# Integrated Care Partnership

14.00 to 15.45, Thursday 25 July 2024

Venue: Room South Bank 2 Coin Street Community Neighbourhood Centre

Co-Chairs:

**Cllr Kieron Williams (KW)** - Leader, Southwark Council
**Richard Douglas (RD)** – Chair, South East London ICB

## Agenda

| No. | Item | Paper | Lead | Timing |
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| **OPEN 14.00** | | | | |
| **1.** | **Welcome and introduction** | | KS | 14.00 |
| **2.** | **Minutes of the previous meeting**<br>**Matters Arising** | **A** | KS | 14.05 |
| **3.** | **Operating context and planning round outcomes for Health and Local Government in SE London** | **B** | SC/PT | 14.10 |
| **4.** | **Our Integrated Care Strategy – progress in our context** | **C** | TG | 14.40 |
| **5.** | **Health and Housing Coalition** | **D** | RK/JL | 15.00 |
| **6.** | **VCSE Charter** | **E** | TR | 15.20 |
| **7.** | **Any Other Business** | **-** | KS | 15:30 |
| **8.** | **Questions from the public** | **-** | KS | 15.35 |
| **CLOSE 15.45** | | | | |

**Presenter**

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| SC | Sarah Cottingham | ICB Director of Commissioning and Improvement |
| TG | Dr Toby Garrood | ICB Chief Medical Officer |
| AB | Andrew Bland | ICB CEO |
| RD | Richard Douglas | ICP Co-Chair |
| PT | Peter Turner | London Borough of Bromley |
| BC | Ben Collins | Director of ICS Development |
| TR | Tal Rosenzweig | Director of Voluntary Sector Collaboration & Partnerships |
| RK | Ranjeet Kaile | Director of Communications and Engagement |
| JL | Jessica Levoir | AD of Partnerships Social and Economic Development and Transformation |

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# Integrated Care Partnership

**Minutes of the meeting on 8 February 2024**
**Bromley Central Library, High St, Bromley BR1 1EX**

**Present**:

| Name | Title and organisation |
|---|---|
| Richard Douglas | Chair, NHS South East London ICB |
| Charles Alexander | Chair Guys and St Thomas's NHS FT |
| Jane Bailey | Chair King's College Hospital NHS FT |
| Mike Bell | Chair Lewisham and Greenwich NHST |
| Andrew Bland | Chief Executive Officer, NHS South East London ICB |
| Joseph Casey | Director, Partnerships and Programmes Kings Health Partners |
| Cllr Jim Dickson | Cabinet Member for Healthier Communities, LB Lambeth |
| Cllr Claire Holland | Leader of Lambeth Council |
| Sir Norman Lamb | Chair of South London and Maudsley NHS Foundation Trust |
| Catherine Mbema | Director of Public Health, LB Lewisham |
| Cllr Baroness Teresa O'Neill | Leader of Bexley Council |
| David Quirke-Thornton | Strategic Director, Children's and Adults Services Southwark Council |
| Cllr Denise Scott-McDonald | Cabinet Member for Health and Adults' Social Care, Greenwich Council |
| Folake Segun | Director South East London Healthwatch |
| Dr Helen Tattersfield | Primary Care Services Representative |
| Andy Trotter | Chair Oxleas NHS FT & London Ambulance Service NHS FT |

**In attendance**

| Name | Title and organisation |
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| Paul Larrisey | Chief Nurse, South East London ICB |
| Sarah Cottingham | Deputy CEO and Director of Planning, South East London ICB |
| Mike Fox | Chief Finance Officer South East London ICB |
| Nicola Noble | Co-Head Teacher at Surrey Square Primary School |
| Stuart Rowbotham | Place Executive Lead Bexley |
| Nick Davis | Deputy Director Health and Adult Services Greenwich |
| Ben Collins | Director of ICS Development South East London ICB |

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| **1.** | **Welcome** |
| 1.01 | Richard Douglas welcomed members to the meeting. |

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| 1.02 | Apologies were received from Cllr Kieran Williams, Cllr Colin Smith, Cllr Paul Bell, Michael Nutt, Tal Rosenzweig, Dr Taj Singhrao, Stephen Kitchman, Cllr Anthony Okereke, Mayor Damien Egan |
| 1.03 | The minutes of the meeting on 26 October 2023 were **approved** as a record of the meeting. |
| 1.04 | The matters arising were noted. |
| **2** | **Update on Social Care** |
| 2.01 | Stuart Rowbotham introduced an update on social care by noting significant financial issues for many local authorities, even those perceived as well-run financially and a question to resolve about the long-term vision for adult social care funding despite several reports, commissions and white papers. In south east London the directors of adult social care worked well together on cross-authority co-operation to share and scale best practice, despite different start points and limited capacity but with more to do. A bid for a small amount of accelerator funding had been submitted by Bromley colleagues on behalf of the six local councils which it was hoped would assist work on priorities The paper outlined key areas such as workforce and vacancy issues which particularly affected re-ablement – a crucial service to restore people's independence. Discharge issues were often perceived to be entirely adult social care issues, but the pressure across pathways was creating significant extra cost to social care. Children and young people's care often involved intensive support was a significant cost. Continuing healthcare, a potential source of friction between health and care in fact generally worked well in south east London although there was discussion about how to work with constrained administrative resources. |
| 2.02 | Nick Davis drew attention to work beyond discharge on prevention and safeguarding and new approaches using assistive technology. Integrated workforce models may help address challenges in the area and coordinated management of the continuing healthcare markets may help address common challenges. |
| 2.03 | David Quirke-Thornton pointed out that the six boroughs facing similar issues in social care and the potential solutions could also be similar. In the context of Care Quality Commission oversight of social care and the restart of inspections it was important to emphasise the benefits and importance of integrated working and not create incentives for adult social care to work in isolation from the rest of the system. Additionally, recent letters announcing funding had required to submit plans to ensure best use of taxpayer's money particularly in reference to 'discredited equality, diversity and inclusion programmes', this meant authorities had a difficult balance to meet public sector equality duties as well as accessing needed funding.<br>There was variation in continuing health care across boroughs and between children and adults, alongside some improvements and good practice it would be useful to learn from perhaps with a team at south east London level to enable colleagues to make good decisions in the best interest of residents. |
| 2.04 | Mike Bell welcomed more detail about how boroughs share of £500m extra funding would be used noted that the Accelerator application was to be welcomed as well as existing work to share good practice. There was variation in the discharge performance of the main boroughs interacting with Lewisham and Greenwich NHS trust and sharing of best practice would be useful. CHC would be a good area of opportunity to equalise practice and approach between boroughs and between health and care organisations. David Quirke-Thornton noted each borough would receive roughly £3m to be allocated across children and adults services, in most cases evenly except where there was particular pressure on childrens services. An expectation had been set in the letter that |

special education needs and disabilities would benefit from the funding.

2.05 Folake Segun asked when making workforce decisions to considering the value impact of early intervention to by social care volunteer to help prevent people reaching crisis. Stuart Rowbotham agreed on the importance of VCSE organisations who delivered nearly all prevention work in Bexley and via a consortium delivered nearly a third of care act assessments. Nick Davis added that in Greenwich on volunteer and prevention point investing in live well infrastructure I think have a look at all of our initiatives across south east London and see where it could be better to join up and do more. Unpaid carers were an increasingly crucial support for residents particularly coming out of hospitals and other care and needed as much support as possible including joint efforts across the boroughs and health and social care. Mike Bell reiterated the importance of work on unpaid carers and suggested further attention on this area.

2.06 Cllr Jim Dickson highlighted the importance of realising the opportunities of working as an Integrated Care System, pointing to great work being done around discharge across the six boroughs as well as admission avoidance. Approaches such as use of AI to predict patterns of falls and prevent them, and in Lambeth re-organise domiciliary care around local care networks were opportunities to share good practice.

2.07 Sir Norman Lamb asked whether there was an opportunity working across health and care to more collectively confront the situation in adult and social care, given pressures in social care had significant consequences for the NHS.

2.08 Andrew Bland noted that the ICB had been required to implement 30% reductions to management costs, and had taken the opportunity to for a separate review of continuing healthcare administration in line with some of the other opportunities for improvement and working together. A discharge group across south east London had been meeting regularly and developing a discharge improvement plan, although some trusts interfaced with a much wider range of local authorities for example up to 14 in the case of Guys and St Thomas NHS FT.

2.09 Sarah Cottingham noted despite good work and investment by the discharge group on common areas of working together there remained some stubborn issues. Potential areas to explore were genuinely integrated approaches which had delivered well in the past both with financial and non-financial benefits. Greater consistency of policy, pathways, paperwork and applications across the six borough would be helpful and there ought to be greater focus on parity between mental and physical health in relation to discharge. The system could consider whether the best return on investment in discharge was being obtained and consider whether challenges faced by all boroughs in relation to particular population groups such as people with dementia, complex needs, and homelessness may be amenable to shared approaches.

2.10 David Quirke-Thornton suggested that local care partnership health and care plans showed a focus on similar areas and there was progress in working across boroughs. Despite efforts however many residents experienced a quite disconnected system where they had to tell their story over and over again to different colleagues working in the system who did not have access to the information that they needed. There was scope for focused decisions on further integration to explore what areas could be reconstituted as a single whole to make the work easier for colleagues and better for residents.

