Integrated Care Partnership

15.00 to 17.00, Tuesday 22 November 2022

Online Via MS Teams Live

Co-Chairs:

Cllr Kieron Williams (KW) - Leader, Southwark Council

Richard Douglas (RD) – Chair, South East London ICB

Agenda

No.	Item	Paper	Lead	Timing
	OPEN 15.00			
1.	**Welcome and introduction to our Integrated Care Partnership** *Receive apologies* *Brief overview of the role of the Partnership and our ambitions for an effective Partnership in SEL* *Consider the draft terms of reference for the Partnership*	**A**	KW	15.00
2.	**'State of the Nation' - health and wellbeing and our health and care context** *An overview of the health and wellbeing needs of people in South east London and the health and care context in which they must be addressed.*	**B**	AB TG	15.20
3.	**Development of our Integrated Care Strategy** *Update on process and engagement so far on the strategy* *Presentation on emerging key themes and potential strategic priorities*	**C**	JH	15.30
4.	**Approach to allocation of resources in South East London** *Brief presentation and initial discussion on how to ensure allocation of resources in South East London reflects our strategic priorities within the context of a Medium-Term Financial Strategy*	**D**	MF	16.20
5.	**Questions from the public**	**-**	RD / KW	16.45
	CLOSE 17.00			

Presenters

AB	Andrew Bland	ICB Chief Executive Officer
JH	Dr Jonty Heaversedge	ICB Joint Chief Medical Officer
MF	Mike Fox	ICB Chief Finance Officer
TG	Dr Toby Garrood	ICB Joint Chief Medical Officer

South East London
Integrated Care System

Integrated Care Partnership
Paper Cover Sheet

Item 1
Enclosure A

Title:	**Draft Integrated Care Partnership Terms of Reference**
Meeting Date:	22 November 2022
Lead / Contact:	Andrew Bland, CEO, SEL Integrated Care Board
Authors / Contributors	Ben Collins, Director of ICS System Development

Purpose of paper:	**The draft terms of reference set out the proposed purpose, operating principles, responsibilities, membership and procedures of the South East London Integrated Care Partnership.**	**Update / Information**	
		Discussion	X
		Approval	X
Brief summary of paper	Throughout Autumn 2021 Spring 2022, there were extensive discussions between leaders across our health and care system on the membership, responsibilities and operating model for our Integrated Care Partnership. In these discussions, leaders agreed on the importance of ensuring that the Partnership would be a key strategic group alongside the Integrated Care Board, with influence over the strategic direction of our Integrated Care System and an active role in ensuring the success of key programmes. These discussions informed decisions on the membership of the Partnership in early 2022 and a paper on the proposed responsibilities of the Partnership of March 2022 (included with the draft terms of reference). The draft terms of reference reflect the proposals in our discussion paper of March 2022, which was supported by leaders across our system. In particular, they set out three main areas of responsibility for the Partnership (setting strategic direction, overseeing system performance and overseeing key programmes) and give the Partnership specific powers to engage with the Integrated Care Board and ensure that it delivers key strategic priorities for our system.		
Recommendation:	**The Partnership is asked to:** • Comment on the draft terms of reference • Approve the terms of reference, subject if needed to revisions or further development.		

South East London Integrated Care System

Integrated Care Partnership

Draft Terms of Reference

November 2022

1. Introduction

1.1. These Terms of Reference set out the role, responsibilities, membership, and reporting arrangements of the South East London Integrated Care Partnership (the "Partnership). The Partnership's duties relate specifically to these terms of reference, which can only be amended by the South East London Integrated Care Board (ICB) in agreement with local authorities in South East London Integrated Care System (ICS).

2. Purpose

2.1. The Partnership will bring together leaders from across health, local authority and voluntary community and social enterprise (VCSE) sector services to enable coordination and joint action to improve health and wellbeing in south east London.

2.2. In particular, the Partnership will support action to help people to stay well and live healthy lives, to help develop whole person care that reflects people's health and social needs, to join up fragmented services, to address health inequalities, to address the social factors that influence people's health and to support resilient communities.

2.3. The Partnership will deliver its purpose through its role in overseeing the development of an Integrated Care Strategy for south east London, helping to oversee system performance in clearly defined areas and supporting key programmes of work for the south east London system as described in section 4 below.

3. Core Principles

3.1. The Partnership will carry out its activities in ways that reflect the overall operating principles of the South East London Integrated Care Board, which are working in partnership, ensuring accountability and subsidiarity.

3.2. The Partnership will operate under a model of collective decision-making, seeking to find consensus between system partners and make decisions based on unanimity as the normal approach to conducting its business.

3.3. The Partnership will operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.

3.4. The Partnership will ensure arrangements for transparency and local accountability, including in holding the majority of its meetings in public with all minutes and papers available online.

3.5. The Partnership will actively draw on the perspectives of residents and service users to inform its decision-making, in line with the South East London ICB Patient and Public Involvement Strategy.

3.6. The Partnership will also draw on the expertise and experience of clinical and care professionals, political leaders and community leaders to inform its decision-making.

4. Duties of the Partnership

Developing an Integrated Care Strategy

4.1. The Partnership will be responsible for agreeing with the ICB a high-level process for developing an integrated care strategy for south east London which draws on our existing understanding of health needs, inequalities and associated priorities in our boroughs whilst engaging staff and the public in effective discussion on how to address significant cross-system challenges.

4.2. The Partnership will develop its Integrated Care Strategy in discussion with the Board on emerging priorities and their implications, so the Board can reflect the strategy in its NHS five-year system plan.

4.3. Members of the Partnership will ensure that the Partnership's strategy is also reflected in their own organisations' strategies, plans and allocation of resources.

Overseeing system performance

4.4. The Partnership will play a role, alongside the Board and national oversight arrangements, in helping to hold the south east London health and care system collectively to account for performance, with regards the agreed deliverables associated with implementation of the Partnership's Integrated Care Strategy. In doing so, the Partnership will draw on the democratic mandate of local authority leaders, the understanding that different members of the partnership bring of the needs of local populations and people's experience of services.

4.5. The Partnership's role in overseeing system performance should be clearly defined and focused on specific priorities, where the Partnership is particularly well placed to oversee and support improved performance, for example areas specifically related to its purpose above and areas requiring collaboration across Partnership members' organisations.

4.6. The Partnership should identify and agree with the Board the key areas where it will play an ongoing role in overseeing and supporting system performance. These should reflect the Partnership's strategic priorities and commitments where it is agreed that Partnership members are best placed to support and oversee the delivery of outcomes and performance.

4.7. The Partnership should agree the key metrics it will use and the information it will need to assess performance in these areas, drawing on theory and evidence on the most effective measures of progress.

4.8. The Partnership should provide its assessment of progress against these key priorities on an annual basis, possibly as part of its revised integrated care strategy.

4.9. In doing so, each of the members of the partnership should also set out the contributions that they have made to the delivery of these priorities including through their allocation of resources and the development of their services.

4.10. In relation to its oversight role, the Partnership will be able to ask the Board to review its approach to areas identified under section 4.6, where there is evidence that the system is failing to deliver its strategic intentions to the agreed timescales.

Supporting key programmes

4.11. The Partnership will agree, with the Board, to oversee and support a small number of key programmes, where this requires the insight and sponsorship of senior leaders from across health, local authority services and the VCSE sector.

4.12. The Partnership will identify members to act as the senior responsible officers for selected programmes and, if needed, to lead sub-committees or working groups related to them.

4.13. The Partnership will agree appropriate resourcing for these programmes with the Board and report annually on progress, including what more needs to be done by the system to achieve the desired objectives.

5. Relationship between the Partnership and the Integrated Care Board

5.1. The ICB will outline how it has taken account of and ensured alignment with the Partnership's strategy in its draft NHS five-year system plan and discuss this with the Partnership before publication.

5.2. The Partnership will assess the Board's five-year system plan and make public its position on whether the plan satisfies the following four principles: (i) reflecting the integrated care strategy alongside national and local priorities; (ii) financial viability; (iii) consistency with the system's commitment to reducing health inequalities and addressing unwarranted variation in equity, experience, service offer and outcomes; and (iv) reflecting the priorities of local populations.

5.3. In doing so, members of the Partnership should articulate briefly how their organisations have reflected or will reflect the strategy in their own plans and how they will allocate resources and develop services to support it.

5.4. The Board will commit to providing the necessary resources to report to the Partnership on progress in relation to specific strategic priorities to enable the Partnership to deliver its role in overseeing system performance, including allowing the Partnership to compare progress across services and places and against baselines. It should also commit to reporting on actions following the Partnership's advice.

6. Membership and attendance

6.1. The Partnership will be constituted of the following members:

- The Chair of the Integrated Care Board (Co-Chair)
- The Chief Executive of the Integrated Care Board
- Six elected members or nominated cabinet members representing the local authorities in south east London (one of whom will be a Co-Chair)
- The Chairs of Guys and St Thomas's NHS Foundation Trust, Lewisham and Greenwich NHS Trust, King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and Bromley Healthcare Community Interest Company
- A lead director of Adult Social Care
- A lead director of Children's Social Services
- A lead director of Public Health
- A representative from primary care services in South East London
- A representative of the VCSE sector in South East London
- A representative of Healthwatch organisations in South East London
- A representative of King's Health Partners

6.2. Staff from across the Integrated Care System may be invited to attend Partnership meetings as required.

7. Co-chairing arrangements for the Partnership

7.1. The Partnership will be chaired by the Chair of the ICB and an elected member or nominated cabinet member of one of the six local authorities in South East London. The co-chairs will work together to set agendas and plan the work programme for the Partnership and alternate in chairing Partnership meetings.

7.2. At any meeting of the Partnership, one of the co-chairs if present shall preside.

8. Quorum and conflict of interest

8.1. The quorum of the Partnership is at least 50% of members including at least the ICB Chair or Chief Executive, at least two elected members or nominated cabinet members of local authorities and at least two chairs of NHS provider organisations.

8.2. The Partnership will operate with reference to NHS England guidance and national policy requirements and will abide by the ICB's standards of business conduct. Compliance will be overseen by the co-chairs of the Partnership.

8.3. The Partnership agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

8.4. Partnership members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

9. Decision-making

9.1. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote and decisions will require a simple majority. In the event of equal votes, the chair of the meeting will have a casting vote.

10. Procedure of decisions made outside of formal meetings

10.1. The Partnership co-chairs will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the Partnership co-chairs by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

10.2. The ICB's corporate and business support team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of that meeting.

11. Frequency

11.1. The Partnership will meet a minimum of four times over the course of a year

11.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

11.3. Members are not permitted to send a deputy should they be unable to attend a committee meeting except in exceptional circumstances and with agreement of the co-chairs.

11.4. Nominated deputies will count towards the meeting quorum and be able to vote in meetings if attendance has been agreed by the committee chair.

11.5. Members and staff from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the Partnership.

12. Reporting

12.1. Papers will be made available a minimum of five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback from within their own organisations.

12.2. The Partnership will report on its activities to the ICB Board via minutes and any further agreed ICB reporting requirements.

12.3. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance.

13. Support for the Partnership

13.1. The committee will be supported by members of the ICB's governance team and system development team.

13.2. The meeting secretariat will ensure that draft minutes are shared with the chair for approval within five working days of the meeting. Draft minutes with the chair's approval will be circulated to members together with a summary of activities and actions within ten working days of the meeting.

14. Monitoring adherence to the Terms of Reference

14.1. The co-chairs of the Partnership will be responsible for ensuring the Partnership abides by the terms of reference.

15. Review of Arrangements

15.1. The Partnership shall undertake a self-assessment of its effectiveness on at least an annual basis.

15.2. These terms of reference shall be reviewed by the Partnership co-chairs on an annual basis, in the context of the self-assessment and any changing business requirements, with changes proposed for approval to the ICB Board.

South East London
Integrated Care System

Appendix: Discussion Paper for SEL Leaders on the Integrated Care Partnership, March 2022

Discussion Paper for South East London ICS Leaders
Role of the South East London Integrated Care Partnership

Introduction

We are developing an Integrated Care System in South East London based on the principles of partnership working and combining our resources and insights to improve care for our local communities. We need to be able to draw on the leadership and capabilities of organisations across our system – health services, local authorities, and the VCSE sector – to address major challenges which have worsened during the pandemic: helping people to stay well and live healthy lives; delivering whole person care that reflects people's needs; joining up fragmented services; and using our significant combined resources in ways that support resilient communities.

While national policy provides limited guidance on the role and operation of the Integrated Care Partnership, we have emphasised the role we want it to play in the leadership of our Integrated Care system, in particular supporting the shift to prevention, enabling closer integration of health and care services, supporting partnership working between heath and a broad range of public services, and helping to deliver our anchor mission. This paper draws on conversations with Local Authority Leaders and CEOs in February and March. It makes proposals on how we can ensure the Partnership can play an effective role in three areas: setting direction; supporting improved system performance; and supporting key programmes that will determine our system's effectiveness.

Legislation and national policy

The national NHS has not set out detailed information on the role or operation of Integrated Care Partnerships. The Health and Social Care Bill 2021 explains that each Integrated Care Board and its local authorities must establish a joint committee, known as the Partnership, for its area. The Partnership must develop an integrated care strategy setting out how the system should meet the needs of local populations, which might include proposals for closer integration of health and social care services. Both the Integrated Care Board and local authorities will be under a duty to have regard to the integrated care strategy in exercising their duties. might work in South East London.

Alongside the Bill, NHS England's guidance documents provide a little further information on how the Partnerships might operate. The national design framework of June 2021 provides guidance on their membership. It describes the role of Integrated Care Partnerships as: aligning purpose and ambitions with plans to integrate care and improve health and wellbeing; and facilitating joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. The Integrated Care Partnerships Engagement Document of September 2021 also emphasises the potential for the Partnerships to support service integration, help tackle health inequalities, help address social determinants of health, support social and economic development and support sustainability.

The policy presents both opportunities and challenges for our system. We can use the flexibility in the draft legislation and guidance to develop a model for the Partnership that works for our system, building on strong partnership working between the NHS, local authorities and the VCSE sector in

recent years, in particular during the pandemic. However, we also need to define with sufficient clarity the roles and relationship between the Partnership and the Integrated Care Board, so we avoid confusion or duplication between the two groups.

Our planned membership for the partnership

In discussions with partners in mid-2021, we agreed that the partnership should be chaired jointly by the Chair of the integrated Care Board and one of our six Local Authority Leaders. We also agreed to establish a relatively small group of 21 members, capable of playing an effective leadership role in our system, including the leadership of our Integrated Care Board, political leaders and officers from our local authorities, and representatives of primary care, the VCSE and Healthwatch. We are completing a process to agree with Primary Care partners how they will determine their representative on the Partnership and the IC Board. The Partnership will also be supported by members of the ICB's executive team including its clinical leaders. (See Annex for membership.)

Our thinking so far on the role of the Partnership

Within South East London, we envisage the Partnership playing a significant leadership and oversight role, alongside and in dialogue with the Integrated Care Board, as part of our collective model of governance for the system. In our draft constitution, we commit to ensuring that the Partnership, alongside the Board, has a key role in and responsibility for setting strategic direction for health and care services and in holding the leadership of south east London, including all health and care organisations, collectively to account for delivering the strategy and acting in a way that is consistent with it in their wider activities. We also describe an important role for the partnership facilitating action across public services to improve health and care in specific areas including addressing inequalities, influencing the wider determinants of health and supporting social and economic development. (See system architecture diagram in Annex.)

