celebrated, but also where we break down siloes to encourage sharing of ideas between teams. Our redesigned CCPL framework will improve collaboration by ensuring visibility of roles but also by baking in connections between places, teams and programmes. We will also seek to promote research and innovation through meetings, webinars and, in June 2024, a joint innovation event hosted by the SWL and SEL ICBs and the Health Innovation Network

South East London Integrated Care System

Appendices

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to Promote Integration	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health-related or social care services, where this would: improve quality of those services reduce inequalities in access and outcomes	Yes	SEL ICB is committed to integrating health services, social care and health-related services to improve quality and reduce inequalities. Our JFP sets out actions to progress local integration through local care partnerships, building on our ICS strategy and JLHWS ambitions. We have a range of provider collaboratives to support horizontal collaboration and integrated approaches. Our care pathway programmes seek to ensure integrated end to end care pathways and our enabler board joined up approaches to enabling infrastructure, recognising there are further opportunities across all these areas.
Describing the health services for which the ICB proposes to make arrangements	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	Yes	Our Joint Forward Plan sets out how SEL ICB will meet the health needs of our population, across key pathway and population groups, reflecting work done at a system level and within our boroughs driven by our understanding of population health need, patient/public feedback and service challenges and opportunities. Our plans focus on all areas of ICB commissioned services with an integrated borough and end to end care pathway focus.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to consider wider effect of decisions	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the triple aim of: (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing) (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	Yes	SEL ICB is committed to the “triple aim” and our JFP includes sections covering our plans to reduce inequalities with respect to health and wellbeing, improve quality of services and ensure sustainable and efficient use of resources by NHS bodies.
Duty to patient choice	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	Yes	SEL ICB is committed to enabling patient choice and has a patient choice policy to underpin this commitment. All work and decisions around commissioning plans, contracting arrangements and delivery of services are completed within this framework, with a wide ranging portfolio of contracted providers to embed choice for patients. Engagement insights and coproduction are embedded into service development processes and we have a Working With People and Committees Strategy recently developed which provides a framework for how we engage, work with and coproduce plans with partners

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Financial duties	The plan must explain how the ICB intends to discharge its financial duties.	Yes	Our JFP includes a section on our medium term financial strategy. SEL ICB is committed to complying with the NHS England financial objectives, directions and expenditure limits, and progressing work to enhance productivity and value for money to ensure a sustainable cost base within the SEL NHS system. Our medium term financial strategy is focussed on our strategic approach to the allocation of the ICB's resources to support the delivery of our integrated care strategy and JFP objectives, plus an ambition around securing financial sustainability over this same period.
Duty to improve quality of services	Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness outcomes including safety and patient experience.	Yes	This is covered throughout the plan but specifically in the quality section outlining the shared commitment across the system.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to promote involvement of each patient	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to: (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	Yes	SEL ICB has multiple programmes of work to implement a comprehensive and consistent approach to Personalised Care which promotes the involvement of each patient in decisions about prevention, diagnosis and their care or treatment. The duty to promote involvement of each patients is covered in multiple sections including context, engagement, personalised care, Local Care Partnerships, and SEL
Duty to involve the public	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	Yes	SEL ICB has continued to undertake significant engagement with people and communities through the year, as set out in the engagement section of our plan. The ICB has a Working With People and Communities Strategic Framework in place which outlines our for building effective partnerships with people and communities. The ICB has developed a range of tools to support engagement including an online engagement platform, a People's Panel, approaches to community engagement and an engagement toolkit.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to obtain appropriate advice	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in: (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	Yes	The ICB has a range of structures for engagement and obtaining advice from partners e.g. Healthwatch and voluntary, community and social enterprise sector (VCSE). The formal governance fora also include a wide range of perspectives including clinical and care professionals to ensure appropriate advice is sought and considered in decision making processes. The ICB's Board includes a Chief Nurse, Medical Director and membership from providers including one nominated by primary care. To increase collaboration with public health and embed public health expertise in ongoing system-wide strategy development and implementation, the south east London Directors of Public Health will attend ICB Partnership Board and ICB Partnership meetings.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to promote innovation	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	Yes	SEL ICB works closely with a range of partners to promote local innovation. This includes work with Kings Health Partners and our Health Innovation Network, to support adoption and spread, with further work to develop our ICB approach to research and innovation.
Duty in respect of research	Each ICB must facilitate or otherwise promote: (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	Yes	SEL has a number of large provider organisations that are heavily involved in research and adoption of practice based on evidence generated through research, with clear links to our service planning and delivery to ensure we are optimising the opportunities to embed evidence based practice. SEL ICS is currently in the process of developing iand implementing ts research strategy and an evaluation framework.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to promote education and training	Each ICB must have regard to the need to promote education and training so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.	Yes	Education and training is an essential lever of SEL's integrated workforce strategy which aligns with the NHS Long Term Workforce Plan. A summary of the workforce strategy and how it supports delivery of services in the short, medium and long term is set out in our JFP.
Duty as to climate change	Each ICB must have regard to the need to: (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets) and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	Yes	SEL ICB is committed to the green agenda, minimising our environmental impact and achieving net zero. The sustainability section of our plan sets out the key actions as part of our plan.