2.11 Sir Norman Lamb pointed out the obligation on partnership to use the resources in the best possible way for the people of South East London, and suggested partners could usefully challenge themselves whether current spending decisions would still be made

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| | if there was a single shared budget and whether more could be done. |
| 2.12 | Richard Douglas summarised the calls of members for more work on possibilities for integration a consideration of any further system wide actions that could be taken on continuing healthcare and discharge. |
| 2.13 | The Integrated Care Partnership **noted** the update. |
| **3** | **Our Integrated Care Strategy** |
| 3.01 | Dr Toby Garrood reminded the partnership that following the development of the integrated care strategy in partnership with communities and colleagues across south east London, some high level proposals for interventions had been brought to the partnership, importantly together with the metrics and outcomes that would measure success:<br>• Prevention and wellbeing – objectives to delivering primary prevention to the most disadvantaged communities would be shown by increased uptake of services by those in most disadvantaged communities.<br>• Early years - the aim to support mums, babies, and families with high vulnerabilities effectively in the first 1,001 days of life would be assessed against data on safer births, fewer complications for families and improvement on the key measures of a good start in life.<br>• Children and young people's mental health – the work to support children's emotional well-being, common mental health challenges would be demonstrated if fewer children developed emotional and mental health problems in disadvantaged neighbourhoods through such measures such as higher school attendance.<br>• Adults' mental health- access to rapid and effective early support for common mental health and social challenges would be shown by fewer people from disadvantaged groups experiencing worsening mental health or entering crisis.<br>• Primary care and long-term conditions – the aim to provide joined-up support would be shown if more people with long-term conditions and people with complex health and social needs reported a positive experience of care, living independently and enjoying good lives. |
| 3.02 | Andrew Bland summarised for the partnership a challenging NHS planning context although guidance continued to be released the challenges and areas of investment required would be significant. The ambitions of the medium term financial strategy in relation to prevention would be maintained but there may be a need to consider the pace of progress in view of this context. |
| 3.03 | Ben Collins outlined some of the approaches which were working well already within the system and beyond could be scaled in relation to each strategic priority:<br>• Prevention - Community health workers, local people hired to support people in deprived neighbourhoods with a range of health and social needs.<br>• Early Years - Intensive generalist approaches to supporting mums and babies and families with the highest vulnerabilities.<br>• Children and Young Peoples mental health - Family zones to support children with families living in disadvantaged neighbourhoods.<br>• Adults Mental Health VCSE and peer-led, socially-orientated approaches to supporting adults with common mental health challenges.<br>• Primary Care and Long term conditions - test case models of integrated neighbourhood teams working in disadvantaged neighbourhoods.<br>Each had been scoped into firmer proposals and projects for a minimum initial period of two years at around £130,000 to £200,000 per project per year, allowing scope to adapt the programme to fit different funding envelopes. Local care partnerships would have the |

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| | flexibility to develop their own projects building on the evidence found, providing an opportunity for collaboratives to learn together, orient care around specific neighbourhoods with provide person-centred support. |
| 3.04 | Nicola Noble described the work of Surrey Square primary school, which served an area where 84% of children were in the highest deprivation index, 25% of children lived in temporary housing and around 10% of the school community had no recourse to public funds. The school was a primary member of the Big Education trust created advocate measurement of schools against a broader range of the areas that children needed to succeed in life beyond academic performance. The school focused on the core of taught values rather than rules and well-being, skills and relationships. This was delivered by a staff whose own wellbeing was prioritised in policies and practices resulting in well above average retention rates and reported wellbeing. Children were taught how to demonstrate values rather than following rules and 25% of school curriculum time was focused on the well-being which would support development of crucial reading, writing, mathematics, and oracy skills. Learning about healthy foods and weekly journalling and pastoral meetings were backed up by specialist support and a family and community co-ordinator. Children's scores on wellbeing and anxiety, alongside academic achievement, demonstrated the value of the approach. |
| 3.05 | Projects in the local community were focused on doing things *with* the community in recognition that previous attempts to do things *to* the community had failed. A community board of 10 local parents and 12 organisations helped to allocate resources and time and celebrate and scale local ideas. These included a marketplace to provide support to families outside school hours, a youth club for year 5 to year 8 children, a fine dining experience in partnership with industry chefs, and a weekend away with child care and coaching and career support for children. The youth-club now involved 60 children every Friday and the marketplace attracted 350 per month, partnering with the NHS to offer vaccinations, healthchecks and signposting to services. The community restaurant provided training to local people and future partnerships with business aimed to allow local people opportunities for careers and starting their own businesses. |
| 3.06 | The data to measure the impact was imperfect but best illustrated by the effect on individuals, who affected all the people connected with them. An example was shared of a single mother experiencing mental health issues who was able to find a sense of belonging, as well as employment and childcare support and able to stop medication and benefit others in the community who had worried about her. |
| 3.07 | Dr Toby Garrood asked how impact was measured and data used to pick up children with developing mental health issues. Nicola Nobles noted that since the pandemic the data developed on wellbeing and anxiety had been tracked alongside academic performance, with a view of identifying issues, measuring the impact of interventions. The school believed this work would avoid children seeking support for mental health and other issues in the future. |
| 3.08 | Cllr Jim Dickson asked that when scaling the project in places care was taken to ensure the impact of investment was measured and that it fitted in with local place initiatives. Ben Collins noted that the proposals were in line with local care partnership priorities, so the next step was to ensure that the local care partnerships felt ownership whilst agreeing to some minimum criteria. |
| 3.09 | Sir Norman Lamb advocated that the small investment in schemes of this be maintained rather than retreat in the face of other financial challenges given their relationship to the purpose of integrated care systems. Andrew Bland noted that the organisations represented on the partnership had the opportunity to work to this end during the planning round. |

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| 3.10 | Jane Bailey emphasised importance of measuring long term outcomes pointed out National Institute for Health and Care research had developed useful research on improving life expectancy of those with multiple health conditions and also addressing health inequalities. It was also important to use acute trusts effectively to support for example by identifying families who could benefit from the initiatives. Dr Toby Garrood agreed that there was a wealth of resource available in south east London and an opportunity to bring in academic rigour to evaluative approaches. |
| 3.11 | Mike Bell paid tribute to those that time been involved in the work groups to develop responses to each of the strategic priorities and commented that the funding was small in comparison to the total overall budget and it was important to keep focus on the key goal of shifting resources permanently into these sorts of activities even if some reprofiling the medium term financial strategy was necessary. Philanthropy was key and there were assets available from a range of charities as well as the scope of using social impact bonds to accelerate and ensure the focus remained upon measuring the outcomes through evaluation. |
| 3.12 | Cllr Denise Scott-McDonald asked for continuing work with the local people, noting that during Covid online engagement had revealed a whole communities of people who had never previously engaged in face to face events illustrating the need to continue to try and reach people in their neighbourhoods. |
| 3.13 | Folake Segun recalled the intention expressed to 'do things differently' when developing the strategy, and suggested this could be achieved through community-led approaches that the Surrey Square example showed were more effective. |
| 3.14 | Richard Douglas thanked all those involved in developing the proposals and the work. |
| 3.15 | The integrated care partnership **supported** the work outlined. |
| **4** | **Questions from the Public** |
| 1.01 | *A member of the public advocated for people with very complex health needs, for example people with spinal cord injuries supported by the Back Up Trust, pointing out that care packages and hours of support had been slashed. Many people required two carers to help with washing for example, and when moving properties across boroughs often had to start from scratch navigating the bureaucracy to set up their care packages which was a waste of money and time. It was frightening and destructive to family structures for people with complex needs if they had to move to care homes if councils could not afford to be kept in the community independently.* |
| 1.02 | David Quirke-Thornton acknowledged the experience of people referred to, noting that there was an opportunity for greater integration and listening to local people to improve. The Care Act applied universally across England to eligibility thresholds and assessments, but some boroughs had different arrangements sometimes focused on reducing the number of double handed packages of care by use of adaptations and equipment. The financial pressure on local authorities had led to some court cases in other areas of the nation around whether people could be care for at home. In south east London colleagues had strong views and focused on equity and enabling people to live at home. |

South East London
Integrated Care System

# Integrated Care Partnership

## Item 3
## Enclosure B1

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| **Title:** | **NHS 2024/25 Planning - Outcome of the planning round, key issues, risks and mitigations** |
| **Meeting Date:** | 25th July 2024 |
| **Lead / Contact:** | Sarah Cottingham SEL ICB Director of Planning |
| **Authors / Contributors** | Sarah Cottingham SEL ICB Director of Planning |

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| **Purpose of paper:** | The purpose of this paper is to provide a summary and overview of the outcome of the 2024/25 operational planning round for the NHS in south east London. | **Update / Information** | X |
| | | **Discussion** | X |
| | | **Approval** | |
| **Brief summary of the paper** | It provides details of the planning context, expectations around planning outcomes for 2024/25, the ICB's final operational plan for the year, a consideration of issues, risks and mitigations plus a forward look to 2025/26.<br><br>It is intended as a contextual briefing which will, when put alongside the equivalent assessment of the position and outlook for SEL's Local Authorities with regards social care, enable the Integrated Care Partnership to consider the operating environment and challenges our health and care economy is facing for 2024/25 and beyond | | |
| **Recommendation:** | To receive the briefing | | |

# 2024/25 NHS Planning

## Outcome of the planning round, key issues, risks and mitigations

## South East London Integrated Care Partnership (ICP) 25 July 2024

### 1 Purpose of the paper

1.1 The purpose of this paper is to provide a summary and overview of the outcome of the 2024/25 operational planning round for the NHS in south east London.

1.2 It provides details of the planning context, expectations around planning outcomes for 2024/25, the ICB's final operational plan for the year, a consideration of issues, risks and mitigations plus a forward look to 2025/26.

1.3 It is intended as a contextual briefing which will, when put alongside the equivalent assessment of the position and outlook for SEL's Local Authorities with regards social care, enable the Integrated Care Partnership to consider the operating environment and challenges our health and care economy is facing for 2024/25 and beyond.

### 2 2024/25 planning context

2.1 The SEL health economy had a challenging 2023/24, driven in the main by:

- An ambitious start year plan, particularly related to the level of financial savings required over the year to meet our system break even financial plan.
- Operational delivery pressures which resulted in increased costs being incurred, for example across our emergency care pathway, in relation to mental health bedded demand and in the need to manage waiting lists through increased utilisation of the independent sector.
- A number of issues in year that impacted on operational delivery and cost. Key was the implementation of Epic, the new patient record system at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. This represented a major transformation programme, with associated impact on operational bandwidth but also resulted in reduced activity over the second half of the year. In addition, Industrial Acton impacted more widely across a number of providers, again impacting on organisational bandwidth but also resulting in an activity, performance and budgetary impact.