As well as describing our governance architecture, the draft constitution emphasises our commitment to the concept of subsidiarity – ensuring decision making and delivery is organised and secured at the level of our system that is best placed to meet our agreed objectives, be that our neighbourhoods, our LCPs (Places), our provider collaboratives or our system. This means that we do want to focus the attention of both the Board and the Partnership to areas where leadership at this level will deliver the greatest benefits.

Role of the partnership in setting strategic direction

The Health Bill and the national NHS's guidance describes specific roles for the Partnership and the Integrated Care Board in determining strategic priorities and translating these into plans for action within local systems. The Partnership will be responsible for developing an integrated care strategy setting out how the system should meet the needs of local populations. Meanwhile the Board will need to take account of the Partnership's strategy in developing its 'forward plan' for the system covering the next five years, which needs to be revised and published by the start of each financial year. In doing so the ICB will also need to take full account of the NHS Constitution and relevant national mandates (usually recorded in the NHS Operating guidance for any given period).
System partners have highlighted the need for this strategy and planning process to be 'bottom up' reflecting the priorities of local care partnerships for their populations driven by borough-level assessments of local people's needs. Local Authority Leaders and Chief Executives have also emphasised the need for formal mechanisms to ensure that the Board itself and sovereign health and care bodies take proper account of the Partnership's strategic priorities and that these are reflected in the Board's resource allocation decisions.

Based on our discussions so far, we would propose the following arrangements to guide the interaction between the Partnership and the Board on strategy and planning:

- The Partnership and Board agree a high-level process and timeline for developing the integrated care strategy and five-year plan from mid-2022 which draws on our existing understanding of health needs, inequalities and associated priorities in our boroughs while engaging staff and the public in effective discussion on how to address significant cross-system challenges;

- The Partnership develops its integrated care strategy by the Autumn of 2022, with time built in for discussion with the Board during the process on emerging priorities and their implications, so the Board can reflect the strategy in its five-year plan to be published by end of March 2023;

- The Board outlines how it has taken account of and ensured alignment with the Partnership's strategy in its draft five-year plan and discusses this with the Partnership before publication;

- Members of the Partnership ensure that the strategy is also reflected in their own organisations' strategies, plans and allocation of resources; and

- The Partnership assesses the Board's plan and makes public its position on whether the plan satisfies the following four principles: (i) reflecting the integrated care strategy alongside national and local priorities; (ii) financial viability; (iii) consistency with the system's commitment to reducing health inequalities and addressing unwarranted variation in equity, experience, service offer and outcomes; and (iv) reflecting the priorities of local populations.

- In doing so, members of the Partnership should articulate briefly how their organisations have reflected the strategy in their own plans and how they will allocate resources and develop services to support it.

Question 1: Do system leaders support these proposals for ensuring the Partnership has sufficient influence on strategy and planning for the ICS?

Role of the partnership in overseeing system performance

While the Integrated Care Board is formally responsible for allocating NHS funding and accountable for its use of resources, the national NHS's guidance on the Partnership recognises that members of the Partnership, like members of the Board, have a potential role to play in overseeing delivery of strategic objectives and system performance. We see an important role for the Partnership (in conjunction with other arrangements including national oversight) in helping to hold the system collectively to account for performance with regards the agreed deliverables associated with implementation of the ICP's health and care strategy. In doing so, the Partnership will be able to draw on the democratic mandate of local authority leaders, the understanding that different members of the partnership bring of the needs of local populations and people's experience of services.

In our discussions so far, local authority leaders emphasised the need for the Partnership's accountability role to be clearly defined and focused on specific priorities, to avoid the risk that it becomes a talking shop on a wide range of system performance issues. They also emphasised the need to define the information and support that the Partnership would need to play this role, and the right feedback loops to track progress and ensure that the Partnership's interventions are acted on.

We would propose the following arrangements to ensure that the Partnership can play an effective system-oversight role with the Board:

- The Partnership should identify and agree with the Board the key areas where it will play an ongoing role in overseeing and supporting system performance. These should reflect the Partnership's strategic priorities and commitments where it is agreed that Partnership members are best placed to support and oversee the delivery of outcomes and performance;

- The Partnership should agree the key metrics it will use and the information it will need to assess performance in these areas, drawing on theory and evidence on the most effective measures of progress.

- The Board will commit to providing the necessary resources to report on progress against these measures, including allowing the Partnership to compare progress across services and places and against baselines. It should also commit to reporting on actions following the Partnership's advice;

- The Partnership should provide its assessment of progress against these key priorities on an annual basis, possibly as part of its revised integrated care strategy;

- In doing so, each of the members of the partnership should also set out the contributions that they have made to the delivery of these priorities including through their allocation of resources and their development of their services.

- The Partnership should have the ability to 'stop the clock' and ask the Board to review its approach in a particular priority area where there is evidence that the system is failing to deliver its strategic intentions to the agreed timescales.

Question 2: Do system leaders support these proposals for ensuring the Partnership can play an effective role in overseeing and ensuring its own contribution to system performance?

Role of the partnership in supporting key ICS programmes

In its guidance, the national NHS recognises that Integrated Care Partnerships will be particularly well placed to support ICSs in tackling cross-cutting challenges that require collaboration across public services, the VCSE and civil society. In discussions so far, local authority leaders indicated a willingness for the Partnership to play this role in defined areas, providing that projects are focused on interventions that added value to local initiatives at Borough level and are enacted in ways that are consistent with the priorities of local populations.

We would propose the following arrangements for the Partnership to lead a small number of key ICS programmes:

- The Partnership to agree with the Board to directly oversee three to four ICS programmes which require the insight and sponsorship of senior leaders from across health, local authority services and the VCSE, for example our system-wide work to promote health and prevent illness, the implementation of strategic priorities in relation to health inequalities, and the delivery of our South East London wide anchors programme, which aims to use NHS and other resources in ways that support the economic and social resilience of our communities.

- The Partnership to identify members to act as the senior responsible officers for selected programmes and to lead sub-committees or working groups related to them;

- The Partnership to agree appropriate resourcing for these programmes with the Board and report annually on progress, including what more needs to be done by the system to achieve the desired objectives.

Question 3: Do system leaders support these proposals for the Partnership to provide active leadership and oversight to a small number of ICS programmes?

Support and advice for the Partnership

Depending on the precise role the Partnership takes on in our system, the Integrated Care Board and Local Authorities will need to ensure appropriate resourcing for it to deliver its functions effectively. This might take the form of ongoing secretariat support and programme management support and potentially, the ability to draw on external experts where needed to advise on particular priorities. The Partnership will also need to be able to draw on staff within the Integrated Care Board and its partner organisations.

Question 4: What specific support do system leaders believe the IC Board should ensure so that the Partnership can carry out its role effectively?

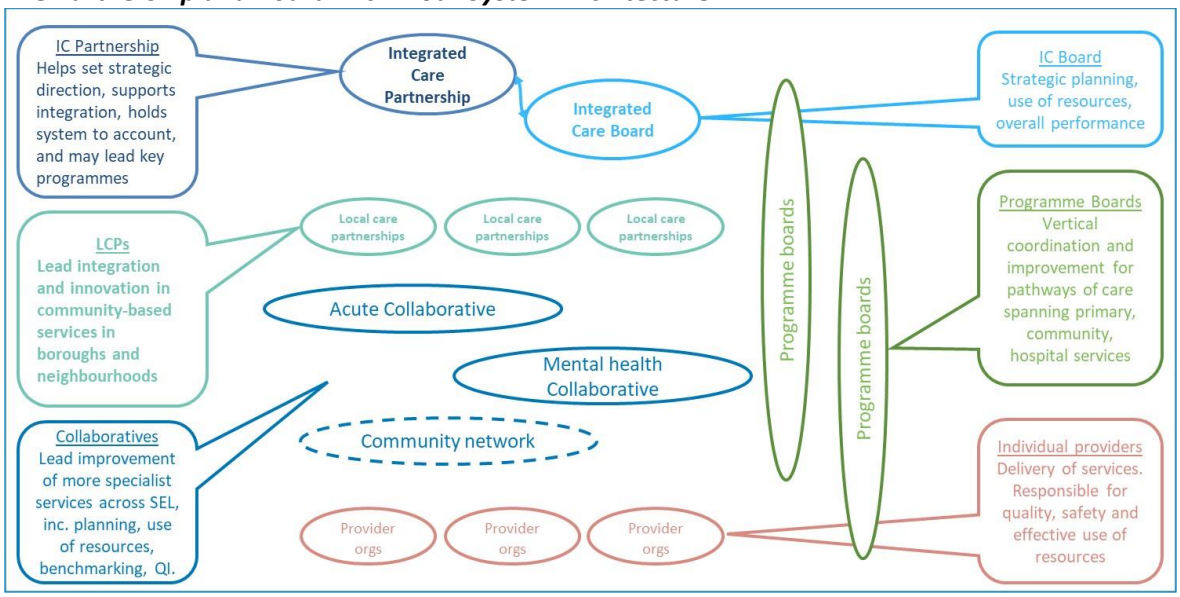
March 2022

Annex

Membership of our Integrated Care Partnership

- IC Board Chair
- IC Board Chief Executive
- Elected leaders or nominated cabinet members of our six local authorities
- Chairs of our main acute, mental health and community service providers: GSTT, LGT, KCH, Oxleas, SLAM and Bromley Healthcare
- A lead Director of Adult Social Care
- A lead Director of Children's Services
- A lead director of Public Health
- A senior representative of King's Health Partners
- A Primary Care / Primary Care Networks representative
- A representative of SEL VCSE services
- A representative of SEL Healthwatch organisations

The Partnership and Board within our System Architecture



South East London
Integrated Care System

Integrated Care Partnership
Paper Cover Sheet

Title:	**State of the Nation: overview of population health and the health and care system in SEL**
Meeting Date:	11th November 2022
Lead / Contact:	Toby Garrood, Joint Medical Director, SEL ICB
Authors / Contributors	Sarah Cottingham, Director of Planning, SEL ICB

Purpose of paper:	**This paper provides a high level 'State of the Nation' overview covering health and health outcomes for south east Londoners, and the current position and outlook for health and care services in south east London. The paper aims to provide context to, and provoke, discussions at the Partnership, acknowledging that further work is needed to develop a more balanced overview of the whole system for future iterations.**	**Update / Information**	X
		Discussion	
		Approval	
Brief summary of paper	**Population health** There are high levels of population health need and inequality across south east London which require collaborative working to address. Particularly stark are the differences in outcomes as a result of deprivation, including premature death. Covid-19 has both highlighted and exacerbated these issues, as well as the challenges we face addressing them, including underlying mistrust in health and care services. Action to address the underlying determinants of health is required now, noting this will likely take some time to have an impact. **Health and care services in the South East London (SEL) system** The NHS system across south east London is under significant pressure, expressed in terms of a significantly challenging financial position and acute and secondary operational performance. The financial challenge over the coming years is expected to increase with some material changes to national allocation policy. In terms of operational performance, there are challenges across the board, indicative of wider system barriers and challenges. The system needs to think differently about the sustainable solutions to current financial and operational challenges. SEL will need to think differently about how to enact solutions and demonstrably adopt approaches that will secure the best value, whilst optimising improvement opportunities. Partners must collaborate to do so, with an approach that has population health as its starting point. **Also attached is an appendices with further detail on three key areas: population health and outcomes, system performance and finance.**		
Recommendation:	**The Partnership is asked to:** • **Note the report**		

State of the Nation

Overview of population health and the health and care system in SEL - a context document

Integrated Care Partnership 22 November 2022

1. Introduction

1.1. The purpose of this paper is to provide members of the Integrated Care Partnership (ICP) with a high level, transparent and open 'State of the Nation' overview covering:

- Health and health outcomes for south east Londoners
- The current position and outlook for health and care services in south east London

1.2. This is intended to provide a helpful overarching baseline position and context to inform the ICP's discussions, recognising the imperative of improving heath, reducing inequalities in access, experience and outcomes and supporting and securing a more resilient and sustainable health and care system.

1.3. These represent the major challenges for the Partnership and the issues the ICS will need to address through collective action. As well as giving context, the paper aims to provoke thinking on our ambition as a result.

1.4. The paper is NHS focussed as the ICS has yet to realise the intention of developing a single version of the truth across our health and care system, four months post establishment. The ICB is keen to be able to provide a more holistic and rounded assessment in the future and hopes to collaborate with Local Authority and voluntary and community sector colleagues to enable this. Despite this gap, the information set out in the paper should provide sufficient information to secure a helpful overview of the challenges faced.

1.5. A number of appendices, again partial in nature, are also attached to provide greater depth, including a summary of population need and inequalities, a focus on NHS performance, and a summary of NHS resource allocation and spend.

2. Population health

2.1. South east London has high levels of health need with a clear link across to the relatively high levels of deprivation and population diversity. Life expectancy for south

east Londoners is below the London average for all boroughs except Bromley. These factors drive significant inequalities, with variance across boroughs including higher levels of need and challenge across our inner south east London boroughs, but with clear inequalities evident within each of our six boroughs. Differences in life expectancy are more marked for those born in the least and most deprived areas across south east London. For example:

- There are significant risk factors that drive inequalities in outcome, both those that are health related and those that are driven by wider social and economic determinants of health.
- A relatively large percentage of premature deaths are attributable to socio economic inequalities, ranging from 21% for Bromley to 45% for Lambeth, with all four inner London broughs between 42 and 45%.
- Five of the biggest risk factors around adult health outcomes are smoking, alcohol, blood pressure, weight and mental health, known as the 'Vital Five'. Smoking for example drives the largest number of deaths attributable to a defined population risk factor and is the leading modifiable factor responsible for health inequalities, accounting for half the ten year difference in life.
- The prevalence of these factors drives relatively high levels of long-term conditions with many people suffering from multiple morbidities or more than one condition. Uptake is low for key wider prevention programmes, across immunisation and vaccination and screening, representing a wider challenge. Low uptake, access issues and late presentations mean the burden of disease is high and SEL has high levels of acute service utilisation as a result.
- Key disease factors driving health inequalities are cancer, coronary heart disease, other long-term conditions such as diabetes and serious mental health, plus many health and outcome challenges across the whole population from maternity through to childhood and then through to old age.

2.2. These issues are not new, but the Covid-19 pandemic has shone a light on them highlighting the fact that underlying inequalities drove significantly higher levels of Covid-19 related risk and poorer outcomes. The wider pandemic impact on access, diagnostic and treatment backlogs has further impacted on health outcomes and south east London's work to encourage Covid vaccination has highlighted the challenges our boroughs face around vaccine hesitancy more generally but also the underlying mistrust many of our more deprived populations have with regards to health and care services.

2.3. The underlying state of population health is therefore stark. There are high levels of population need and inequality; working collaboratively to address these issues represents one of the four main purposes of ICSs and a significant challenge for the South East London (SEL) system. Tackling the underlying causes will require a genuinely collaborative effort across the NHS and Local Authorities given the interplay of health and socio-economic risk factors. Doing more of the same will be insufficient - ICS partners need to challenge themselves and each other to do things differently.

2.4. The ICS will need to secure an optimal balance across generic and targeted population approaches, listen carefully to ensure a responsive offer, ensure a focus on inclusive recovery and provision and shift focus from managing ill health to prevention, early detection and intervention. In doing so ICS partners must act to address the needs of children and young people as well as adults. The system knows enough about evidence-based interventions but has much more work to do to understand how

to tailor these to make them appropriate for and responsive to the diverse populations served. There is a need to plan and act now for the medium to long term recognising that that action to address the underlying determinants of health is unlikely to demonstrate quick results and impacts. Importantly the above is before considering factors such as poor housing, unstable employment or unemployment or the cost of living crisis.