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Addressing the particular needs of victims of abuse	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	Yes	Addressing the needs of victims of abuse is covered within the CYP section of our JFP. SEL ICB safeguarding policy covers the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions for both Adults and Children and Young People. As part of our statutory duties the ICB is committed to delivery of the Safeguarding Accountability and Assurance Framework and the following safeguarding programmes; Child Protection Information Systems, Female Genital Mutilation, Prevent, Working Together, Modern Slavery and Human Trafficking, Domestic Abuse and Liberty Protection Safeguards/Mental Capacity Act protections.
Addressing the particular needs of children and young persons	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	Yes	Our JFP includes a section on our plans related to Children and Young People (CYP).

Legislative Requirements

Legislative Requirement	Description	Status	SEL ICB Response
Duty to reduce inequalities	Each ICB must have regard to the need to: (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities.	Yes	SEL ICB is committed to delivering high-quality healthcare for all, through equitable access, excellent experience and optimal outcomes. Reducing inequalities is a golden thread throughout our JFP and contains specific objectives and priority actions to achieve this. Our plans set out our focus on the delivery and further development of integrated, holistic and personalised care. In addition our medium term financial strategy sets out an approach through which we will secure dedicated additional investment to target our work on reducing inequalities. SEL ICB complies with the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010.
Implementing any JLHWS	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	Yes	The plan has a section for each of our Local Care Partnerships which clearly references the alignment across the 6 boroughs

Glossary (1)

Abbrev	Description	Abbrev	Description	Abbrev	Description
A&E	Accident and Emergency Department	BCF	Better Care Fund	CQC	Care Quality Commission
ACP	Advanced Care Practitioners	BFI	Baby Friendly Initiative	CVD	Cardiovascular Disease
AHC	Adult Health Check	BP	Blood pressure	CYP	Children and Young People
AHSN	Academic Health Science Network	CAMHS	Children and Adolescent Mental Health Services	DASS	Director of Adult Social Services
AI	Artificial Intelligence	CDC	Community diagnostic centre	DES	Directory of Enhanced Services
ALD	Adult Learning Disability	CETR	Care Education Treatment Review	DSR	Dynamic Support Register
AHP	Allied Health Professional	CESEL	Clinical Effectiveness South East London	ECH	Eltham Community Hospital
APC	Acute Provider Collaborative	CHC	Continuing Health Care	ED	Emergency Department
ARI	Acute Respiratory Infections	CHD	Coronary Heart Disease	EDI	Equality Diversity and Inclusion
ARRS	Additional role reimbursement scheme	CKD	Chronic Kidney Disease	EHCNA	Education Health Care Needs Assessment
ASC	Adult Social Care	CMHS	Community Mental Health Services	ENT	Ears Nose and Throat
ASD/ADHD	Autistic Spectrum Disorder / Attention deficit hyperactivity disorder	COPD	Chronic Obstructive Pulmonary Disease	EPEC	Empowering Patients Empowering Communities
BAU	Business As Usual	CPES	Cancer patient experience survey	FIT	Faecal Immunochemical Testing