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- These factors exacerbated our already challenging financial, operational delivery and performance position and also inhibited our ability to secure and offset the benefit of productivity and efficiency improvements and cost reductions. This resulted in our year end position being worse than anticipated at the start of the year in relation to the level of activity undertaken, finance and performance.

2.2 The 2024/25 planning context for south east London was therefore difficult, noting too the national expectation of year-on-year improvement around financial delivery and performance. National guidance set out a number of key objectives including:

- An expectation that systems secure a break-even financial plan for 2024/25, whilst also adhering to a number of requirements associated with the allocation of resources, such as the Mental Health Investment Standard.
- Improved performance across a number of key metrics, focussed particularly on waiting times for Accident and Emergency services, elective Referral to Treatment Times and cancer but also covering a range of wider targets across primary care, community and mental health services. .
- A requirement that systems demonstrate ambition around activity planning and improving productivity and efficiency, with a specific focus on the balance across workforce and activity growth, noting that since Covid workforce has growth at a greater rate than activity, leaving a productivity gap or challenge to be addressed.

## 3 2024/25 planning round outcome

3.1 National planning guidance was issued for the NHS at the end of December 2023 with a series of planning submissions made by ICBs and their NHS systems over Quarter 4 and in to 2024/25. This included near final 2024/25 operational plans submitted by systems to the national team on 2 May. These set out planned activity, performance, workforce and financial plans for this year, with our plan comprising an aggregated SEL ICB/system plan plus organisational plans for our five major NHS providers.

3.2 Meetings with all systems were held with the national and regional team at NHS England in mid-May to review the submissions and agree any changes, to enable any final plans to be secured and endorsed. The SEL ICB plan was recognised to be challenging in terms of the underlying and stretch improvement assumed. The second cut performance and activity plans were endorsed on this basis, noting that our year end trajectories do not meet national standards in all cases, but do assume a material year on year improvement across all key target areas. Key headlines in terms of the activity and performance commitments made by the SEL system are as follows:

- Delivery of the national standard for Accident and Emergency four hour waiting times of 78% by March 2025, with some variation by provider/site within this overarching position. The plan for each provider/site includes an assumed material year on year improvement, recognising that Accident and Emergency performance will require action to manage demand and improve flow across the whole of the urgent and emergency care pathway.
- A significant improvement on our referral to treatment maximum wait position with the elimination of 78-week waiters at the end of Quarter 1 and improvement in our over 65 week waiter position over the year. Our plans do not however support the full elimination of over 65-week waiters, in the context of some significant specialty

challenges in south east London which we are working to resolve through sustainable demand and capacity solutions.

- A significant improvement in our cancer performance, including delivery of the 28-day Faster Diagnosis Standard. Whilst our 62 day waiting times position will also improve the complexity of shared care pathways in south east London means that we will not secure full compliance over this year across all providers.
- A commitment to delivering the activity targets set nationally for our system in support of elective recovery.
- Further commitments around improving access and waiting times for other areas across community-based care and mental health, including significantly reducing the number of mental health out of area placements.
- These commitments rely upon us managing demand and flow effectively, including maximising community-based alternatives, improving productivity and efficiency and supporting care pathway improvement and transformation opportunities.

3.4. On finance a £100m deficit plan has been agreed for the SEL system for 2024/25. This is away from the national objective and requirement for each system to secure a financially balanced plan and break even in terms of its revenue position. It does however represent a plan that demonstrates both a very material improvement from first cut to final plan and a significant commitment around improvement, including:

- The application of strict organisational and system cost controls to ensure we are managing expenditure over 2024/25.
- Ambitious cost improvement plans that assume the delivery of a minimum 4% of influenceable spend by organisation over 2024/25.
- A plan that secures improved productivity and efficiency over the year, through driving up activity and reducing workforce, thereby starting to address our current productivity gap and opportunity.
- Managing the impact of national funding adjustments and particularly the convergence factor that reduces growth available to those systems that are currently over target with regards allocation and spend compared to benchmarked expectations.
- The containment of inflationary and other cost pressures.

3.5. Securing our agreed plan for 2024/25 has however also required some difficult decisions with regards the use of the ICB's allocation. Our plan maximises income to the provider sector from the SEL ICB, which means we have deferred a number of planned investments in discretionary areas. The most significant area of impact relates to targeted investment in inequalities, where we have been unable to retain the additional funding, we had originally planned to invest in new initiatives for 2024/25. This represents a departure from the aspirations set out in our Medium Term Financial Strategy and represents an opportunity cost in terms of investment we would otherwise have been able to make.

3.6. In the positive we have been able to retain an uplift for mental health to reflect an above average investment to meet the Mental Health Investment Standard, have retained ring fenced dental spending. We have also retained planned uplifts for community based care services, albeit with some planned slippage on our in year investment. In developing our plans we have also triangulated our activity, performance and finance

plans to ensure our financial position and plans will support the delivery of these wider commitments.

3.7. The planning process has been both complex and challenging. It has required significant input from a wide range of system partners alongside the development of and commitment to underpinning plans associated with performance improvement, activity and capacity planning, workforce and financial delivery.

3.8. We are now just over a third through the year so have been implementing these plans we will be endeavouring to meet them and secure the best possible outcome for residents over the year ahead. As highlighted in the section below we have already faced a number of unplanned issues and challenges, which when combined with the risks inherent in the ambition included in our start plan, mean a particularly challenging year ahead.

## 4 Key issues, risks and mitigations

4.1 Our plans did not assume any impact of Industrial Action. We have already experienced some industrial action in 2024/25 and this will have an impact on activity, performance, cost and income which we will be tracking and quantifying. Given our overall capacity, workforce and financial constraints the flexibility to mitigate the risks through increasing activity to manage the impact of industrial action is likely to be limited.

4.2 Furthermore, the cyber-attack on SEL's pathology provider has and will have a significant impact across all areas of provision, including primary care, community, mental health services and acute services. This includes impacts on activity, performance and waiting times, noting managing the incident will also impact on cost. Our restoration plan is focused on ramping up capacity back to pre incident levels across both pathology and impacted services, but it will take time to fully restore, and backlogs will have built up as a result. We will need to work through the pace of recovery in the context of available options given the capacity and wider constraints outlined above. The incident has had a further significant impact on organisational bandwidth which is likely to result in some delays in taking forward our plans around the delivery of our operational plan, particularly productivity and efficiency and care pathway improvement and transformation.

4.3 More broadly the ICB and system partners have plans in place that underpin the delivery of our operational plan commitments, including performance and cost improvement plans. We have established mechanisms through which these are monitored to enable timely mitigating action to be identified and secured.

4.4 We have recognised as a system that we need to plan for the medium rather than the short term with the specific objective of securing plans that support the delivery of a sustainable SEL health system. The key area of focus will be financial sustainability but the identification and testing of options will include a focus on the sustainable delivery of high quality and high performing health services that are responsive to the needs of south east Londoners and the wider populations served by our providers.

4.5 The Integrated Care Board has established an NHS System Sustainability Group, led by our Chief Executives, to drive forward this work over the coming months. The objective is to identify medium term proposals that will inform our planning for 2025/26 and beyond, with a clear emphasis on system structural and service changes alongside our historic

focus on organisationally focussed cost improvement plans. This approach recognises that the scale of the challenge is such that individual organisational solutions will be insufficient to support a sustainable NHS for the future.

## 5 A forward look to 2025/26 and beyond

5.1 Our 2024/25 outturn, across all the key delivery domains of activity, workforce, performance and finance, will be key to the outlook for 2025/26 and beyond. We are therefore focussed on ensuring the best possible outturn position, recognising the risks involved in doing so.

5.2 The outputs from our system sustainability work will be key in securing the additional layer beyond organisational cost improvement approaches that will be required if we are to make material inroads into our underlying deficit. It will be important to ensure that alongside a consideration of cost drivers and opportunities we embed approaches that take due account of population health, care pathway transformation, productivity, and efficiency. We will need to work to identify quick wins and actions that we can take forward for 2025/26 and beyond, recognising this will be a multi-year approach and programme but one which will need to demonstrate benefits realisation as we progress.

5.3 We have also initiated a review of our current Medium Term Financial Strategy (MTFS) , recognising that the ambitions set out within it around rebalancing our investment towards community based care, mental health and children and young people remain as does our commitment to ensuring targeted investment to support inequalities. The outcome of the 2024/25 planning round has impacted on the pace and scale of delivery. Our MTFS refresh will include a rebasing of the 2024/25 position and forward modelling and a reconsideration of our allocative strategy in that context, recognising the imperative too of securing a plan that gets south east London to a break even position financially whilst securing the effective delivery of national performance standards and other targets. We will further review the scope of the commitments made in our Joint Forward View to ensure the continuation of strategy driven allocative approaches as part of our refresh.

5.4 Whilst the scope for additional or new investment in year and potentially going forwards has reduced there remains significant investment across our NHS services and scope for supporting change and improvement through using our existing resources and assets differently. This will be important in maximising the opportunities for change and improvement in the context of our financially challenged position.