3. Health and care services in south east London

3.1. The NHS in south east London faces significant challenges. Again, whilst these are not new, they have been exacerbated by the Covid pandemic and its impact. These challenges are often expressed in terms of finance and performance, but headline metrics are driven by a range of complex and interrelated drivers, including workforce, demand and capacity and the impact of constrained growth or investment across estate, infrastructure and revenue funding. There are, of course, improvement opportunities too, in relation to productivity and efficiency and care pathway redesign and transformation.

3.2. There is a link too to underlying population health. For example the pattern of urgent and emergency care demand, late presentation and over representation across more deprived communities in south east London drives a higher than expected cost in one of the most expensive areas of service provision in the NHS.

Financial position

3.3. The NHS financial position in south east London, noting that this includes the entire financial health of providers located in south east London, is one of overall recurrent underlying deficit. In some areas these deficits are long standing and significant, noting financial pressures have increased due to 2022/23 allocations which have sought to reduce spend back to pre-pandemic levels through reducing the additional Covid funding that built up during the pandemic. This is in the context of significant increased cost drivers including inflation and excess energy costs.

3.4. It is expected that NHS finances will continue to rebalance over the next couple of years alongside some material changes to national allocation policy, including shifts to the allocation formula and a move to population-based budgets for specialised services, all of which are expected to increase the financial challenge facing SEL and its provider sector.

3.5. These future changes will exacerbate the challenge around future financial resilience and sustainability - the year to date position estimates that SEL will breakeven in 2022/23, however, this in itself has significant challenges through Covid related service pressures, and demand for emergency and mental health services. This year's position is also supported by non-recurrent monies such as Covid allocations, and there is an expectation that non-recurrent income will reduce significantly in 2023/24.

3.6. South east London was an outlier pre-pandemic in terms of its underlying financial position, with a large underlying deficit. However, the pandemic has resulted in a wider NHS challenge and the position now does not particularly stand out at a system level. Regardless of this South east London has a significant and long standing issue to address. Improving financial sustainability and resilience will be important, including enabling the allocation of funding and targeting investment to meet population outcome improvements rather than support financial bottom line positions.

3.7. There are opportunities to improve productivity, noting that the NHS has lost some productivity during the period of the pandemic, and more broadly to improve efficiency and reduce cost through care pathway redesign. System partners will need to work collaboratively to harness these opportunities, recognising that securing genuinely cash releasing savings that do not adversely impact on the service offer will be challenging to do.

Performance

3.8. The NHS system places high importance and focus on a number of key performance targets, focussed on the acute sector and around access and waiting times. Whilst a partial lens, the south east London position vis a vis these targets is indicative of wider care pathway and system challenges, and long waiting times are detrimental from a health outcomes perspective.

3.9. South east London's performance against national expectations with regards to key performance targets is most challenged in urgent and emergency care, with performance significantly below expected national standards.

- The challenge is a long standing one: pre-pandemic SEL was an outlier in terms of relative performance.
- The pandemic impact has resulted in the SEL position now being comparable to others in London, noting London's performance exceeds or is better than that of other Regions.
- Regardless of the south east London relative position, urgent and emergency care represents an on-going and significant challenge, with acute access, waiting times and flow constraints indicative of a wider system under pressure and a lack of capacity, resilience and sustainability in community based services.

3.10. On other key performance targets again the Covid pandemic has reframed overall delivery expectations and our relative position. SEL has historically faced long term challenges in delivering core access standards across elective, cancer and diagnostic services. These challenges have been exacerbated by the pandemic, during which period significant backlogs built up. The equivalent impact in other systems has resulted in the ICS being less of an outlier and recovery, particularly in elective care, has been very positive to date in absolute and comparative terms. Despite this, south east London remains far from a resilient and sustainable position, with a significant distance to reduce waits to pre-pandemic national standards, recognising that these were not being met pre-pandemic.

3.11. Other areas of NHS provision have far less visibility than the headline acute related targets, but there are similar issues across mental health and community services with challenges around timely access and waiting times. Despite more primary care appointments being available meeting primary care demand remains a massive challenge, with primary care type attendances evident across the system, including in our Urgent Treatment Centres and Accident and Emergency Departments.

3.12. In overall terms, SEL's historic and current performance challenges are indicative of wider system barriers and challenges. The SEL system has mismatched demand and capacity, both physical and staffing capacity. For example, across all areas, workforce is an ongoing challenge and constraint. The vacancy rate in NHS Trusts is projected to be at 12.8% in March 2023, with 7,326 substantive posts expected to be vacant (Ref. 2022/23 Operational Plan). Whilst the vacancy rate is reducing from the overall

14.4% vacancy rate seen in 2021/22, workforce supply and physical capacity remain a challenge.

3.13. Vacancy challenges within Primary Care and Social Care are also complex and, whilst challenging to attach a single vacancy figure to these sectors, these are being addressed through new roles, new ways of working and improved retention strategies. There are other improvement opportunities related to both productivity and efficiency, care pathway transformation and the systematic roll out of evidence based best practice and SEL partners will need to ensure we collectively embrace and optimise these opportunities. Many will require working across organisational boundaries and SEL partners will need to enable these opportunities, recognising the very real benefit, as evidenced by the Acute Provider Collaborative approach to elective recovery, that system working can bring.

Thinking differently

3.14. However, South east London also needs to think differently about the sustainable solutions to these underlying financial and performance challenges. On urgent and emergency care for example there will only be so much partners can do through improving the productivity and efficiency of existing care pathways - the more sustainable solution will come from taking a population approach that understands the drivers of urgent and emergency care demand and tackles these. For example, ensuring timely and proactive planned care access and management, combined with a targeted risk-based approach founded on early detection and intervention, would over time help drive reduced demand for urgent, emergency and crisis care.

3.15. Local Authorities face similar challenges to the NHS, related to finance, workforce, capacity and market development and management, impacting on children and young people's services, adult social care and public health. Over recent years Local Authorities have had to take tough decisions to enable spend to be contained within available funding. This has been exacerbated in 2022/23 by the withdrawal of pandemic related funding, most notably the Hospital Discharge Fund. Looking forward, it is unlikely that national funding will ease the position and the impact of adult social care reform will add further uncertainty and challenge. Workforce is a key challenge across care services and capacity is an increasing challenge too noting that acuity and patient complexity is increasingly difficult to manage within the current market, alongside the cost of doing so.

3.16. South east London's legacy and current position is one of significant challenge, both financial and operational. Whilst the ICS is not a material outlier in these areas, the challenges are longer standing than many other ICSs face, and therefore potentially more intractable in terms of securing sustainable solutions.

3.17. Partners will need to tackle the underlying drivers, such as right sizing capacity, securing the workforce required to meet demand and improving our estate and wider infrastructure. This will be challenging in an environment of constrained funding and will require partners to ensure they are optimising value based care and value for money on a system basis. Sustainability solutions will also lie within the south east London population, so a different approach is needed to address these issues, one that focusses less on marginal changes across care pathways and more on starting and finishing with an understanding of population health and a proactive approach to population health management.

4. Next steps – the challenge for our Integrated Care Partnership

4.1. As this paper is both brief and partial it does not do full justice to the range and complexity of issues facing the ICP. However, along with the existing knowledge of SEL's population and health and care services our partner members have, it is enough to know that:

- There are very significant challenges to address population health and equity of access, experience and outcomes for the south east London population - this represents a historical challenge exacerbated by the pandemic.
- There are long standing challenges in terms of the resilience and sustainability of the current service delivery model, with underlying financial and performance issues indicative of a wider system under significant strain, with the barriers to a sustainable system including mismatched demand and capacity, poor estate and enabling infrastructure and workforce.

4.2. Solutions to this will take time. There is no quick or easy fix. However, this must not prevent the ICS from agreeing and acting in the short term and keeping faith until the medium and longer term benefits are felt. The solutions will not be located within individual organisational or parts of our system - there will be a need to work collectively and collaboratively to identify, implement and secure solutions.

4.3. South east London will need to change the way it thinks about and enacts solutions, and demonstrably adopt approaches that secure best value and optimise productivity, efficiency and care pathway improvement opportunities. However, SEL partners will need to combine work to do so, with an approach that takes as its starting point population health.

4.4. This requires proactive management to improve equity of access, experience and outcomes, alongside a concerted focus on targeted prevention, early detection and intervention, proactive anticipatory care and a local offer rooted in south east London communities through genuinely integrated neighbourhood teams that are person not organisation or service centred. We will also need to consider system enablers in relation to risk, gain share and incentivising change, recognising where national funding and performance regimes do not lend themselves to innovation, to ensure funding follows the patient/service user and radical approaches to resource allocation.

4.5. Enabling change is however, with a collective endeavour and commitment, within south east London's gift. As the ICP considers key outputs and actions as a partnership, this state of the nation challenge should provide helpful context against which to consider SEL's strategic priorities, approach to infrastructure development and an allocative framework.

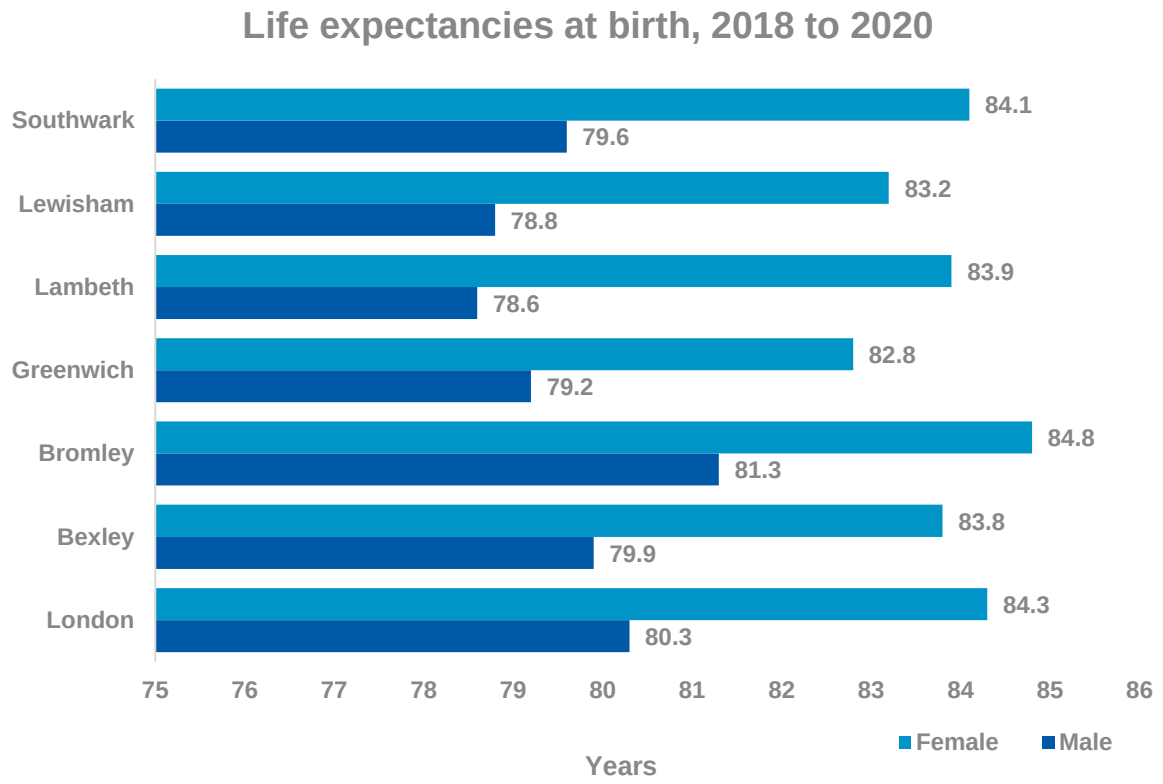
South East London Integrated Care System

SEL Integrated Care System
'State of the nation' overview: Appendices

Prepared for the SEL ICP, 22nd November 2022

The life expectancy at birth of the South East London population is generally lower than the London average

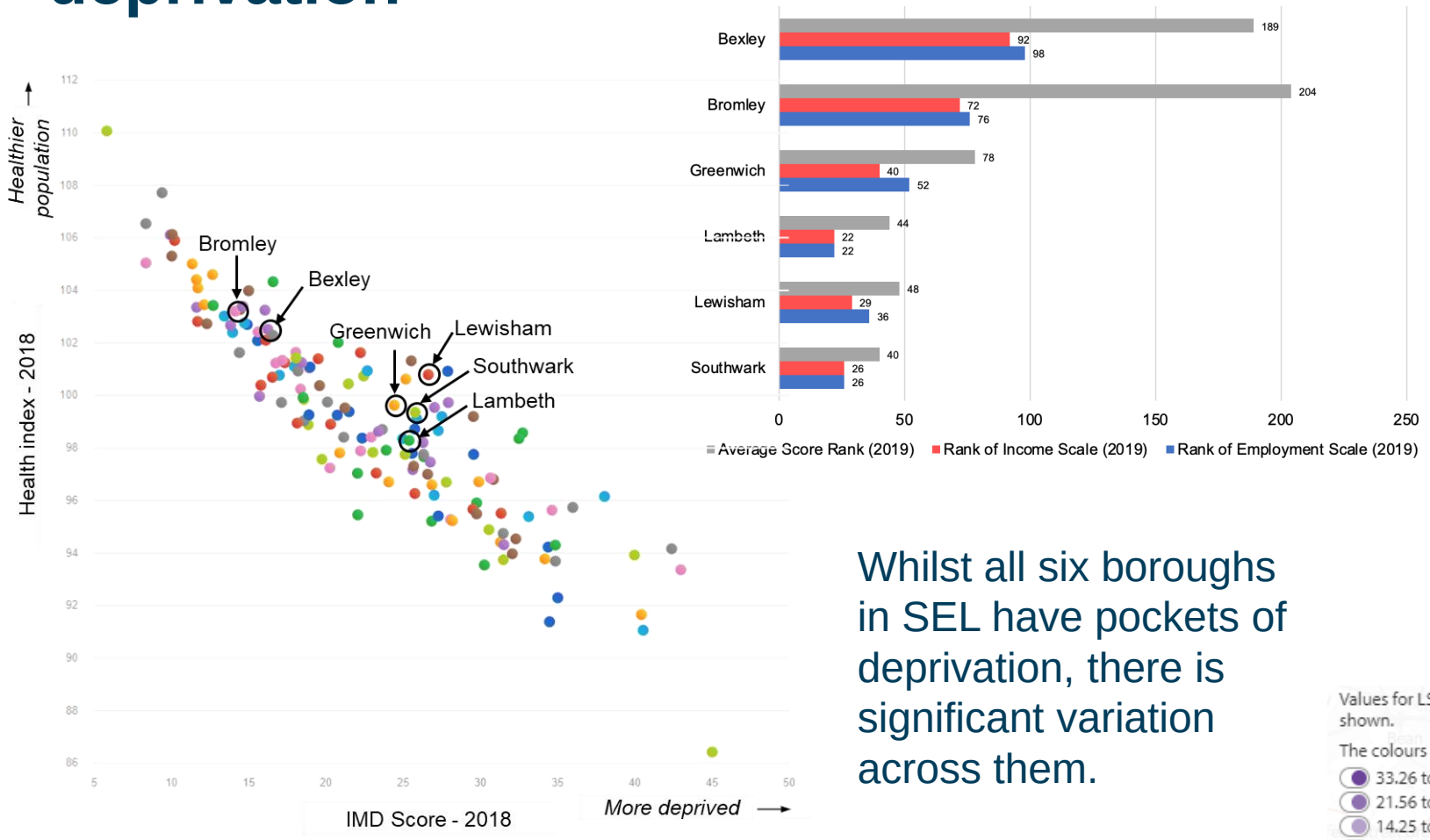
- The life expectancy at birth of the Lambeth, Lewisham and Greenwich populations is lower than the London average.
- Bromley has a life expectancy that is statistically higher than the London average.