Glossary (2)

Abbrev	Description	Abbrev	Description	Abbrev	Description
G&A	General and Acute hospital beds	ICS	Integrated Care System	LCP	Local Care Partnership
GIRFT	Getting it right first time	INT	Integrated neighbourhood teams	LDA	Learning Disability and Autism
GLA	Greater London Authority	IPC	Infection prevention and control	LeDeR	Learning from the lives and deaths of people with learning disability and autistic people
GSTT	Guys and St Thomas' NHS Foundation Trust	IUC	Integrated Urgent Care	LFPSE	Learn From Patient Safety Events
HCAI	Healthcare associated infections	JFP	Joint Forward Plan	LGA	Local Government Association
HGP	Healthier Greenwich Partnership	JLHWS	Joint Local Health and Wellbeing Strategy	LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and other sexual identities
HVLC	High volume low complexity	JSNA	Joint Strategic Needs Assessment	LGT	Lewisham and Greenwich NHS Trust
HWB	Health and Wellbeing	JWA	Joint Working Agreement	LHCP	Lewisham Health and Care Partnership
HWS	Health and Wellbeing Strategy	KCH	Kings College Hospital NHS Foundation Trust	LIP	Local Implementation Plan
IAPT	Improving Access to Psychological Therapies	KCL	Kings College London	LMHS	Local maternity and neonatal system
ICB	Integrated Care Board	LA	Local Authority	LOS	Length of Stay
ICHM	Integrated Child Health Model	LARC	Long Acting Reversible Contraception	LTC	Long Term Condition
ICP	Integrated Care Partnership	LBL	London Borough of Lambeth	LWNA	Living Well Network Alliance

Glossary (3)

Abbrev	Description	Abbrev	Description	Abbrev	Description
MH	Mental Health	OD	Organisational Design	PTL	Patient tracking list
MDT	Multi-disciplinary Teams	PCN	Primary Care Network	PTSD	Post Traumatic Stress Disorder
MHMDS	Mental health minimum dataset	PEOLC	Palliative and end of life care	QEH	Queen Elizabeth Hospital
MMN	Maternal medicines network	PHB	Personal Health Budget	QMS	Queen Mary's Sidcup
MSP	Market Sustainability Plan	PHC	Physical Healthcare Check	QOF	Quality Outcomes Framework
MSK	Musculo Skeletal	PIFU	Patient Initiated Follow Up	SACT	Systemic anti-cancer therapy
MSW	Maternity support worker	PHM	Population Health Management	SDEC	Same Day Emergency Care
MTFS	Medium Term Financial Strategy	PMO	Programme Management Office	SEL	South East London
MVP	Maternity voice partnership	PODs	Pharmaceutical, general optometry and dental services	SELCA	South East London Cancer Alliance
NAPC	National Association for Primary Care	PReP	Pre-exposure prophylaxis	SEND	Special Educational Needs and Disabilities
NICE	National Institute for Health and Care Excellence	PROMs	Patient reported outcome measures	SLAM	South London and Maudsley NHS Foundation Trust
NVQ	National Vocational Qualification	PRS	Private Rented Sector	SLP	South London Partnership
NWL	North West London	PSIRF	Patient Safety Incident Response Framework	SMI	Serious Mental Illness

Glossary (4)

Abbrev	Description	Abbrev	Description	Abbrev	Description
STI	Sexually Transmitted Infection				
SWL	South West London				
TBC/D	To be confirmed / determined				
TLHC	Targeted lung health check				
UCR	Urgent Community Response				
UEC	Urgent and Emergency Care				
UKHSA	UK Health Security Agency				
UTC	Urgent Treatment Centre				
UTI	Urinary tract infection				
VCSE	Voluntary, community and social enterprise sector				