South East London Integrated Care System

# Integrated Care Partnership

**Item 3**
**Enclosure B2**

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| **Title:** | **Adult Social Care – 23/24 Outturn and system pressures** |
| **Meeting Date:** | 25th July 2024 |
| **Lead / Contact:** | David Quirke-Thornton – Strategic Director, Children's and Adults Services. London Borough of Southwark<br>Peter Turner. Director of Finance. London Borough of Bromley |
| **Authors / Contributors** | Ian Buchan, Programme Lead SEL DASS Group |

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| **Purpose of paper:** | To update the ICP on the current pressures in local authorities and particularly in adult social care departments in South East London.<br><br>To explore these challenges as a partnership and how the partnership might respond in a collaborative way to secure solutions which support the whole system. | **Update / Information** | |
| | | **Discussion** | X |
| | | **Approval** | |
| **Brief summary of the paper** | Local authorities have to by law set and maintain a balanced budget but currently they have a number of challenges which make this a complex and very challenging task. This paper sets out the outturn position of the SE London boroughs for 23/24 prior to one off funds and reserves being applied to ensure the local authorities maintained a balanced position. It focuses on particular pressures relating to adult social care, however wider significant pressures persist in relation to Children's Services, temporary accommodation and meeting wider statutory duties.<br><br>1. Local authorities managed a range of cost pressures in 23/24 which will feed into the ongoing budgetary pressures for 2024/25 and beyond.<br>2. The budgetary pressures in Adult Social Care stem from,<br>a. The demand for higher than budgeted for, inflationary uplifts from care providers.<br>b. The increased costs of care homes beds, coupled with the lack of capacity locally to meet demand, particularly for those with complex care needs.<br>c. We have seen an increase in residential and nursing home placements following a hospital discharge in several boroughs, with particularly high costs associated with dementia care.<br>d. Workforce challenges in the recruitment, retention of staff and the use of agency staff when this is not possible, qualitied social workers and occupational therapists post are most affected.<br>e. The high cost of care arrangement for those transitioning into adult social care services from Children's. | | |

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| | f. The increased acuity and numbers of people accessing support, particularly from hospital requiring higher cost care packages and placements.<br><br>3. Cost pressures for local authorities in meeting its responsibilities under housing legislation and the associated costs of a higher use of temporary accommodation and higher market costs in meeting these responsibilities.<br><br>4. Cost pressures from the increased demand in Children Social Care, as they respond more positively to the support needed by children and young people who are neurodivergent and SEND. |
| **Recommendation:** | **The Partnership is asked to:**<br><br>I. Consider the opportunities to work across boroughs and accelerate the Integrated Neighbourhood Based Care (Fuller) to improve health outcomes and reduce admissions, by coordinating this with work the Accelerating Social Care Reform Fund Programme is doing so we can work in a more joined up way across our local authorities and 'Places' to realise the benefits and efficiency this would bring.<br><br>I. Identify further opportunities for integration and workforce development.<br><br>II. Explore urgently how we might collectively increase access to therapies and support for people in the community to help earlier identification of individuals with care and support needs and therefore increase levels of independence, reduce admissions to hospital, as well as increases people's independence and self-care in the longer term.<br><br>III. Work together to get better access to psychological support to assist in the planning of discharges for individuals with complex and challenging needs related to dementia etc. To improve decision making and identification of the most appropriate care on discharge.<br><br>IV. We welcome the inclusion of a Director of Adult Social Care in the Continuing Health Care Review process so we can work as a system on ensuring people get the right care from the right organisation, and have their rights protected. |

# South East London Integrated Care Partnership

# Adult Social Care – 23/24 Outturn – 24/25 Context and system pressures

## 1. Introduction

Local authorities have a duty to set and maintain a balanced budget and are not allowed to carry forward a deficit. Therefore, with the current demands and no significant new money into the system in the long term, they are having to carefully consider how they manage and respond to the range of issues identified below. 23/24 saw a use of reserves and one off funding to offset the overspend positions of local authorities and adult social care departments. This is clearly unsustainable in the long term and creates risks for future years.

We note that all partners are challenged financially, and the only solution will be to work together to identify those residents who will benefit the most from early support and increase their independence/ self-care, and thereby reduce demand on the system in the long term. Opportunities to work with partners on early interventions in the community, alternatives to acute care, and the discharge of people with complex needs and circumstances needs further discussion.

## 2. National policy context

The Government's adult social care reform white paper, 'People at the Heart of Care' set out a 10-year vision for care and support in England based around three key objectives:

1. People have choice, control, and support to live happier, healthier and independent lives
2. People can access outstanding quality and tailored care and support delivered by a skilled and valued workforce in an integrated health, care, and community system.
3. People find adult social care fair and accessible, fees are transparent, information and advice are user-friendly, and no one is subject to unpredictable and unlimited care costs.

Many of the ambitions of 'People at the Heart of Care' were not taken forward by the last Government and funding for reform was re-purposed to prevent the system falling over. The new Government have so far said relatively little about their plans other than the need for a 10-year plan and ambition to work in partnership to agree a Fair Pay Agreement.

The Care Act 2014, The Mental Capacity Act 2005, The Mental Health Amendment Act 2007, along with Equality and Human Rights Legislation set out the basis for the work local adult social care departments do.

These acts of parliament set out the role local authorities should take in their localities and defines a range of duties and responsibilities they have in supporting their populations. The Care Quality Commission (CQC) will 'assure' all local authorities against these duties and responsibilities by Autumn 2025. The CQC have commenced their assurance process for Adult Social Care nationally, which so far is focusing in London on local authorities in the north west and north central London sub regions. All local authorities in SE London are working to prepare for the CQC Assurance Process which is placing additional demands on staff.

## 3. Local Authority Context

Social care across children's and adults' services makes up the majority of Council budgets (approximately 65-70%) and will need to find efficiencies in order to achieve a legally balanced budget this year.

Adult social care funding has not kept pace with changing demographics, the increase in demand for services to respond to complex needs and the cost of services in general, so we are starting from a large deficit position. Where we have welcomed additional funding, it has been used in the areas as directed such as hospital discharge etc.

Local authorities report three areas where they see ongoing cost pressures generally,

1. Children and Young People social care, particularly in responding to the needs of young people who are neurodivergent as we respond to the historically poorly understood group, as well as those young people with special educational needs and disability.

2. The challenge of Homelessness and the increased demand for temporary accommodation and associated costs of accommodation in London.

3. Adult Social Care (ASC) – the areas ASC see pressures are detailed below.

    a. Fee rate increases – while inflation has come down, we have failed to see the benefits of this in the care markets, as the increases in wages has been high and have a direct impact on fee rates. It is driven by the increases to the National Living Wage of 9.8% in April 2024, and the London Living Wage of 10.04%. As staffing in care market makes up the majority of the unit price, with contracted care and support being the largest element of our budget, this is a significant cost pressure for all local authorities.

    b. The cost and availability of care home placements have been an issue for most local authorities over the last year, not just due to the wage increases for staff. As of the 15th July 2024 in South East London there were only 48 dementia nursing beds available, with many in homes at fee rates above what we would usually pay, or homes unwilling to take further residents with complex needs due to the high level of need they are already supporting, resulting in placements outside of the local area, at higher costs.

    c. We have seen an increase in residential and nursing home placements following a hospital discharge in several boroughs, with particularly high costs associated with dementia care, for the reason detailed above.

    d. Staff vacancy levels in some boroughs continue to impact us, despite work done to address this challenge. It impacts our ability to respond in a timely way to requests of support and meet all of our statutory responsibilities in the timescales we would want. Where we are able to recruit agency staff the costs are higher and does not always fill all our vacancies. There are particular challenges in recruiting qualified Social Workers and Occupational Therapists.

    e. Transitions (young people moving between Children's and Adult Social Care responsibilities as they get to 18 years of age) cases on average have a higher care cost than most individuals receiving support from an Adult Social Care Departments and therefore can be a

cost pressure given their complexity and needs. This and the increased demand for support from working age adults has been the driver of at least one local authority's significant overspend and only requires a small number of individuals with high needs to put the budget under significant pressure.

f. While the acuity of people being referred to ASC has increased both from the community and from hospital, for all local authorities in SE London, a number of local authorities are reporting an increase in the overall number of people they are supporting, on average ASC is seeing a 17% increase in England. Some SE London boroughs are seeing an increase in their over 65's population, which feeding through into increased numbers of referrals for support. Lambeth are showing an increase in their over 65 population in the next ten years of 44%, and Bexley 21% have an increase in the next 5 years of 21%, these increases are already being felt in boroughs.

## 4. Hospital Discharge

Hospital discharge work is a key area for local Adult Social Care Departments, given the increased acuity of people on discharge from hospital which has been well set out previously, we see this as a driver for higher long term costs which local authorities have to absorb.

This higher acuity and the nature of earlier discharge processes pass a number of costs on to local authorities, as people don't access the same level of therapy support in hospitals as they would have previously, and we have not, due to recruitment and financial challenges ensured there is adequate therapy provision in the community to support people in a timely way back to previous levels of independence.

Adult Social Care have good and affective working relationships with acute colleagues and manage the flow of people out of hospital efficiently but acknowledge that in a few complex cases, discharge planning and securing the right service to support the individual on discharge is challenging and can take some time, as detailed above. We are working with acute colleagues to identify these individuals earlier in the process so we can start working with the person and their families to find the appropriate support to facilitate discharge. But would welcome additional psychological support in some of these complex cases so we can ensure the right service is engaged to meet their needs.

We have previously talked about the negative narrative, that social care causes significant delays in discharging people from hospital, which does not set out the full range of reasons for people's length of stay in hospital. Colleagues are working collectively across the system to support the flow of people out of the acute setting; however, this is at a cost to the local authority and wider community services.

For example, two local authorities based on their best case scenarios are projected to spend between £1.3m and £2.3m more than the Discharge Fund allows for in 24/25. This will also create an ongoing cost to the authority which is unfunded. As these are best case scenarios having not taken into account the increase in discharges over the winter period, the real costs are likely to be in excess of these figures by several million.

As advised by the DHSC one local authority is working to its discharge fund allocation but could support further activity if they were funded to do so.

## 5. Continuing Health Care (CHC)

We welcome the opportunity of gaining a better understanding behind the reduction in the number of local people eligible for CHC since 2017, (26% reduction in SEL when comparing numbers of eligible CHC cases per 50,000 population between 2017 and 2023), which we have previously raised with the ICP. This reduction has the potential to shift financial responsibility to local authorities and the individual themselves given the different charging arrangements health and social care have.