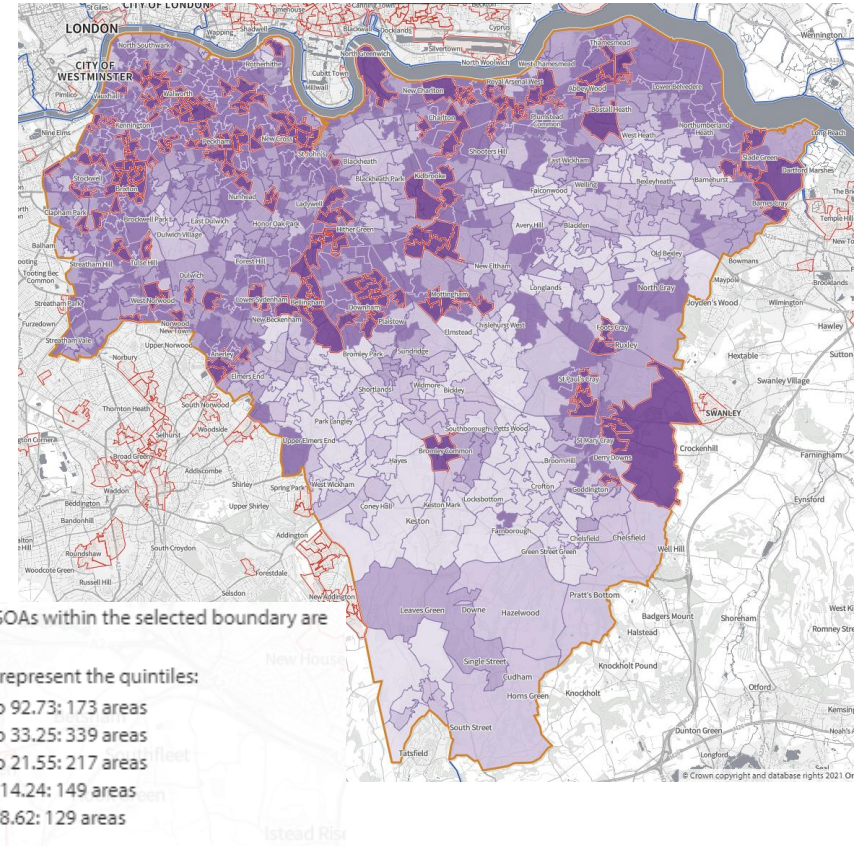
References

1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

Across South East London (SEL) there are areas of high deprivation



Scatter Chart showing ONS Health Index (Y axis) against IMD (x axis) for local authorities in England



Whilst all six boroughs in SEL have pockets of deprivation, there is significant variation across them.

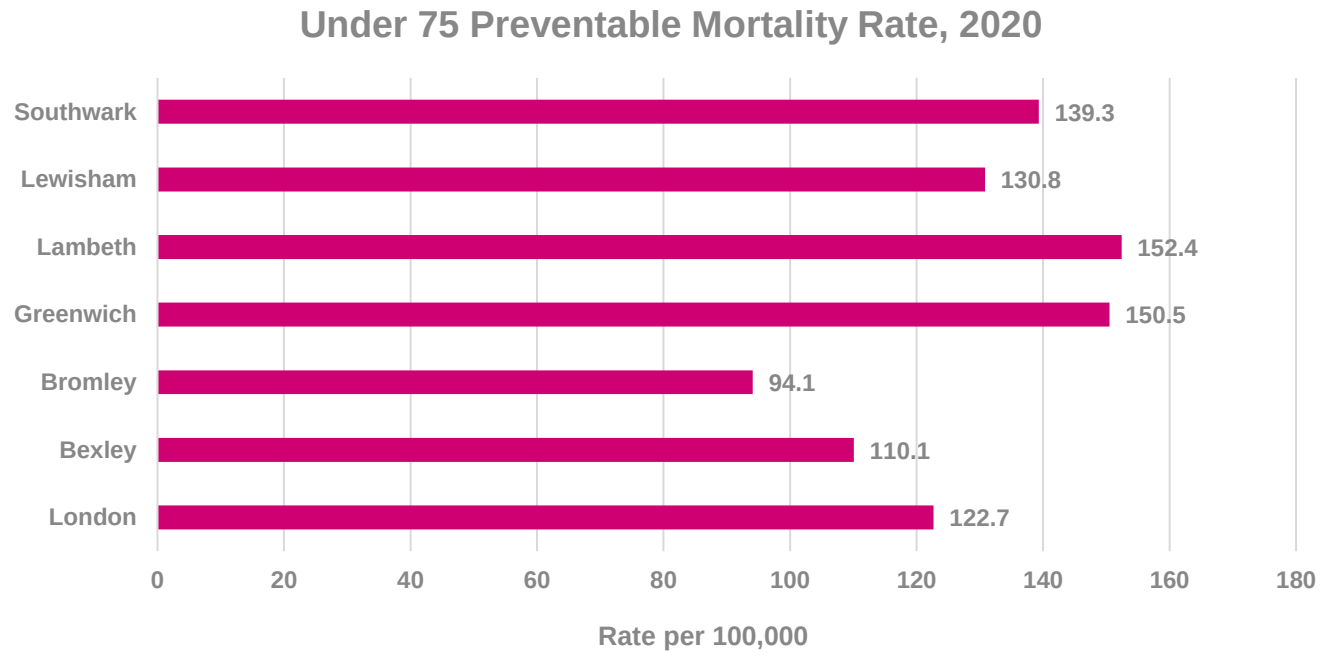
There is a clear relationship between health and deprivation.

References

1. SHAPE analysis tool

Most boroughs within South East London have a preventable mortality rate higher than the London average

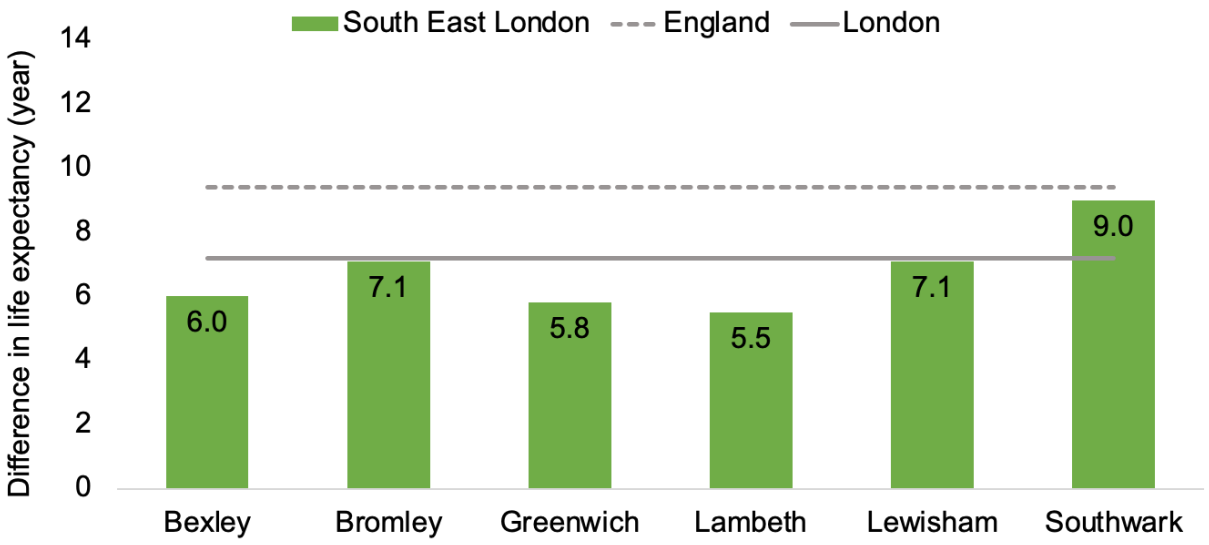
- The preventable mortality rate in Lambeth and Greenwich was higher than the London average in 2020
- Bromley had a preventable mortality rate that statistically was significantly lower than the London average



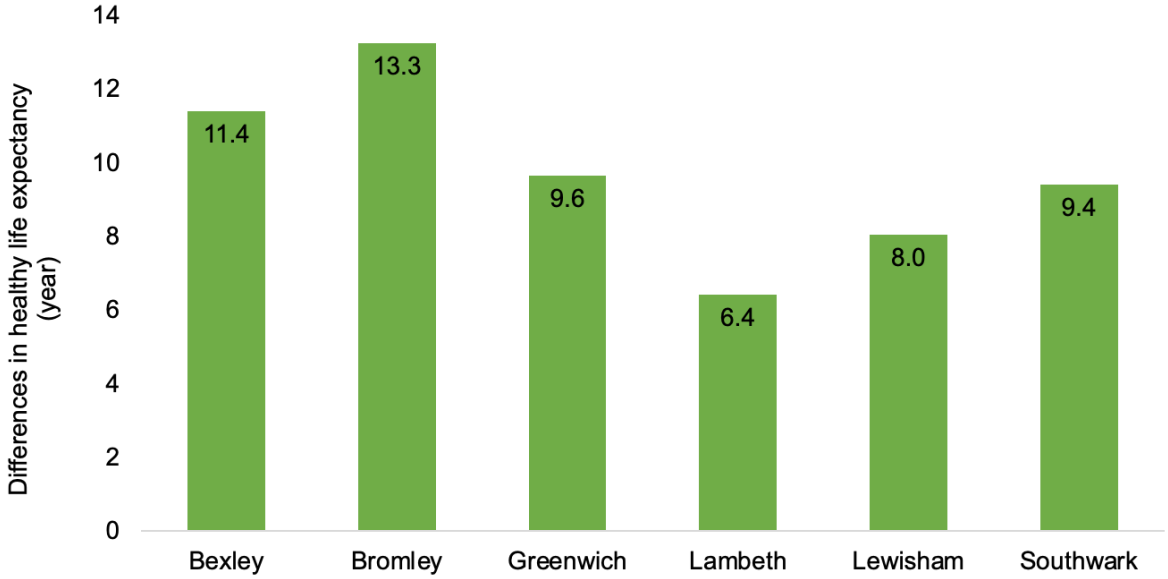
References

1. OHID 2022. Fingertips tool. Public Health Outcomes Framework. Diseases considered preventable as per OHID 2019 definition set.

In all Boroughs there is a significant difference in life expectancy & healthy life expectancy



Differences in life expectancy at birth (males) between least and most deprived areas for boroughs in south east London, London region, England (2015-17).



Differences in healthy life expectancy at birth (males) between least and most deprived areas for boroughs in south east London, London region, England (2015-17).

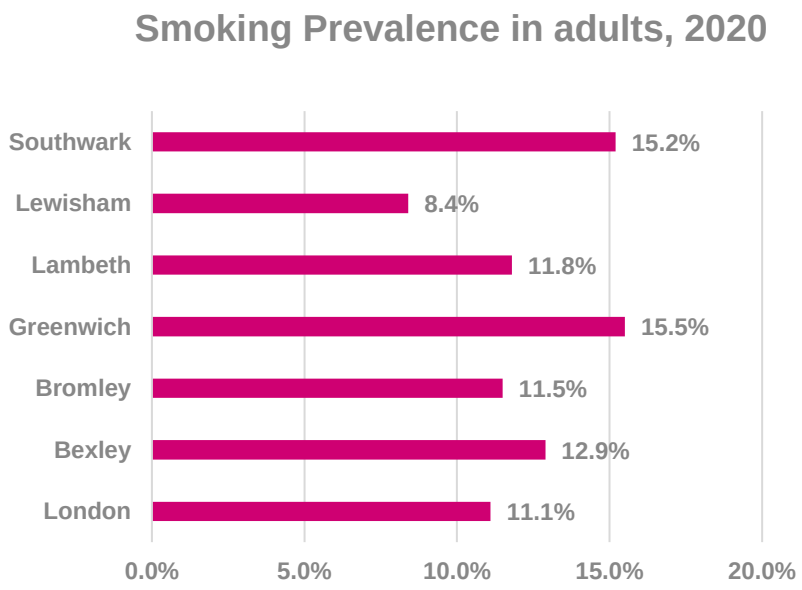
References: Public Health England, extracted from Public Health Outcomes Framework, available at https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/

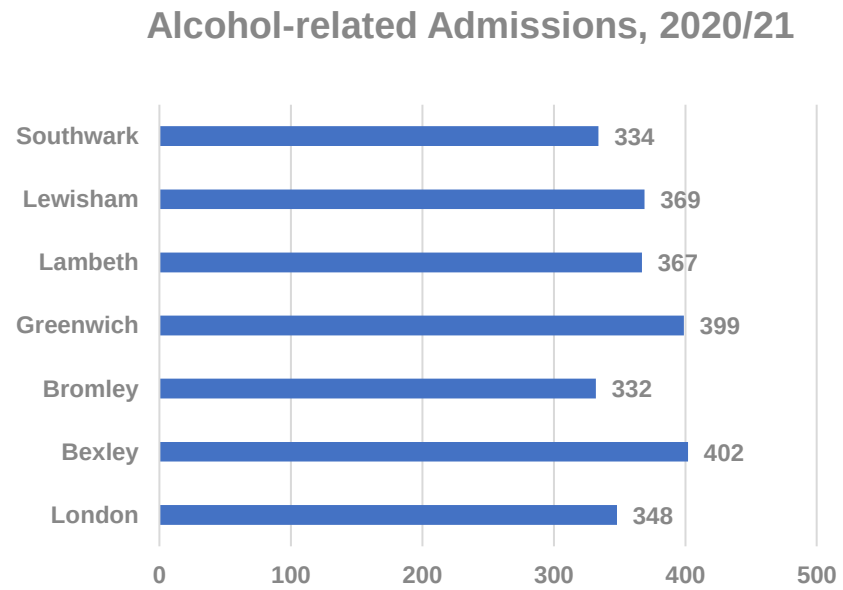
The SEL smoking prevalence and alcohol-related admission count varies in relation to the London average

South East London Integrated Care System

MODIFIABLE RISK FACTORS

- The smoking prevalence within the Greenwich and Southwark populations was significantly higher than the London average.
- Lewisham had a smoking prevalence that was significantly less than the London average.
- Greenwich and Bexley had the highest number of alcohol-related hospital admissions.