## 6. Budgetary Position (where known)

Given the financial reporting cycles for local authorities, not all the information is available to include in this report. However, the position below sets out their Outturn Position for 23/24 without any reserves or one off funding being applied to meet the legal requirement to balance. We are not able to report on the 24/25 position at month 3 for all authorities as internal assurance and governance processes are not yet completed. It is safe to say that all authorities have a number of significant savings and efficiency programmes in place to try and achieve a balanced position, but it is too early to say if these will be fully delivered and will be sufficient to meet demand and inflationary pressures.

**The table below sets out the financial position of each local authority.**

| **Local authority** | **23/24 Outturn before reserves and one off funding applied** | **24/25 position where known – these figures will include some identified efficiencies** |
|---|---|---|
| | | |
| **Bexley** | £8.4m Council overspend.<br>£2.99m ASC and Public Health | £2m Projected overspend<br>£2.62m Projected ASC overspend |
| **Bromley** | £13.7m Council overspend.<br>£1.3m for ASC overspend | |
| **Greenwich** | * These are provisional figures<br>£22.4m Council overspend.<br>£6.2m for ASC | |
| **Lambeth** | £19m Council overspend<br>£8m ASC overspend | £29.3m projected Council overspend<br>Estimated £10m projected overspend for ASC |
| **Lewisham** | £21.6m Council overspend.<br>£6.2m for ASC | £22.3m Council overspend projection<br>£5.9m ASC projected overspend |
| **Southwark** | £5.4m Council overspend.<br>£2.6m ASC | ASC - £4,25m projected overspend |
| | | |

## 7. Areas of opportunity to explore.

There are several areas where, as a system by working together at scale (across boroughs) would assist us to address costs, improve outcomes for local people and enable them to access services they have a right to.

I. Consider the opportunities to work across boroughs and accelerate the Integrated Neighbourhood Based Care (Fuller) to improve health outcomes and reduce admissions, by coordinating this with work the Accelerating Social Care Reform Fund Programme is doing so we can work in a more joined up way across our local authorities and 'Places' to realise the benefits and efficiency this would bring.

I. Identify further opportunities for integration and workforce development.

II. Explore urgently how we might collectively increase access to therapies and support for people in the community to help earlier identification of individuals with care and support needs and therefore increase levels of independence, reduce admissions to hospital, as well as increases people's independence and self-care in the longer term.

**III.** Work together to get better access to psychological support to assist in the planning of discharges for individuals with complex and challenging needs related to dementia etc. To improve decision making and identification of the most appropriate care on discharge.

**IV.** We welcome the inclusion of a Director of Adult Social Care in the Continuing Health Care Review process so we can work as a system on ensuring people get the right care from the right organisation, and have their rights protected.

# Integrated Care Partnership

## Item 4
## Enclosure C

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| **Title:** | **Implementing our South East London Integrated Care Strategy** |
| **Meeting Date:** | 25 July 2024 |
| **Author:** | Toby Garrood (ICB Medical director) |
| **Executive Leads:** | Andrew Bland |

| | | | |
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| **Purpose of paper:** | To seek the IC Partnership's support and advice on proposals to progress delivery of our Integrated Care Strategy given financial pressures in our system. | Update / Information | X |
| | | Discussion | X |
| | | Decision | X |
| **Summary of main points:** | - | | |

In our strategy publication of 2023, we committed to action across SEL to address five priorities: prevention, early years, children's and adults' mental health and primary care and long-term conditions. In discussion with the Partnership in Spring 2024, we agreed proposed interventions to help deliver our strategic priorities.

However, the financial pressures upon our system at present our such that we have had to depart from aspects of the approach in our Medium Term Financial Strategy, and we are not in a position to invest significant funds at the moment to projects to help deliver the interventions agreed on in early 2024.

This paper provides a brief overview of work in train and funded across our system that will help us to deliver our strategic priorities.

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| | Alongside this work, we propose to establish three spread and scale collaboratives to support the delivery of our strategic priorities. These collaboratives will bring together NHS and VCSE services across our six places with an interest in developing the care models outlined in the strategy, so that they can develop their shared understanding of the approaches in the strategy and start incorporating them into their work.<br><br>This should allow us to make some practical progress, that we can report back to the Integrated Care Partnership, in introducing and testing the approaches we identified in the strategy. It would also allow us to deepen our understanding and evidence base and to act quickly to set up new projects or expand existing ones when there is greater scope for investment.<br><br>- |
| **Recommendation:** | - <br><br>The Partnership is asked to note and approve these proposals, subject to feedback, and also to support our teams and collaboratives as we move into the delivery phase. |

# Implementing our south east London Integrated Care Strategy

## Integrated Care Partnership 25 July 2024

### 1. Introduction

1.1. In 2022 the ICB engaged extensively with our patients, communities and other stakeholders to agree five areas of priority for our strategy, with focus on prevention, early years, children's and adults' mental health and primary care. Since then we have carried out further work with subject matter experts to refine our approach, the outputs of which included logic models illustrating drivers of poorer outcomes and areas of opportunity, preliminary output and outcome metrics, and specific interventions based on established and innovative models of care from south east London and elsewhere.

| Priority | Challenge | Ambition | Proposed intervention |
|---|---|---|---|
| Prevention and wellbeing | Delivering primary prevention effectively to our most disadvantaged communities | Close the gap in uptake of these services for people from disadvantaged groups | Community and relationship-based approaches to prevention which seek to establish sustained relationships with people from under-served communities and provide support for a wide range of health and wellbeing challenges |
| Early years | Supporting mums, babies and families with high vulnerabilities effectively in first 1001 days | Safer births, with fewer complications for families with high vulnerabilities, improvement on key measures of good start in life. | Intensive, generalist approaches to supporting parents, babies and families with high vulnerabilities, which support families to tackle major challenges while connecting them into support networks and local resources |
| Children's and young people's mental health | Supporting children's emotional wellbeing and common mental health challenges in disadvantaged neighbourhoods | Fewer children developing emotional and mental health problems in disadvantaged neighbourhoods, higher school attendance. | Partnerships between local communities and VCSE organisations, schools and public services to develop 'Family Zones' to support children and families' wellbeing in disadvantaged neighbourhoods |
| Adults' mental health | Ensuring access to rapid, trusted and effective early support for common mental health and social challenges. | Fewer people from disadvantaged groups entering crisis or developing more severe mental health problems. | VCSE and peer-led, socially-oriented support for adults with common mental health challenges in disadvantaged neighbourhoods |
| Primary care and people with long-term conditions | Delivering proactive, joined up support for long term conditions and people with complex health and social needs. | More people with LTCs and social challenges who report a positive experience of care, live independently and enjoy good lives. | Developing 'test case' models of integrated neighbourhood teams in disadvantaged neighbourhoods so that we can codify effective service designs and approaches to transitioning to a team-based model of primary, community and social care |

1.2. As our planning round updates to the Board have made clear, the financial pressures upon our system at present our such that we have had to depart from aspects of the approach in our Medium Term Financial Strategy, which would have seen significant investment in these priority areas over and above core spend. That resource is not currently available to us and so we are not in a position to invest significant funds at the moment. Whilst this is disappointing, it gives us an opportunity to develop our frameworks for delivering pathway transformation and innovative, joined up models of care which are centred around the patient and focus on the areas of greatest unmet need.

1.3. This paper reiterates out commitment to our stated strategic priorities and sets out how we will start to demonstrate impact over the next 12 months. Whilst we have had to adapt out short-term approach, it is our intention start to deliver on our commitments, recognising that these represent areas of focus identified as being most important to our communities, whilst building the foundations for a consistent approach which makes the best use of the extensive resources in our system and in particular builds on work in our system which is already making a difference to our citizens. The Partnership is asked to note and approve these proposals, subject to feedback, and also to support our teams and collaboratives as we move into the delivery phase.

## 2. Ongoing work to implement our strategy across our system

2.1 There is work happening across our system, in our places, our Trusts and other partner organisations, to help deliver our strategic priorities for prevention, early years, mental health and primary care. This work is set out in our plans and strategies, not least the Joint Forward Plan for 2023/24 onwards and at every stage we have sought to ensure that work aligns to our ICP strategy and progresses its ambition. The specific proposals detailed in this paper will build on existing work in our system and seek to maximise impact through shared learning and alignment around agreed outcomes whilst seeking opportunities to learn from national and international examples of best practice.

2.2 For example, on prevention, local care partnerships (our Borough LCPs) are taking action to improve uptake of NHS health checks and vaccinations, targeting support for smoking and weight management, developing early intervention approaches for long term conditions and expanding social prescribing support.

2.3 **For early years,** work across our system includes

- Roll out of the Start for Life offer in a number of our boroughs which supports parenting in early years, including infant feeding, and perinatal mental health
- Implementation of the Integrated Child Health Model in Primary Care;
- Expansion of the Empower Parents Empowering Communities (EPEC) programme. EPEC groups aims to improve child development and difficulties, parenting, family resilience and coping through offering access to effective parenting support particularly for socially excluded, black and minoritised communities
- Rolling out the family hubs programme including piloting colocation of services
- South London Listens, with Parent Action, have established Mindful Mamas, which aims to improve the mental wellbeing of mothers with young children, and Parent Upskilling, which aims to improve mental health and wellbeing of parents through peer support
- Continued work with the Maternity and Neonatal Voice Partnerships to improve engagement with local communities

2.4 **For children's mental health,** work across our system includes:

- developing mental health teams in schools,
- establishing single point of access for CAHMS services,
- Further specific examples include:
    - Opening of a dedicated crisis house for children and young people
    - Supporting the implementation of the iThrive framework principles across all our Places and further developing the use of the Healthy Schools and Health Early Years Frameworks
    - Establishing children's health hubs in Bromley and developing relationships with schools
    - Closer working with schools in Bexley to support the mental health of LGBTQ+ pupils
    - Piloting NHS partnerships in Lambeth with community and school-based organisations such as the Well Centre, Coram and Place 2 Be
    - South London Listens (SLL) has successfully trialled virtual CAMHS waiting room in four boroughs and is supporting further expansion of the model, and is working with schools in Lewisham to pilot work exploring parent and student engagement around mental health

2.5 **For adult mental health,** key work programmes include:

- Major initiatives to transform core community mental health services, including improving and streamlining access to services and developing more holistic, team-based models of care
- Development of mental health hubs and supporting closer integration between these and other services
- Increasing capacity in home treatment teams;
- Establishment of better crisis support services, such as the Bridge Café in Lewisham
- As above, development of services to support new parents and protect their well-being, such as delivery of the Mindful Mums and Being Dads programmes.