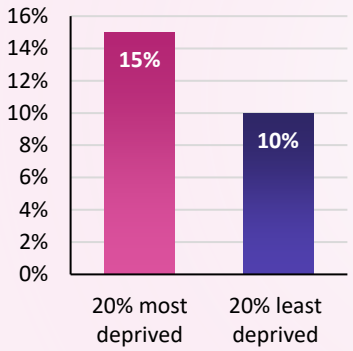
References

1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

Impact of smoking in SEL[1]

Core20: **Above-average smoking rates among the most deprived reduces their healthy life expectancy and increases pressure on the NHS**

National smoking rates APS (2020)



In our ICS smoking rates among the routine and manual population are 24%

Annually smoking causes

- 9,251 hospital admissions
- 4,200 premature deaths

Additional impact on communities

- Costs society 663.82M a year
- 70,737 smoking households live in poverty
- 9,576 people out of work due to smoking
- 28,638 people receive informal care from friends and family because of smoking

PLUS: The most deprived groups have the highest smoking rates

National smoking rates among:

- Homeless (77%)
- People entering prison (80%)
- 11–16-year-olds with a mental disorder (22%)
- Social housing (26%)

ICS smoking rates for those receiving addiction treatment:

- opioids 81%
- alcohol 47%

5: Five clinical areas of focus are all impacted by smoking Acknowledgement – provided by ASH[1]

1. Maternity	2. Severe Mental Illness	3. Chronic respiratory illness	4. Early cancer diagnosis	5. Hypertension
Smoking is the leading modifiable risk factor for poor birth outcomes In your ICS 5% of women smoke at time of delivery ~ 920 women annually	Smoking is the leading cause of the 10-20 year reduction in life expectancy for people with SMI. In your ICS 41% of people with SMI smoke	Around 86% of all COPD deaths are caused by smoking In your ICS 626 people a year die from COPD	Smoking is the leading preventable cause of cancer responsible for 27% of cancer deaths In your ICS 637 people a year die from cancer caused by smoking	Smoking cessation is embedded in NICE guidelines on hypertension because smokers' CVD risk is double that of non-smokers. In your ICS 192 people a year die from CVD caused by smoking
Find out more	Find out more	Find out more	Find out more	Find out more

What the ICB/P can do:

1. **Prioritise implementation of the NHS LTP funded tobacco dependency treatment pathways** in maternity, mental health and acute inpatient services by 23/24 with mainstreaming by 24/25. Current timeline for implementation variable across the system. ICB leadership is needed to drive action.

2. **Ensure prevention plans** are developed in collaboration with local government, the system leader for public health and focus on tobacco and inequalities. The NHSE 22/23 operating guidance requires plans to include action on tobacco. ASH recommendations here.

3. **Sign the NHS Smokefree Pledge** a public commitment to tackling smoking by NHS leaders on behalf of their organisations. Nationally the Pledge has been endorsed by the NHSE Chief Executive, ADPH, AoMRC, BMA, FPH and RCM.

4. **Support regional models for tobacco control.** Collaboration with local government on a regional footprint has been proven to be a cost-effective way to tackle smoking and reduce inequality. ASH report and summary.

References

1. Action on Smoking and Health (ASH), 'Impact of smoking on Core20Plus5: Guide for NHS South East London ICB'. Available at ash.org.uk/uploads/Guide-for-NHS-South-East-London-ICB.pdf?v=1649675833

Cancer in South East London (SEL) – Headlines

South East London Integrated Care System

Incidence

- In 2019, the number of cancers diagnosed in SEL was just over 8,000 cancers. Incidence of cancer is generally higher in more deprived populations.
- From 2015-2019, SEL had a crude rate of 1,327 per 100,000. That is the highest rate of all the London Cancer Alliances (NWSWL: 1,321: per 100k, NCL: 1,249 per 100k, NEL: 1,097 per 100k).
- A significant proportion of cancers are preventable if risk factors are removed or modified. The most important factors are smoking, alcohol and a high body mass index.

Early diagnosis

- The proportion of all cancer diagnosed at stage 1 and 2 in SEL in Q3 2019 was 55.7%. SEL had a lower proportion of cancers diagnosed at an early stage compared to London (56.6%), but a higher rate than the average for England (54.3%)
- The proportion of cancers diagnosed at an early stage decreases with increasing deprivation.

Screening

- The overall screening uptake and coverage is lower in SEL than the England average but is higher than London. There is variation across SEL; inner SEL boroughs have a lower uptake and coverage.
- Screening uptake and coverage in SEL is lower in non-white, non-English main language, and highly deprived populations.

Survival

- One-year net cancer survival (2019) - all cancers (%): SEL 74.6%, England 73.9%
- Five-year net cancer survival (2019) - all cancers (%): SEL 53.7%, England 54.6%
- There is a wide variation by tumour site.
- The picture regarding differences by ethnicity is less clear due to poor historic data capture.
- Survival rates are lower with increasing deprivation.

1 Year and 5 Year Cancer Survival For Colon Cancers in SEL, London and England By Gender
England Deprivation

	Survival	Male	Female
Most Deprived	1 Yr Survival	72.2	70.1
	5 Yr Survival	51.8	52.7
Least Deprived	1 Yr Survival	80.8	77.9
	5 Yr Survival	61.4	60.6

SEL screening data

Metric	Period	Does latest data cover pandemic period?	Benchmark	RAG Key	SEL	London	England
Bowel screening coverage (60-74) (%)	2020/21	Y	60% (PHE target)	Green - above benchmark Amber - within 5% of benchmark Red - below 5% of benchmark	62.2	61.1	68.8
Bowel screening uptake (60-74) (%)		Y	60% (PHE target)	Green - above benchmark Amber - within 5% of benchmark Red - below 5% of benchmark	64.4	62.4	70.7
Breast screening coverage (50-70) (%)		Y	80% (PHE target)	Green - above benchmark Amber - within 10% of benchmark Red - below 10% of benchmark	54.9	51.5	61.3
Breast screening uptake (50-70) (%)		Y	80% (PHE target)	Green - above benchmark Amber - within 10% of benchmark Red - below 10% of benchmark	58.7	55.6	62.8
Cervical screening coverage (25-49) (%)	Q3 2021/22	Y	80% (PHE target)	Green - above benchmark Amber - within 10% of benchmark Red - below 10% of benchmark	65	60.3	68.1
Cervical screening coverage (50-64) (%)		Y	80% (PHE target)	Green - above benchmark Amber - within 10% of benchmark Red - below 10% of benchmark	73.4	71.5	74.8

- Nearly 50% of cancer deaths are caused by preventable risk factors — smoking, alcohol use and obesity.[1]

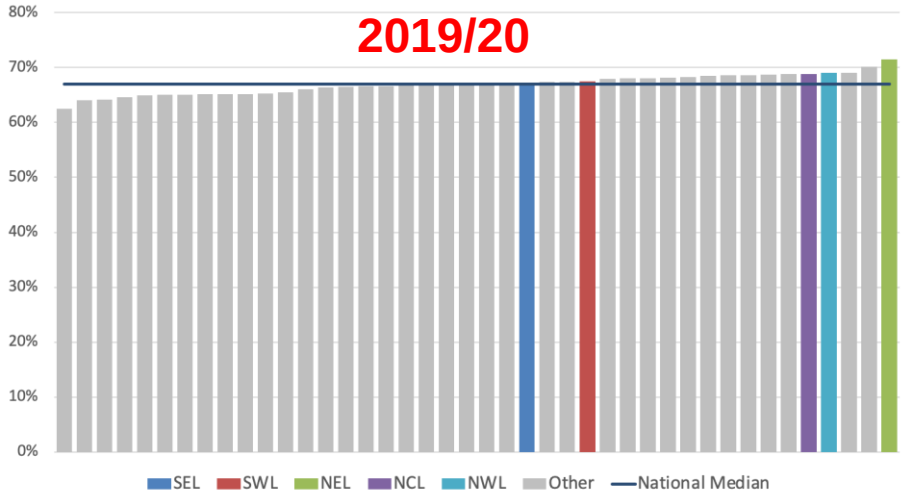
References

1. G. Guglielmi, 2022. “Almost half of cancer deaths are preventable”. Nature. Available at nature.com/articles/d41586-022-02355-x?utm_source=Nature+Briefing&utm_campaign=dc4c023d09-briefing-dy-20220902&utm_medium=email&utm_term=0_c9dfd39373-dc4c023d09-45736774

Hypertension Patients aged 79 years or Younger with a blood pressure (BP) of <140/90

Patients aged 79 years or under, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less.

2019/20

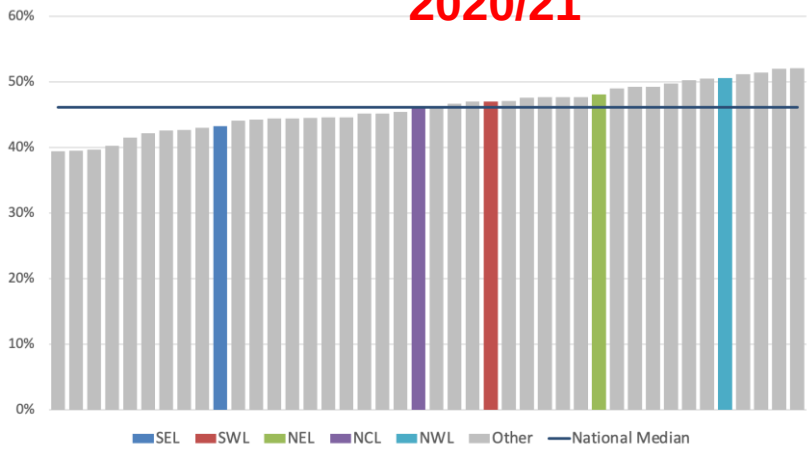


ICS	Value	Quartile
SEL	67.3%	Quartile 3
SWL	67.5%	Quartile 3
NEL	71.5%	Quartile 4
NCL	68.8%	Quartile 4
NWL	69.0%	Quartile 4

Median	Value
London	68.8%
England	67.0%

Reporting Date
2019/20

2020/21



ICS	Value	Quartile
SEL	43.3%	Quartile 1
SWL	47.0%	Quartile 3
NEL	48.1%	Quartile 3
NCL	46.1%	Quartile 2
NWL	50.6%	Quartile 4

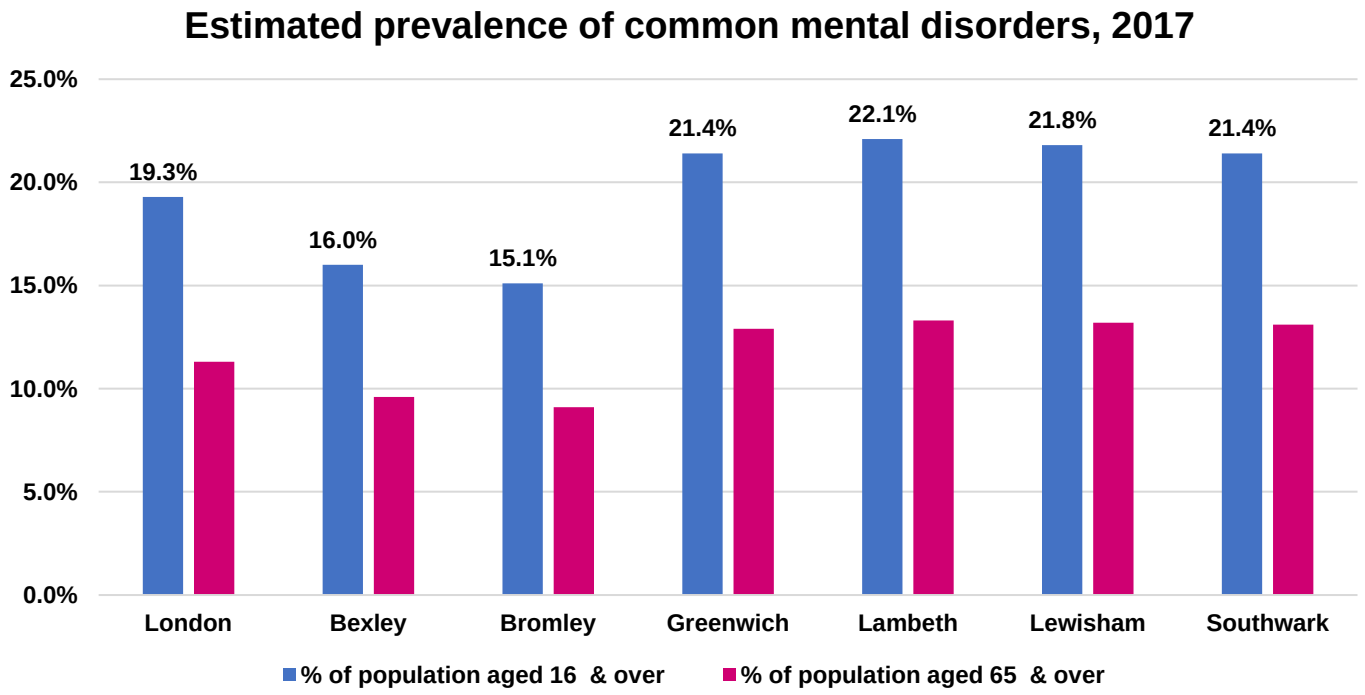
Median	Value
London	47.0%
England	46.2%

Reporting Date
2020/21

- SEL was the worst performing London ICS, and our position has worsened due to the pandemic.
- Research using Lambeth DataNet shows that approximately:
  - C. 20% of the population has hypertension (which equates to an estimated 60,000 people in Lambeth).
  - C. 50% of these people are known to general practice (an estimated 30,000 people in Lambeth).
  - Of those known to general practice, c. 50% have well controlled blood pressure (an estimated 15,000 people in Lambeth).
  - Therefore, c. 75% of those with hypertension (an estimated 45,000 people in Lambeth) are either not identified or their hypertension is not well controlled.
- Drugs to treat hypertension are available, effective, safe and cheap. The challenge is reaching people.

The estimated prevalence of common mental health disorders in SEL is above the London average

- Four of the six South East London boroughs had a higher prevalence of common mental health disorders compared to the London average.
- Lambeth had the highest prevalence of common mental health disorders amongst both the over 16 and over 65 population groups.



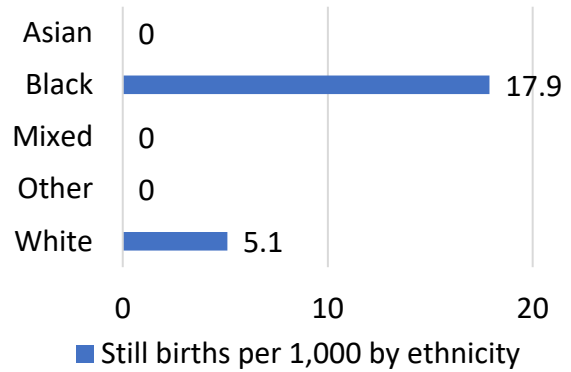
References
House of Commons Library
https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06988

References
1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

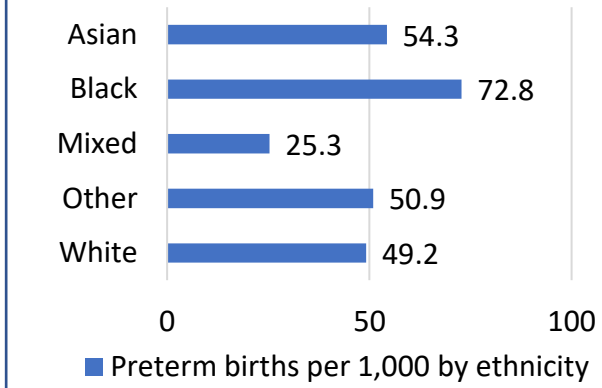
Pregnancy and Maternal Health

- Across the UK, the maternal mortality rate is four times higher for women from Black ethnic backgrounds, and two times higher for those from Asian ethnic backgrounds, then for White women[1].
- In South East London c. 50% of women and birthing people b-ooking for care are White, c. 16% are of Black ethnicity and c. 8% of Asian ethnicity. As elsewhere, prevalence of still births and pre-term births differs by ethnicity (*see below*).