2.6 Our LCPs also have programmes of work to develop integrated neighbourhood teams within primary care, bringing together staff and resources across primary care, community services, social care, the VCSE and the hospital system. This includes work across our places to clarify the overall model for integrated neighbourhood teams and approaches to delivering holistic care for particular high risk groups such as the frail elderly.

2.7 While these initiatives go beyond the specific interventions outlined in our strategy, they should make a significant contribution to improving outcomes across prevention, early years, mental health and primary care. For more information see our Joint Forward Plan for 2023/24 onwards.

## 3. Spread and scale collaboratives to support delivery of our strategic priorities

3.1 Alongside this work across our system, we propose to establish three spread and scale collaboratives to support the delivery of our strategic priorities. These collaboratives will bring together NHS and VCSE services across our six places with an interest in developing the care models outlined in the strategy, so that they can develop their shared understanding of the approaches in the strategy and start incorporating them into their work. This should allow us to make some practical progress, that we can report back to the Integrated Care Partnership, in introducing and testing the approaches we identified in the strategy. It would also allow us to deepen our understanding and evidence base and to act quickly to set up new projects or expand existing ones when there is greater scope for investment.

3.2 We propose to base these collaboratives alongside our System Leadership Academy, which currently has three strands, a 'Collaborate' programme to develop system leaders, a 'Connect' programme to connect staff and share learning, and a 'Create' programme, to support spread of innovation. The collaboratives would align with the Collaborate programme with the aim of developing leaders whilst delivering on real-world projects, ensuring that our investments in spreading innovation are closely aligned to our strategic priorities, the models of care we want to develop and the evidence on effective interventions and practice. We will also work with collaboratives and system partners to develop a scalable framework for supporting, testing and scaling innovation.

3.3 **Objectives for the collaboratives.** Given these ambitions, we propose that the spread and scale collaboratives should focus on the following objectives

- Identifying enthusiastic partners drawn from both the NHS and VCSE sector, aligned around shared objectives, and building momentum for the types of new approaches identified for our strategic priorities
- Enabling these groups to deepen their understanding of the evidence base and underlying features of these approaches and share this with the system
- Learning from leaders and organisations that have implemented these approaches within and beyond south east London
- Supporting each group in identifying and implementing steps to incorporate these new approaches in their services and in evaluating them
- Evaluating the impact of these initial changes so that we can build the evidence base for future investment in the approaches identified in the strategy

3.4 The collaboratives should also allow to us to develop and test a more structured process for spreading and scaling service innovation across south east London including more rigorous approaches to reviewing the evidence, setting objectives, replicating essential features of service innovations, adapting to local conditions and measuring impact (See section 3 for a discussion of the broader work to develop the capabilities of a learning system, which the collaboratives would draw on and contribute to.)

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3.5 **Initial focus for the collaboratives.** We are proposing to establish in the first instance three collaboratives to support the development of the following three strategic priorities:

- Early years – the development of intensive, relationship-based and holistic support for mums and babies with the greatest vulnerabilities
- Children's mental health – the development of partnerships with schools in disadvantaged neighbourhoods and family zones bringing together schools, parents, the public sector and the VCSE in a neighbourhood to address the broad range of issues impacting these children's mental health and broader life chances
- Adult mental health – the development of social models of community mental health support which focus on providing friendship, connection, meaningful activity, recovering agency, finding appropriate training and employment and addressing social challenges.

3.6 We believe we need to limit ourselves to three collaboratives in the first instance given available resources, but this will give us the opportunity to develop the collaborative models to deliver maximum impact and optimise use of enabling functions. We have suggested starting with these three strategic priorities because we have established partnerships with organisations that can help us set them up quickly. We are not proposing a collaborative for the development of integrated neighbourhood teams at this stage given the complexities of this work and the activity already in train across our system.

## 4. Developing our enabling functions

4.1 As we form and progress our collaboratives we will develop what we believe are key enabling functions which will support the groups in the short-term as well as ensure we have robust foundations for scaling our approach to shared learning.

4.2 **Making the best use of available data through a population health management (PHM) approach** is key to defining our approaches and measuring success. We will do this by ensuring we make the best use of all available data sources to understand the unmet needs in our populations and target interventions to areas of greatest need. We are proposing a joint appointment between the ICB and the KCL School of Life Course and Population Sciences. This will bring academic expertise into the programme, specifically in application of PHM

4.3 **Robust evaluation,** built into the life cycle of a project, will ensure that projects are clearly defined, have clear measures of success and are sufficiently resourced to deliver their stated objectives. Ultimately, we are seeking to understand the value of a service, project or intervention as determined by the outcomes as a function of cost. This is complex, as metrics are multidimensional and include the process of care, including patient and staff experience, and outcomes which need to be appropriate to the population as well as the individual patient. Our approach to evaluation in SEL and more broadly in the NHS is not always consistent. For long-established services outcomes are not always measured and we have a tendency to rely on process measures as a surrogate for longer-term impact. Where we do undertake formal

evaluation the approach can be variable as we work with a range of internal and external partners to deliver evaluation which can mean inconsistency of approach.

4.4 To ensure progress on our strategic objectives is underpinned by a clear and proportionate approach to evaluation we are working with system partners to reach consensus around guidance and process with an emphasis on making the best use of organisational expertise in SEL. A comprehensive evaluation framework includes (but is not limited to) problem definition, evidence review, project design, outcome definition and health economic analysis. We have formed a working group who, alongside the collaboratives, will focus on our initial strategic priorities in parallel with our collaborative to develop this framework.

4.5 **Our approach to improvement.** As we convene individuals and organisations around our initial priorities we will take a consistent approach to delivering improvement, bringing together expertise from within the system with shared methodology. In doing so we will test and develop our maturity do this within the five domains of the NHS IMPACT framework as follows:

- Building a shared purpose and vision.
- Investing in people and culture.
- Developing leadership behaviours.
- Building improvement capability and capacity.
- Embedding into management systems and processes.

4.6 **Innovation.** We also need to develop and bring together our innovation capability across south east London so that we can better support the types of service innovation needed to deliver our strategic priorities and address our financial challenges. We have substantial capability in the design and spread of service innovation, but it is highly fragmented across our system and arguably not focused on the biggest opportunities for improvement. In the summer and autumn, we will map our current capability and capacity, make a rapid assessment of how this is being used at present, and identify what simple and pragmatic changes might allow us to bring our innovation capabilities together and focus them more effectively.

4.7 **Supporting and developing our leaders.** We are currently undertaking an evaluation of our two flagship Leadership Academy programmes, Collaborate and Create, to understand how we build on them to ensure we are providing the best support with an emphasis on how we develop service improvement and transformation and in particular as applied to our strategic priorities.

4.8 **Relationship building.** Developing mechanisms for delivering our strategy will allow us to explore how we further develop cross-system relationships, in particular with our VCSE sector. These will be aligned to components of our VCSE charter, in particular building strategic partnerships, leadership development, identifying opportunities for funding and investment and leveraging innovation as well as demonstrating the impact of closer working.

## 5. Outline of proposed approach and next steps

5.1 For each collaborative, we propose to bring together leaders from several services across South East London, with representation from across NHS and VCSE organisations, as well as academic partners where appropriate, and our six places. Once we have identified participants, we propose to codesign the collaborative with them, so that the programme specifically meets their ambitions and needs. However, it is likely that the programme for each collaborative will include:

- Bringing together and sharing the evidence base on the model or approach identified in the strategy
- Agreeing objectives and measures of success, including measures to support evaluation of impact
- Sharing of methodologies and practical experience of leading service change, in particular to implement innovative models of care
- Sharing and practical application of approaches to spreading and scaling service innovation in healthcare
- Time with leaders from within south east London and beyond who have successfully implemented these innovations to learn about their approaches;
- Design and testing of service changes using a PDSA cycle and sharing of learning with the collaborative
- Establishing a framework for evaluating the impact of changes, depending on how far participants are able to go in implementing substantive new models given available resourcing.
- Sharing of learning across our system, for example through our Leadership Academy's Connect Programme.

5.2 **Costs for the collaboratives.** Given our financial position, we will need to deliver the collaboratives with limited funding of approximately £100,000 or £33,000 per collaborative. This funding should be sufficient to cover the costs of some participation from successful leaders and national organisations, where needed, to bring expertise and practical experience to the collaboratives. We would want to engage some of the local and national organisations that were instrumental in supporting our work in developing the strategic priorities, for example Birth Companions, Big Education, Place2Be, Mosaic Clubhouse and Rethink Mental Illness. The funding would need to cover the costs of face-to-face meetings for the collaboratives. We would need to rely on in-house resources to capture most of the learning from the collaboratives. We also would want to support the development of enabling functions, in particular evaluation, as cross-cutting themes.

5.3 **Timescales for setting up and running the collaboratives**. If the Integrated Care Partnership supports these proposals, we plan to:

- hold introductory online meetings with potential participants in late August/ early September 2024
- select participants with our place leaders by end September 2024

- hold initial scoping sessions on design of the collaboratives in October 2024
- We would launch the Collaboratives in November, with regular meetings up until Autumn of 2025

5.4 We propose to work closely with the IC Partnership sponsors who led work on our strategic priorities on the collaboratives and report back to the Partnership on progress at its quarterly meetings.

# Integrated Care Partnership

## Item 5
## Enclosure D

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| **Title:** | **South London Health and Housing update** |
| **Date:** | 25 July 2024 |
| **Authors:** | Ranjeet Kaile (Director of Communications & Engagement, SEL ICB), Jessica Levoir (Associate Director of Partnerships & Socioeconomic Development,SEL ICB) |
| **Executive Lead:** | Ranjeet Kaile - Director of Communications & Engagement, SEL ICB), |

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| **Purpose of paper:** | This paper seeks to update and engage ICP members on the progress of the Health and Housing work in South London and emergent areas of focus, as well as the process underway to develop solutions and an action plan to address the health impact of housing.<br><br>This paper also seeks the ICP's approval of proposals for reporting and oversight arrangements of this work. | Update / Information | X |
| | | Discussion | X |
| | | Decision | X |
| **Summary of main points:** | Following a successful listening campaign towards the end of 2023, during which local people consistently raised housing as a key issue, South East London Integrated Care Board (SEL ICB) and South West London Integrated Care Board (SWL ICB), alongside ICS partners, made a commitment at two community assemblies to take action on the health impact of the housing crisis by convening system partners to identify solutions and create an action plan.<br><br>The goals of this work are to:<br>• Reduce the impact in South London of the adverse health outcomes that arise because of poor quality, unsafe or insecure housing.<br>• Reduce barriers to healthcare access for people experiencing housing issues (such as people living in temporary accommodation).<br>• Improve our measurement and understanding of housing as a cause of poor health among South London communities.<br>• Improve early intervention for people experiencing housing issues to reduce the impact of homelessness on local government and NHS cost pressures – with a specific focus on mental health.<br>• Address the impact of housing challenges on NHS recruitment and retention of staff, and the health and wellbeing of staff.<br><br>This paper sets out the scope and areas of focus for the Health and Housing work, as well as the steps underway to develop an action plan. | | |

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| **Recommendation:** | We are in the process of engaging system partners and welcome comments and steers from the ICP on the proposals so far and the process outlined. Some suggested discussion points set out in the paper are listed below:<br><br>• We know a partnership approach will be key to developing and delivering successful solutions to the Health and Housing work (as scoped). How do you think our System can best work together on the Health and Housing issue? Where else other than the ICP should this work go for discussion?<br>• The areas of focus were developed through conversations with South London communities. Are there other opportunity areas not listed that you are hearing from your communities and, therefore, we should consider?<br>• What do you think the key levers for success are for this work?<br><br>Given the nature of this work and the important role ICSs have in this agenda we ask the ICP to approve the proposals for oversight and reporting outlined in the paper, including that the Health and Housing work reports into the ICP for SEL. |

# South London Health and Housing Work

# Update for SEL Integrated Care Partnership

## 1. Purpose

1.1. This paper seeks to update and engage ICP members on the progress of the Health and Housing work in South London and emergent areas of focus, as well as the process underway to develop solutions and an action plan to address the health impact of housing.

1.2. This paper also seeks the ICP's approval of proposals for reporting and oversight arrangements of this work.

## 2. Background

2.1. In September 2023 the South East London Integrated Care Board (SEL ICB) and South West London Integrated Care Board (SWL ICB) built on the work of South London Listens[1] and launched a listening campaign called 'Going Deeper', in partnership with the national charity Citizens UK[2], as part of our commitment to tackle health inequalities and address the issues that matter to local people.

2.2. During the listening campaign, which heard from over four thousand people across South London on what affects their ability to thrive, we consistently heard that housing is a key issue affecting the physical and mental health of South London communities. Poor conditions in the private and social rented sectors, rising housing costs, the stressors of precarious and insecure housing tenure were all issues impacting some of our most under-served communities.

2.3. We heard from people living in temporary accommodation and therefore living with housing insecurity, and heard that they face barriers to healthcare access as a result of their precarious and changeable housing situation – for example difficulties attending appointments or registering with a new GP. We also heard stories from people who are at risk of homelessness, for example because of increasing mortgage or council tax arrears, or landlords wishing to evict them due to affordability concerns. Some people said they had struggled to find a place to rent due to their immigration or employment status, or felt that they were being discriminated against because of their race or due to being on benefits.

2.4. As a result, SEL ICB and SWL ICB and other system partners pledged publicly at two community assemblies[3] to take action on the **health impact of the housing crisis** by convening system partners to identify solutions and create an action plan.

2.5. This is a significant opportunity for our system to work together on an agenda which both our communities have asked us to prioritise and which clearly aligns to the

[1] South London Listens
[2] Home - Citizens UK
[3] NHS and local authority leaders pledge to vital action to tackle health inequalities in south London

purpose of an ICS. ICSs have a clear mandate with regards to tackling health inequalities in outcomes, experience and access and helping the NHS to support broader social and economic development, both of which we know housing has an impact upon (see appendix A and B for more information on the links between housing and health inequalities). As a partnership of large anchor organisations in SEL, our ICS provides an opportunity for us to work together to maximise our impact on this important agenda.

## 3. Overview of the South London Health and Housing work

3.1. The goals of this work are to:

- Reduce the impact in South London of the adverse health outcomes that arise because of poor quality, unsafe or insecure housing.
- Reduce barriers to healthcare access for people experiencing housing issues (such as people living in temporary accommodation).
- Improve our measurement and understanding of housing as a cause of poor health among South London communities.
- Improve early intervention for people experiencing housing issues to reduce the impact of homelessness on local government and NHS cost pressures – with a specific focus on mental health.
- Address the impact of housing challenges on NHS recruitment and retention of staff, and the health and wellbeing of staff.

3.2. We know that there is a significant amount of focus and work already taking place in this space at national and regional level and across South London. We want to better understand where through working in partnership we can support and scale this work where relevant, and work with partners and communities to identify solutions where there are gaps in current thinking and where we could go further as systems to reduce housing-related health inequalities. This work will focus on action areas where health and housing policy and delivery intersect. Areas **not in scope** include influencing social housing waiting lists, eligibility criteria, the rental market, funding housing repair and enforcement. Going forward the scope of this work will be further refined with partners.

## 4. Delivery and oversight

4.1. Work to develop solutions and an action plan, using existing resources, is being delivered by the SEL System Anchor Programme and South London Listens, working in partnership with Citizens UK. This combined team has started to engage system partners, and key activity which will continue over the course of the next few months includes:

- Mapping work to explore current work ongoing and key groups already established, as well as good practice within our systems and beyond, in partnership with the charity Impact on Urban Health[4].
- A series of one-to-ones and workshops with system partners and community leaders to refine scope, explore issues and develop tangible solutions. An initial

[4] Impact on Urban Health

South London wide workshop was held 10 July 2024 and further workshops are being planned.

- Establishment of a South London Health and Housing Coalition, with representation from leaders across the NHS, Local Authorities, the housing sector, voluntary community and social enterprise (VCSE) sector, and local universities. This coalition will co-design the action plan based on the workshops and mapping, and then oversee delivery of this plan across South London.

4.2. In SEL, we propose this work will report into the ICP via the new SEL Socioeconomic Development Board that will be stood up in the autumn.

## 5. Areas of focus identified for further exploration

5.1. From research and engagement so far, including co-production workshops held during the listening campaign, we have some initial ideas for how the NHS could play a role in supporting better health and housing integration in South London that we will build on over the coming months. These include:

5.2. Embed housing advocacy within health services that support people with housing-adjacent health needs, such as:

- Improving identification of people with housing-related health needs due to unsafe or unhealthy housing, as well as better identifying risks to housing tenure related to mental or physical ill-health
- Supporting housing associations and other housing providers with identification of health needs

5.3. Strengthen the role of the NHS as an anchor institution in supporting the creation of affordable housing, such as:

- Considering how the NHS can factor housing into land and estates redevelopment and embed housing into large redevelopments in the long term
- Exploring meanwhile use for unused NHS land and estates for temporary housing
- Working alongside developers to influence the development of keyworker housing for NHS staff

5.4. Strengthen the role of the health system in identifying housing issues, such as:

- Consolidating research and evidence to create a shared understanding of the links between health and housing in South London
- Strengthen capability within health services including primary and secondary care to increase the impact of referrals and signposting for people experiencing housing issues
- Improve the monitoring and evaluation of the impact of housing on health inequalities

## 6. For discussion

- We know a partnership approach will be key to developing and delivering successful solutions to the Health and Housing work (as scoped). How do you think our System can best work together on the Health and Housing issue? Where else other than the ICP should this work go for discussion?
- The areas of focus listed in section 3 above were developed through conversations with South London communities. Are there other opportunity areas not listed that you are hearing from your communities and, therefore, we should consider?
- What do you think the key levers for success are for this work?