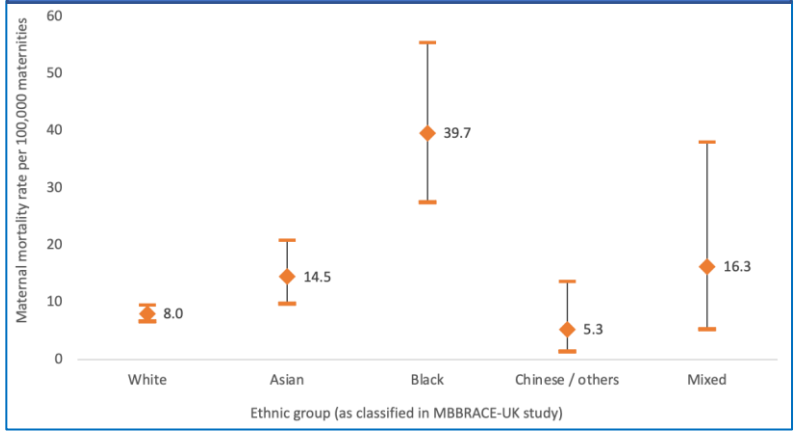
Still births per 1000 by ethnicity, South East London[1]



Pre-term births per 1000 by ethnicity, South East London[1]



Maternal mortality rate by ethnic group for England (95% confidence intervals)



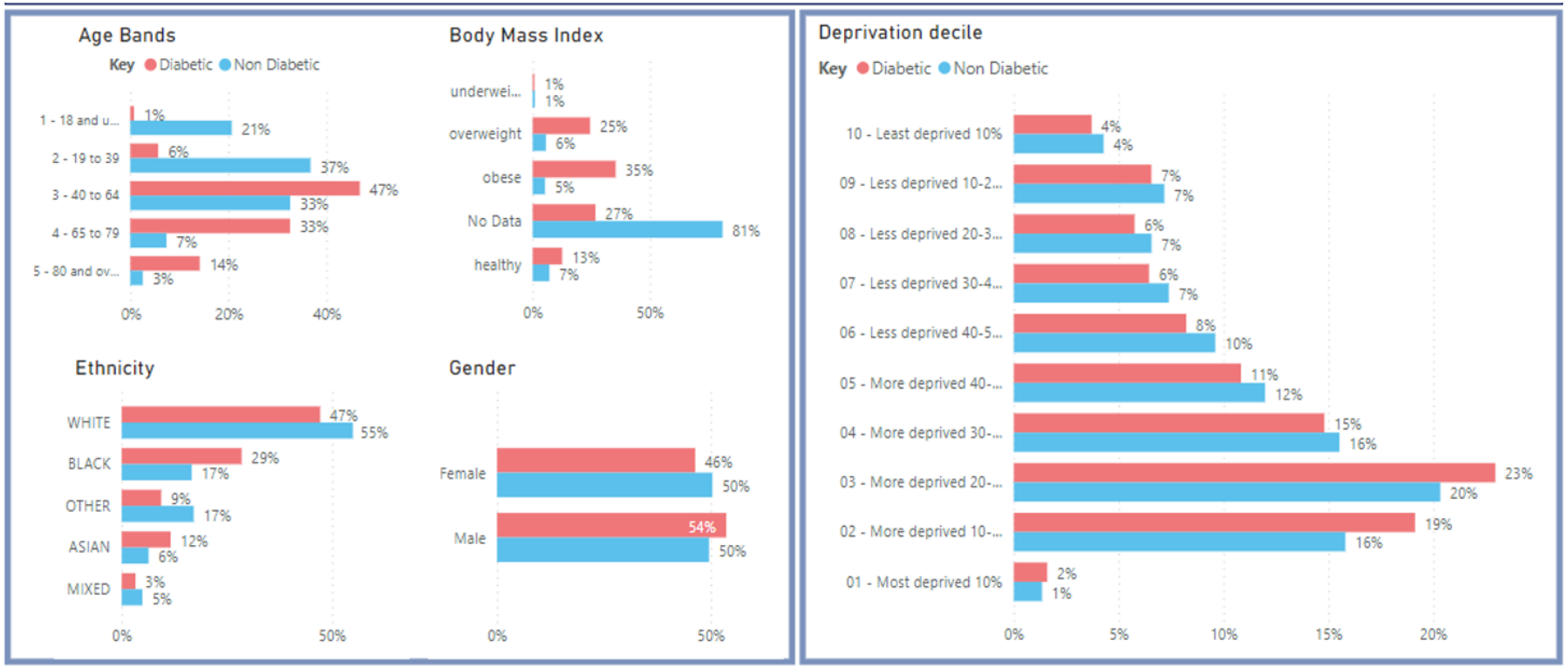
- In response, we have a **£5m partnership with Impact on Urban Health which aims to significantly contribute to reducing health inequalities** across South East London's six boroughs by improving health services for those who typically have the worst experiences.

References

1 South East London Local Maternity and Neonatal System Equality and Equity Health Needs Assessment, May 2022 - 'Other' is the average rate for those described as 'Other', 'Not stated' or 'Unknown'.

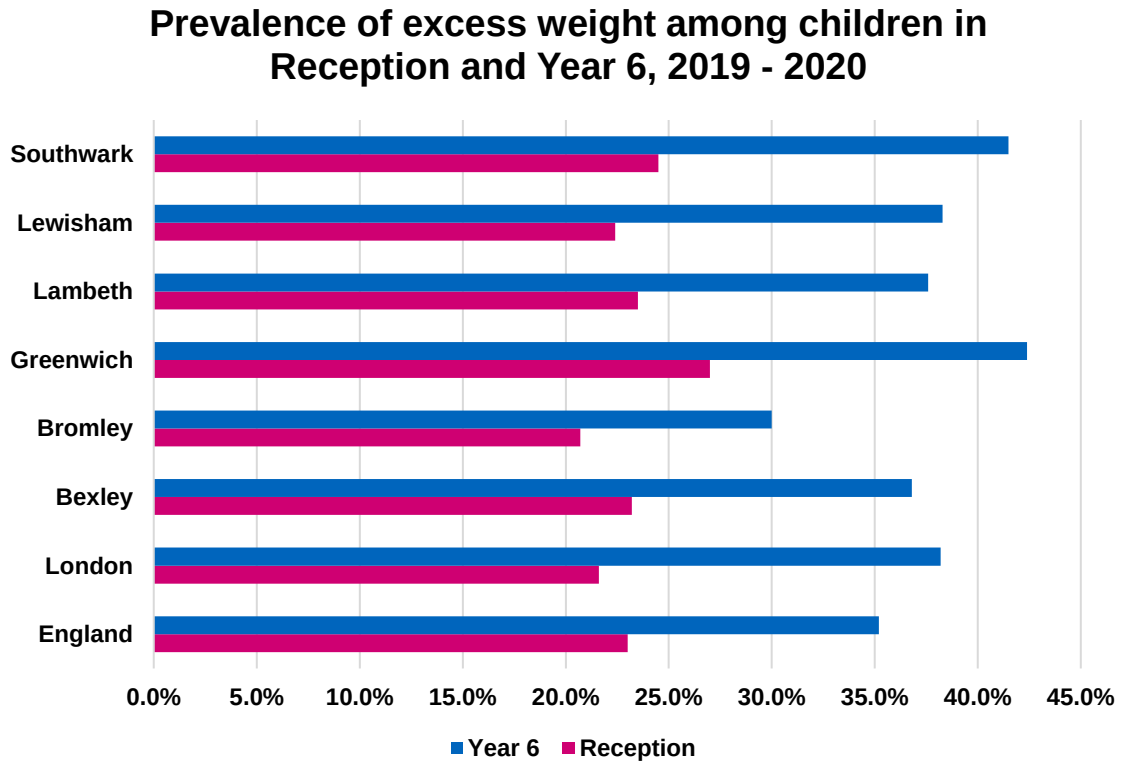
Diabetes and Obesity

- There are around 100,000 people with Type 2 Diabetes in SEL and around 6,000 with Type 1 Diabetes.
- Our 3-treatment target performance across SEL (i.e. good control of blood sugar, blood pressure and cholesterol) **has fallen significantly since the pandemic** (similar to the rest of the country).
- SEL has developed a diabetes and obesity outcomes dashboard based on primary care data allowing real time insights into SE London performance, including sub analyses for gender, ethnicity, age and deprivation.



A significant number of children in South East London are overweight or obese

- In comparison to the London average, Southwark, Greenwich, Lambeth and Lewisham had statistically higher levels of excess weight amongst Year 6 children, while Bromley had a statistically lower rate of excess weight.
- Childhood obesity disproportionately affects marginalised communities, especially Black and Minority Ethnic children, and children of low socioeconomic status.

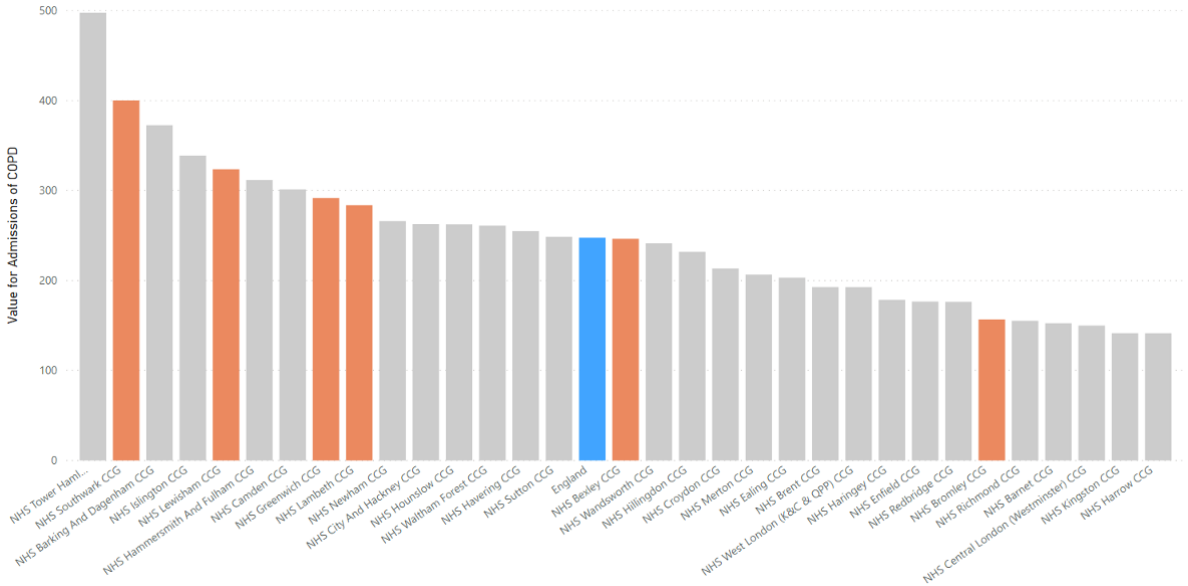


References
1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

Respiratory and chronic obstructive pulmonary disease (COPD)

- Four of the boroughs have higher rates of emergency admissions for COPD (Lewisham, Southwark, Greenwich, Lambeth) than the national average. It is estimated 626 people in SEL year die from COPD annually
- Three have higher rates of emergency admissions for respiratory disease (Greenwich, Lewisham and Southwark).
- Respiratory cancers and COPD, for which smoking tobacco is a major risk factor, account for approximately 20% of premature deaths attributable to socioeconomic inequalities.

Number of emergency hospital admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population by borough with south east London boroughs and England average highlighted



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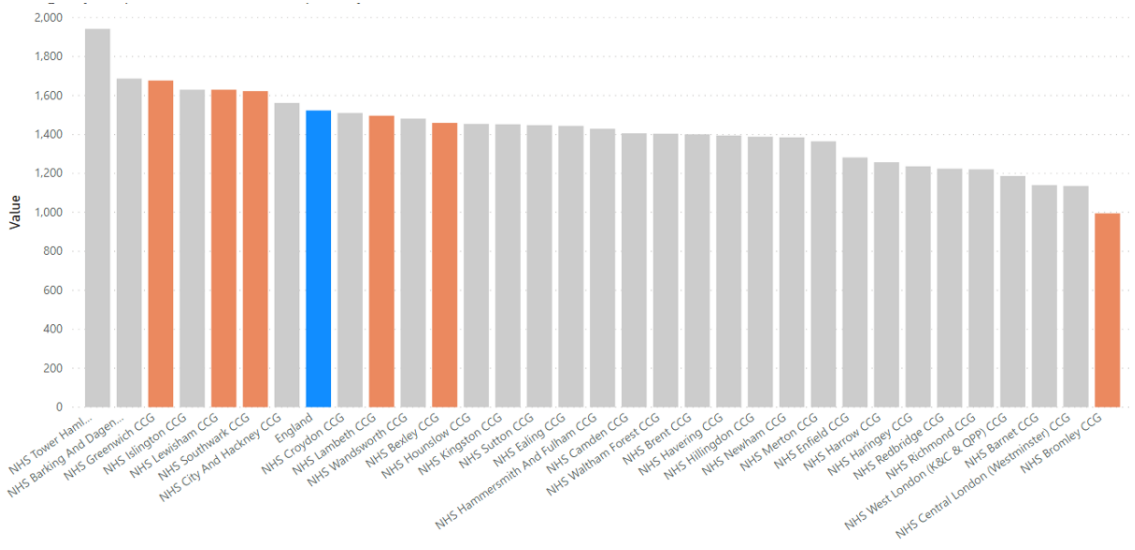
Number of emergency hospital admissions for respiratory disease per 100,000 population by borough with south east London boroughs highlighted



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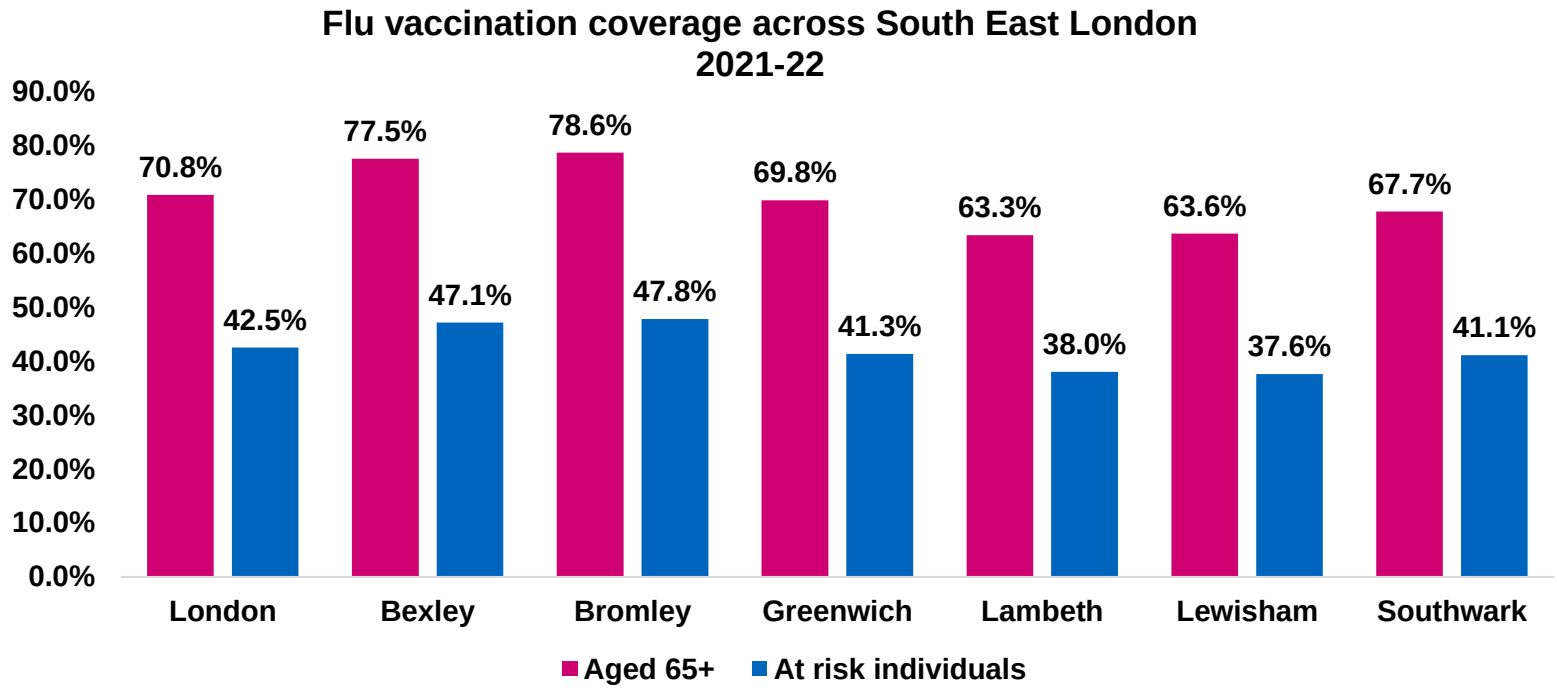
Most boroughs within South East London have lower flu vaccination coverage than the London average

- Lewisham, Lambeth, Greenwich and Southwark all had a flu vaccination coverage that was significantly lower than the London average from 2021-22.
- Bromley and Bexley had a significantly higher flu immunization than the London average for both individuals at risk and over 65 years old.



References

1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

COVID-19, circulatory conditions and cancer are the main drivers of the gap in life expectancy within boroughs

South East London Integrated Care System

- The life expectancy gap between most disadvantaged and least disadvantaged communities within South East London boroughs ranges from around 2 years to over 7.5 years.
- The main contributors to this gap are: death caused by COVID-19, followed by death due to circulatory conditions and cancer.

Table 1: Gap in life expectancy between the most and least deprived communities within each borough and a breakdown of the top contributing causes

	Life expectancy gap in years		Percentage contribution to the gap (%)**									
			COVID 19		Circulatory		Cancer		Respiratory		Mental Health	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
London	5.1	6.9	25.3	22.9	19.8	23.8	17.7	14.9	11.4	10.6	4.7	3.5
Bexley	2.2	5.2	17.5	19.4	31.2	17.9	2.9	15.4	20.8	6.3	0	5.3
Bromley	5.5	6	13.3	17.5	16.3	23.1	11.3	17.1	20.3	13.5	13.7	8.5
Greenwich	6	5.6	15.7	17.9	20.7	23.7	19.7	13.5	13.9	18.3	10.8	0
Lambeth	4.8	5.7	49.8	22.7	10.1	26.5	11	19.1	13.3	7.6	1.7	2.2
Lewisham	6.5	5.5	13.4	21.8	24.6	7.4	17.8	24.3	23.7	13.9	6.5	7.2
Southwark	6.2	7.6	23.1	10.5	19.3	29.6	18.8	13.1	17.4	14.3	5.9	3.6

References

1. OHID 2022. Fingertips tool. Public Health Outcomes Framework.

Performance summary

- These slides are designed to give a flavour of performance in SEL across key areas of care within the system; urgent and emergency care, cancer, elective, primary care, community care, mental health and learning disabilities and autism.

- Data available within the system – which is mainly driven by the national metrics – are skewed towards the acute part of our system. As a result the data within this pack also has an acute skew. However, performance against these acute metrics is an important lens through which to view system performance because they are good indicators of wider system pressures. For example, high A&E demand is indicative of how people are accessing services, and challenges discharging people who are medically fit is an indicator of pressures within community care and care home placements.

- The pandemic presented a number of challenges for services and we continue to see the effects of this; large increase in the number of people waiting for treatment, and within this the backlog for cancer care, increase demand for mental health services and particularly for children and young people's services, and demand is outstripping supply for general practice appointments despite increases in number of appointments.

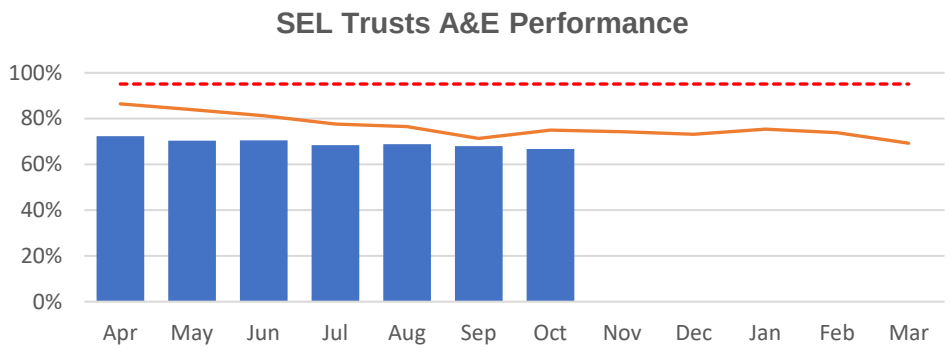
- However, we must recognise that SEL has had long standing performance challenges due to demand and capacity imbalances and challenges getting patients to the right place first time, and has not met national targets for many years.

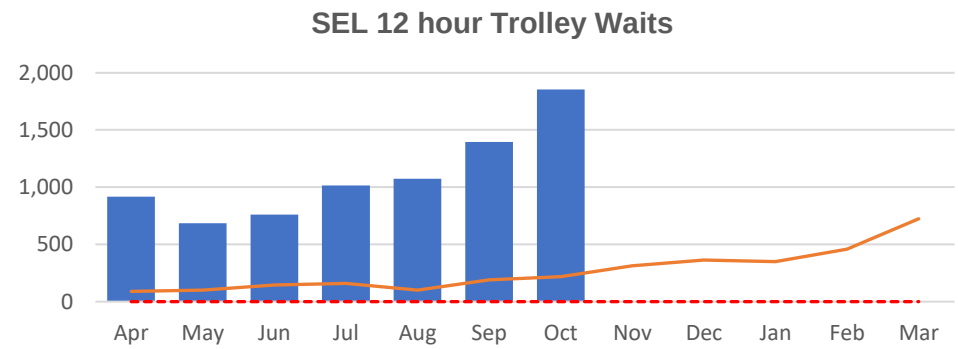
- We are also gaining more information about the inequalities within our system and need to do more to support our communities to access services that are available, with an increased focus on prevention and early intervention

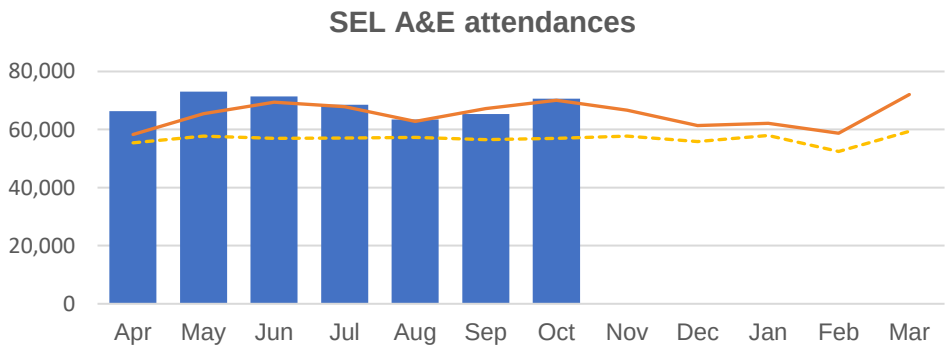
Urgent & Emergency Care (UEC)

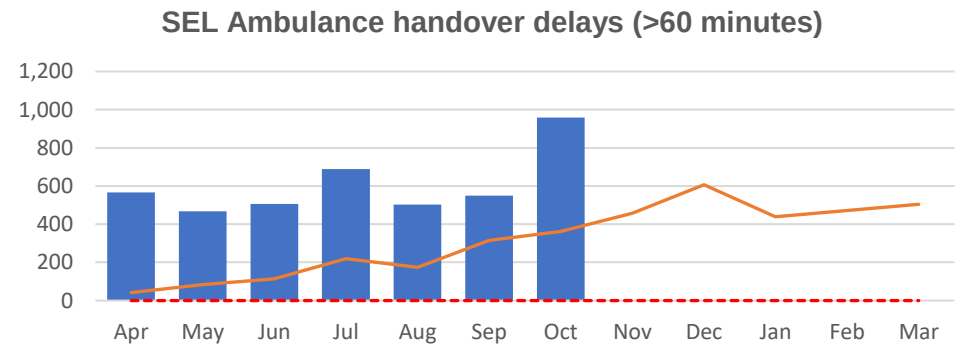
Where are we

- In Sept 2022, SEL Trusts achieved 67.9% against the 95% target. 71% was achieved nationally.
- Historically we have a challenged UEC performance position - SEL has long standing issues with A&E and discharge performance and has not met the target for many years
- SEL generally performs poorly on the 4 hour target compared to other areas of London Comparison regionally / nationally, noting the position is differential across Trusts
- A&E attendances are significantly above planned levels
- SEL performance for ambulance 60-minute delays and 12-hour trolley waits is also sub-optimal, and only approx. 50% of people are discharged at the point at which they are medically fit. Together, these metrics give an indication of pressures in the wider hospital and community based system.









2022/23 2021/22 Standard OP traj

Urgent & Emergency Care (UEC)

Context

- Performance in terms of UEC delivery in the NHS tends to be considered through the lens of the acute sector - A&E waiting times and discharge delays. Whilst these give an indication of the level of pressures the acute system is under and the flow through the UEC pathway from attendance through to discharge, challenged acute performance is also a symptom of wider system pressures and performance, recognising that the same measures are not in place to enable a good end to end pathway assessment.

Narrative overview

- National constitutional standard of 95% of A&E attendances being seen and discharged within 4 hours has long been an aspiration rather than a reality in SEL and nationally, as has being able to discharge people at the point at which they are medically fit
- This position has been exacerbated by the pandemic - linked to periods of heightened demand and need (across physical and mental health) and the challenges of managing red/green pathways within infection prevention and control guidance
- We know there are opportunities - we have undertaken missed opportunity audits at our A&E front door - 68% of patients attending do not need to be there - and we are missing opportunities to divert people to our community Urgent Community Response services rather than admitting them. Within hospital there are opportunities to by pass A&E, to increase Same Day Emergency Care and reduce admissions, and to improve length of stay by improving discharge. Addressing these issues needs a whole system focus, across both health and care.

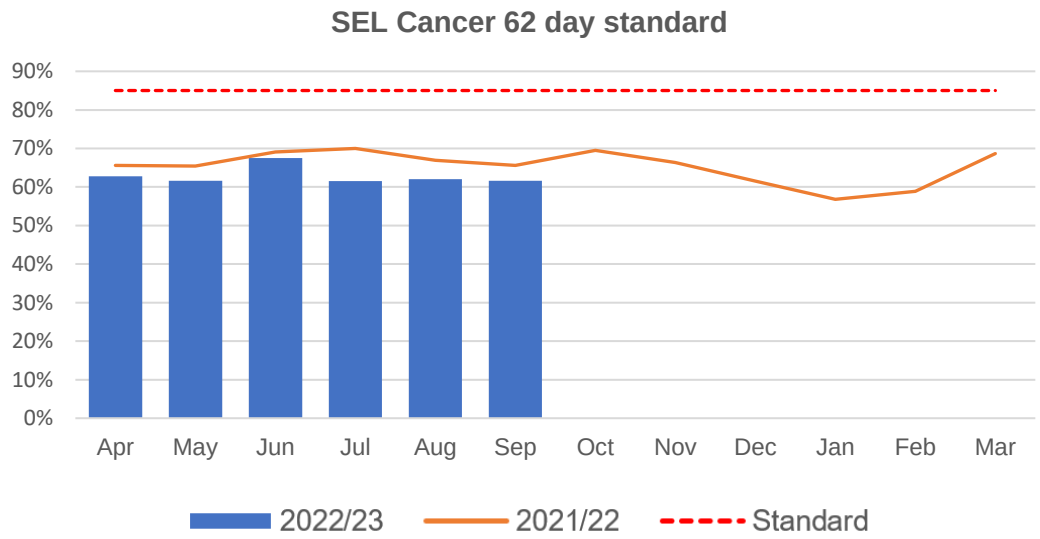
Challenges & opportunities - areas that we might improve upon/consider are:

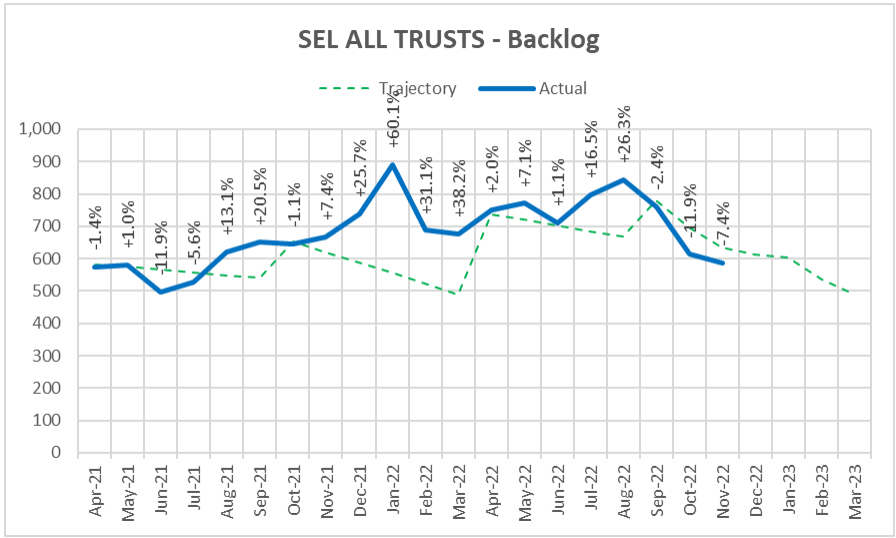
- Behavioural and culture change - patients, staff and services
- Sign posting and getting people to right place first time
- Addressing out of hospital same day urgent care demand out of hospital - through the further development of community based care offers and right sizing out of hospital care capacity
- Improving within hospital flow through the pathway - diversion/redirection, admission and discharge planning - and then right sizing capacity on the back of what is needed to meet 'acute' demand
- Joining things up - integrated approaches - a myriad of services/pathways etc and how we could streamline
- Developing staffing models and approaches
- Enabling funding - whilst also driving productivity/a value based care pathway as we know there are savings opportunities too and UEC account for a significant amount of spend
- Shift to population health management opportunities - start now for medium term impact - to address known inequalities in UEC access and outcomes and support prevention, early detection and intervention

Cancer

Where are we

- SEL has historically struggled with cancer performance and has not met the target for 85% of patients to start their first treatment for cancer within 62 days of referral for many years. In August 2022, SEL achieved 61.6% against this target.
- SEL also currently struggles with performance in other key areas such as the Faster Diagnosis Standard (75% getting a confirmed diagnosis within 28 days) although this is expected to be met in year; Sept 2022 performance was 72.2%.
- The COVID-19 pandemic led to an increase in the cancer backlog, which is broadly in line with London-wide and national averages. There is been excellent progress on backlog reduction over the last few months. The GSTT IT outage caused the overall SEL backlog to grow but GSTT have made good progress in recovering from this and are now below their pre-IT outage position. We are currently on track with our backlog reduction plan to be at a pre-covid position by the end of March 2023.
- Overall screening uptake and coverage is lower in SEL than the England average but is higher than London. There is variation across SEL; inner SEL boroughs have a lower uptake and coverage. Post Covid breast screening recovery has been particularly challenged in part due to the change to open invitations (nationally mandated). SEL screening uptake and coverage is lower in non-white, non-English main language, and highly deprived populations
- The London position is variable by Cancer performance metric and by month. Overall, SEL is at or close to the London average on most performance metrics. However, as a system we have been behind specifically for 31 day treatment performance in the last few months although the most recent data has shown some improvement.
- A key challenge within diagnostics, is cancer diagnostic imaging turnaround times; latest data showed that turnaround for CT is longer than the 7 day target at all sites and only QEH achieves the 7 day target for MRI





Cancer

Context

The advances in cancer care over the last few decades have meant that many more people now survive for 5 years following a cancer diagnosis, but have also increased the importance of early diagnosis due to the correlation with better outcomes. There are huge numbers of people referred into cancer pathways – most of whom do not have cancer – but this reduces the chances of missed opportunities for an early diagnosis. There are numerous national performance targets for cancer, which are aimed at monitoring the timeliness of the different stages of the patient pathway through to treatment e.g. wait for first appointment, wait for diagnosis and the start of treatment. Alongside national performance metrics, the system utilises the national Cancer patient experience survey (NCPES) and outcome metrics to help determine areas for an improvement focus. Cancer Alliances are in place across England and are tasked with transformation of cancer services, spanning the whole cancer pathway from GP referral through local hospitals to specialist care provided by tertiary centres, and services to support people who are living with / post a cancer diagnosis.