## 7. Appendices

### Appendix A – Existing evidence on housing and health inequalities in London

**Health Foundation data on housing quality/affordability and health**

- People on the lowest incomes and people from Black and Asian ethnic backgrounds are more likely to be in non-decent homes (homes not meeting the decent home standard).
- People on low incomes and people from minoritised communities are more likely to have high housing costs relative to their income.
- 28% of private renters in non-decent homes rate their health as fair/bad/very bad compared to 22% in decent homes

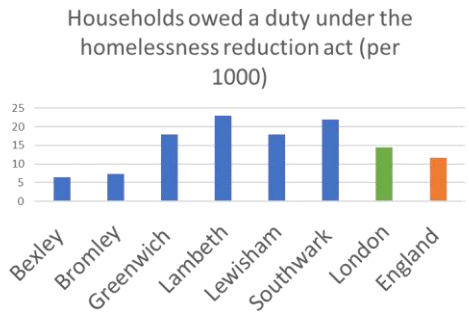
**Institute of health equity review of housing and health in London**

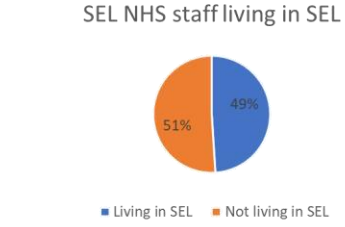
- A rapid evidence review by the Institute of Health Equity found that London experiences:
  - Higher rates of poverty after housing costs are taken into consideration
  - The highest rate of housing overcrowding in England
  - The majority of children living in temporary accommodation (TA) in England are in London
  - Challenges related to overheating and housing, disproportionately impacting older people and young children
  - Financial, policy and land ownership barriers to building social housing and affordable housing
- (Source: Marmot et al, 2022)

**Trust for London data on homelessness in London**

- By mid-2023, 170,000 households were homeless and living in temporary accommodation and one in 50 individuals was classified as homeless.
- 79% of people in temporary accommodation (TA) in London stay in TA for more than a year. Households in London have an average stay in TA that is is five times longer than elsewhere in England (Source: London Councils. in London Assembly Housing Committee, Call for evidence, October 2023).
- Research by LSE found a 41% reduction in properties for rent since the pandemic leading to a surge in demand

### Appendix B – Data and evidence on housing in South East London




Higher than average rate of temporary accommodation in Southwark, average everywhere else

Higher than average housing affordability in Bexley, average everywhere else

Higher than average rates of rough sleeping in Lambeth, lower in Bromley and Bexley

**Centre for Mental Health** review of child development in Southwark and Lambeth, commissioned by **Impact on Urban Health** found that housing inequalities impact children's mental health including:

- Overcrowding impacting on education and sleep quality
- Damp and pests at home influencing antisocial behaviour due to wanting to be out of the house
- A view from mental health professionals that their influence on unhealthy housing conditions was limited

(Source: Centre for Mental Health, 2023)

Research published in 2020 carried out **by Community Links Bromley** and **Healthwatch** found 73% of people in TA in Bromley had a mental health diagnosis and 48% had a longstanding illness or disability

# Integrated Care Partnership

## Item 6
## Enclosure E

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| **Title:** | **SEL ICS Voluntary, Community and Social Enterprise (VCSE) Charter implementation- What have we done so far?** |
| **Date:** | 25th July 2024 |
| **Authors:** | Andrew Bland (Chief Executive Officer, NHS South East London ICB); Tal Rosenzweig (Director of VCSE Collaboration and Partnerships and ICP member), |
| **Executive Lead:** | Andrew Bland, Chief Executive Officer, NHS South East London ICB |

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| **Purpose of paper:** | The purpose of this paper is to update ICP members on the progress made with the implementation of SEL ICS VCSE Charter and to seek members steer on proposed next steps. | Update / Information | X |
| | | Discussion | X |
| | | Decision | |
| **Summary of main points:** | Following Charter sign off by the Partnership in October 2023 we have been working to progress plans and actions for implementation of commitments made in the Charter.<br><br>In this paper we provide the partnership with update on implementation of:<br><br>1) VCSEs as strategic system leaders (VCSE System Leadership roles)<br><br>2) Use of NHS Estates for the benefit of communities (providing easy and equitable access for VCSEs to NHS estates)<br><br>3) Capacity building and support for micro, 'By and For' VCSEs<br><br>We will also present in the meeting on our plans for next steps for collaborative-engagement and implementation, which we would like to invite discussion on. ICP members support and championship during this next stage will be crucial. | | |

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| **Recommendation:** | ICP members are asked to discuss and provide steer on:<br>- Ideas for further implementation of the three Charter commitments discussed<br>- Implementation ideas for the fourth commitment around transforming ICB procurement<br>- How can the partnership further Champion and support the progression of this work |

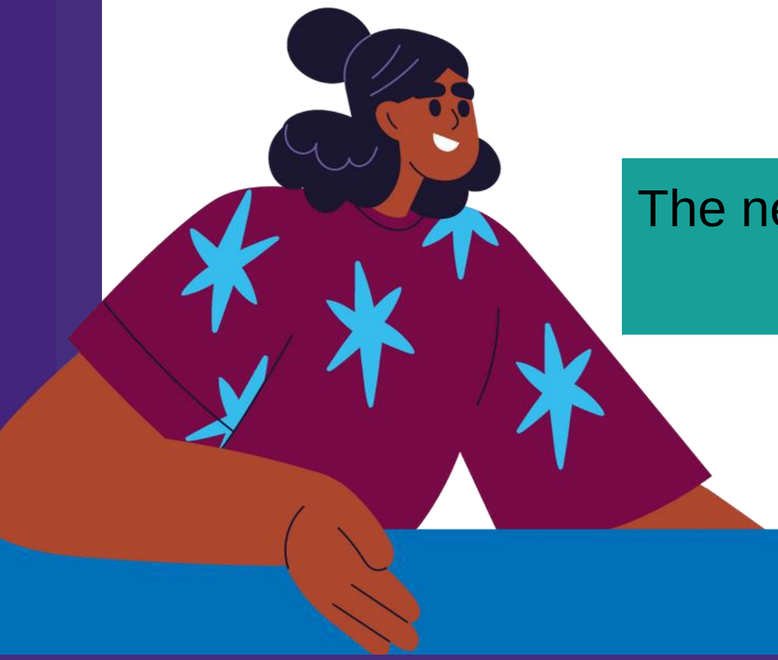
South East London
Integrated Care System

SEL Voluntary, Community and Social Enterprise Strategic Alliance


# SEL VCSE Charter Implementation: What have we done so far?

# Background

- The SEL VCSE Charter has been agreed by the partnership in October 2023 (see full Charter here)
- We have been working collaboratively across our system to implement the commitments we signed up to in the Charter
- We are initially focusing on creating structures and capacity which will enable an ongoing shift in our system's approaches and ways of doing.



The next few slides provide an update on the work we have done so far and planned next steps

South East London Integrated Care System

# VCSEs as strategic system leaders

- The ICB has ringfenced part of its Clinical and Care Professional Leads (CCPL) funding to create dedicated VCSE leadership roles for key areas of system function.

- We have identified initial key parts of our system where VCSE leadership is needed

- We are working with SEL VCSE Strategic Alliance leads and ICB's Organisational Development and CCPL development leads to ensure the roles are part of the clinical and care professional leadership ecosystem.

- We are finalising recruitment and 'support& learn' structures for the roles (to complement and enhance current CCPL offer)

- Roles are to be independent, hosted within the VCSE sector but embedded within key teams/programmes

**Next Steps:**

1. To finalise system area/ programmes where leadership roles to be placed
2. To work with VCSE Strategic Alliance and key ICB leads to develop individualised specifications for each VCSE leadership role
3. To start the recruitment for roles



South East London
Integrated Care System

# NHS Estates for Benefit of Communities

**Two main new approaches for enabling free access for VCSEs to NHS vacant spaces:**

## 1. ‘Open Space’

New online booking platform for SEL NHS properties. In the process of registering all vacant SEL NHS spaces onto the platform and creating a simple and free vetting and registration process for VCSEs across SEL. All micro/small VCSEs who are serving our communities will then be able to book any available space for free or at heavily discounted rate. SEL ICB is covering the platform cost for VCSEs.

## 2. Collaborative re-design of community-based NHS health centres

Bringing together a wide range of stakeholders- local communities, VCSEs, ICB, LA, primary care, NHS trusts, local education institutes and more, to re-imagine together how we can use community-based NHS spaces to better meet the needs of local communities and those most underserved. The Waldron Health Centre in Lewisham is the first example of this approach (to be launch in the summer)

**Next Steps:**

- Identify the next community health centre to be re-designed and start collaborative coordination of re-design
- Complete development of VCSEs Open Space vetting process
- Promote Open Space platform across SEL VCSE sector and deliver dedicated ‘how to’ training for small VCSEs
- Evaluate usability and access of Open Space and impact of health centres re-design approach

South East London Integrated Care System

# ‘By and For’ Capacity Building

**Two ICB ‘By and For’ funds:**

1. **Micro, ‘By and For’ capacity and skills building fund**

To enable specialist infrastructure VCSE organisations to provide tailored, dedicated capacity & skills building support for micro, ‘By and For’ grassroots VCSEs who are embedded in Inclusion groups and communities (funding per SEL Place).

Working with key ICB, LA and VCSEs to develop individualised, borough specific approach, to compliment and enhance existing capacity building offer.

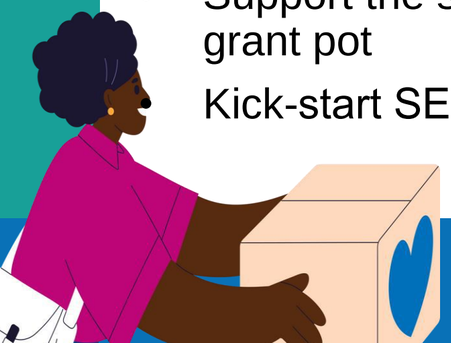
We are creating a ‘Reflect and Learn’ structure to bring all those who will be responsible for this work together so we can capture impact and share & spread learning throughout the process.

2. **Micro ‘By and For’ Enhanced Grant pot**

One off small grants for Micro ‘By and For’ VCSEs to support strengthening of provision (e.g. purchasing of equipment needed for delivery; refurbishment of space etc) (funding per SEL Place). Complimenting the capacity building fund, providing micro ‘By and For’ VCSEs the means to strengthen their community-embedded work.

**Next Steps:**

- Continue supporting boroughs to finalise their approach to both funds
- Support the scaling of collaborative grant-making approaches across SEL to support the distribution of the enhance grant pot
- Kick-start SEL ‘Reflect and Learn’ space for specialist capacity building work



South East London Integrated Care System

# More to do…

- Support implementation across SEL NHS Trusts (and further develop the role Trusts play in this work)
- Review and revise ICB procurement policies and approaches to best enable the Charter
- Further develop the role of the SEL VCSE Strategic Alliance across this work
- Develop the thinking around capturing impact of partnering with the VCSE sector

What role can the ICP play in progressing this work across our system?

South East London Integrated Care System