Narrative overview

- Cancer referrals decreased during the pandemic which was of particular concern. Post-Covid, referrals have increased compared to levels seen pre-covid. Whilst overall growth is line with expectations many services have struggled to match capacity to these expectations and some services have seen large growth. There has also been an increase in referral spikes with capacity not setup to flex which has caused particular issues.
- The COVID-19 pandemic led to an increase in the cancer backlog, which is broadly in line with London-wide and national averages. There is been excellent progress on backlog reduction over the last few months and SEL are currently on track with our backlog reduction plan to be at a pre-covid position by the end of March 2023.
- The SEL Cancer Alliance has held tumour group specific summits to identify improvement actions that would improve the pathway and associated performance; these actions are now being implemented
- SEL has a particular challenge around timely inter-trust transfers to GSTT (and to a lesser extent KCH) for specialist cancer treatment.
- The primary focus for Cancer during the last year has been backlog reduction and maintaining or increasing activity levels (diagnostic, outpatients and treatments) and meeting the FDS standard. In 2022/23 the focus will be on largely the same areas with an expectation that FDS is met as early as possible in 2022/23.

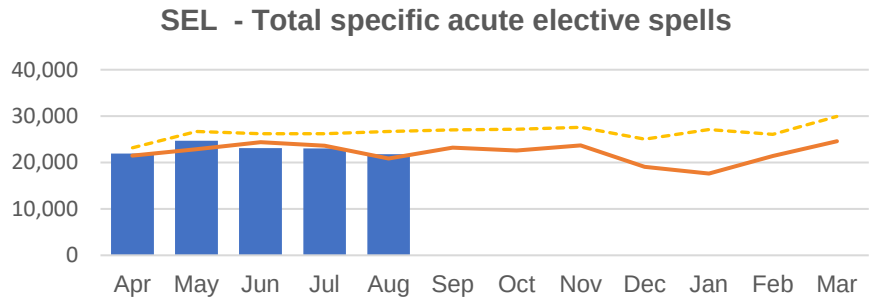
Challenges & opportunities - areas that we might improve upon/consider are:

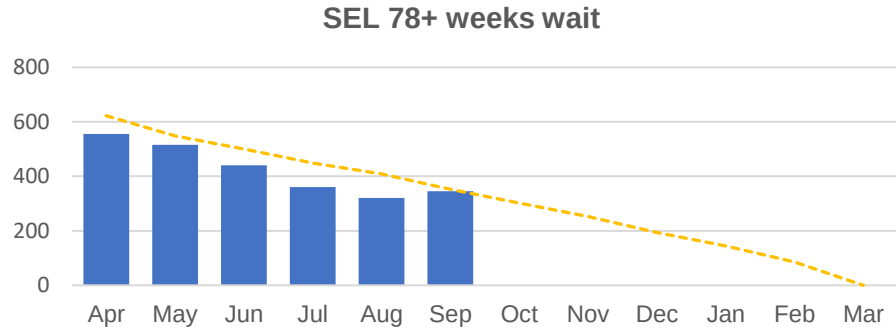
- Earlier identification & Primary Care - Awareness of Cancer, Communications, Screening, Targeted Lung Health Checks, GRAIL, Faecal Immunochemical test (FIT), Cancer decision support tools
- Faster Diagnosis & Improved performance - holding summits for additional tumour groups enabling a pathway by pathway approach to tackling performance challenges, Rapid Assessment Diagnostic Clinics, CDCs linking to Cancer Pathways, Targeted use of timed pathway data, innovative pathways e.g. Telederm
- System working and relationships - Cancer pathways are complex and interconnected, they are impacted by issues and challenges seen in all areas. Ensuring cancer is a priority in the system and that the system works together to solve issues.
- Reducing inequalities and variation in patient experience and performance, understanding and addressing inequalities throughout workstreams.
- Workforce challenges - understanding workforce and working as a system with national and regional colleagues on these challenges

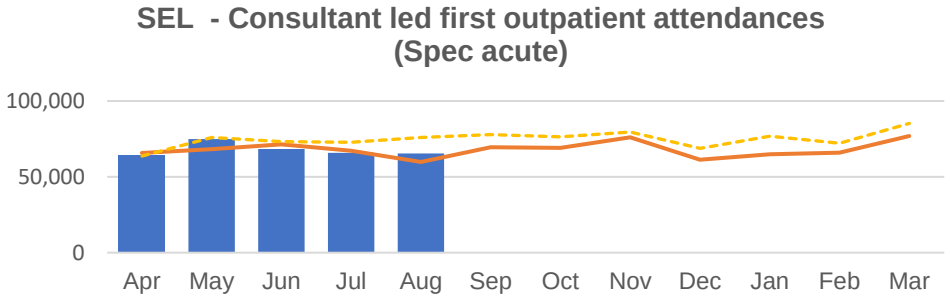
Elective care

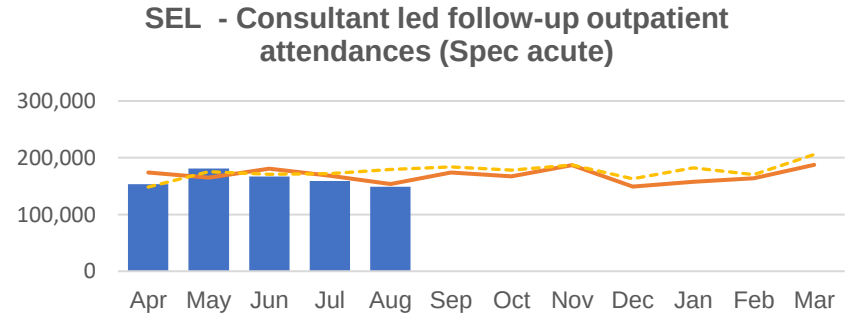
Where are we

- Historically a challenging position – increasing number of people on a waiting list and the proportion of people waiting over 18 weeks for treatment had been steadily increasing across all three acute trusts, with none meeting the national target of 92% of patients being treated within 18 weeks.
- The pandemic has led to increases in the numbers of people on waiting lists and the total number of people waiting for treatment is significantly above pre-pandemic levels. There has also been a significant increase in length of time people are waiting
- SEL is however performing well against targets to reduce the number of patients waiting a really long time for treatment (over 104 weeks and over 78 weeks). 104 weeks have mainly been eliminated in SEL and good progress is being made in the cohort of patients who will breach 78weeks by end of March 23, although there has been a recent increase in numbers and there is significant risk to achieving this target
- Total acute elective spells remains behind plan for 22/23, as does outpatient activity
- As with many parts of the system, diagnostics was severely impacted by the COVID-19 pandemic, but the number and percentage of patients waiting over 6 weeks for diagnostics has steadily decreased from the height of the pandemic. The national target is for less than 1% of people to wait more than 6 weeks for a diagnostic test.









Elective care

Context

Elective care covers a “planned” pathway which takes a patient from a referral from their GP, through outpatient appointments and, if they require it, to onward treatment and surgery. The national target is for 92% patients to receive their treatment within 18 weeks of referral but, as with other performance targets, this has long been an aspiration rather than a reality for SEL Trusts.

Narrative overview

- Inequalities in access and waiting times for services across SEL depending on where people live
- Demand and capacity imbalances in particular Trusts / services
- Lack of protected “green” capacity in SEL – capacity that is on a site which does not have an A&E and therefore can’t be impacted by wider system pressures and challenges. SEL surgical hubs have been established for high volume, low complexity surgery, to try mitigate an element of this challenge
- The pandemic has led to increases in the numbers of people on waiting lists and the total number of people waiting for treatment is significantly above pre-pandemic levels. There has also been a significant increase in length of time people are waiting
- Prior to COVID, minimal outpatients were being delivered virtually. During the pandemic there was a significant shift to virtual with over 30% appointments being delivered virtually. Although there has been a steady decrease as restrictions have lifted, 22% of outpatient appointments are still being delivered virtually.
- A key area of focus post COVID has been increasing diagnostic activity levels to help clear the backlog, and also address historic demand and capacity mis-matches within systems.
- A key priority with diagnostic transformation is establishing Community Diagnostic Centres (CDCs). Partners across SEL have been working collaboratively to develop an agreed strategy for CDCs, including collaborating with key regional and national colleagues to ensure our approach fully reflects the rapidly evolving national programme.

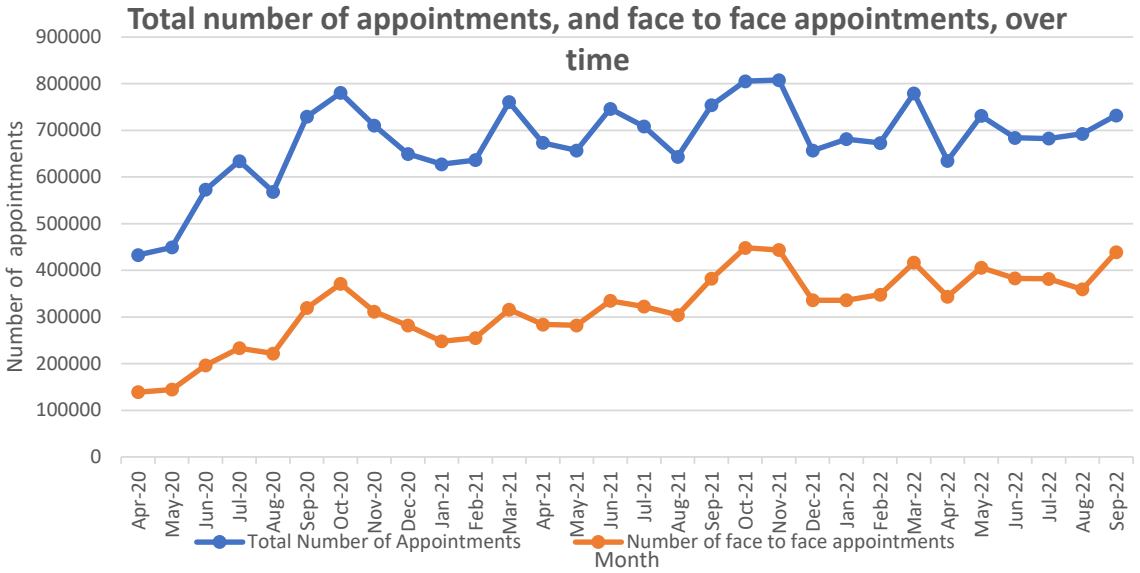
Challenges & opportunities - areas that we might improve upon/consider are:

- Ongoing work on SEL’s clinical elective care strategy to ensure we are making best use of our capacity for the benefit of SEL patients
- Work to standardise core offers across SEL to equalise access to services and ensure best use of scare acute resources
- Referrals and ensuring patients get to the right place first time – through work to improve quality of referrals and implementing approaches like Advice and Refer
- Reducing non-value adding follow-ups, by implementing patient initiated follow-up (PIFU) across of range of specialties. PIFU allows patients to initiate a follow-up appointment when they need it rather than at arbitrary time periods
- Productivity improvements along the pathway including outpatients and theatres
- Truly collaborative approaches to managing patient referrals and waiting lists to equalise waits for services across SEL
- The opportunity presented by Community Diagnostic Centres to deliver diagnostic activity outside the acute hospital sites
- Demand and capacity within modalities – understanding total demand for scanners / equipment and right sizing capacity across SEL and equipment replacement schemes across SEL
- Opportunities presented by the SEL imaging network to enable networked reporting of images and access to electronic ordering platforms for primary care across SEL

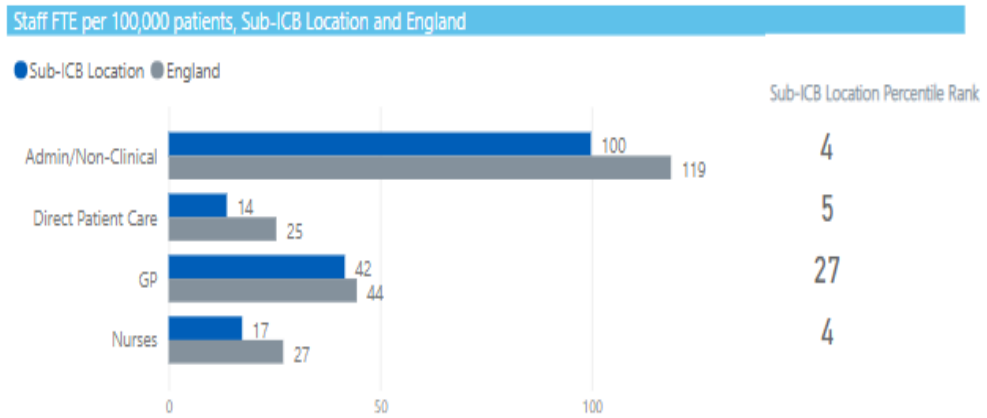
Primary Care – General Practice

Where are we

- Appointments delivered within core general practice services dropped at the start of the Covid-19 pandemic and have been increasing over time. They are now back to pre-pandemic levels.
- The share of appointments delivered face to face has seen a significant increase since its lowest point at the start of the pandemic. Whilst a variety of access models are still available within general practice, the number of face to face appointments delivered in 2022/23 is broadly in-line with pre-pandemic levels.
- Despite the increase in appointments, demand is outstripping capacity. This is leading to poorer patient experience of general practice services and challenges with access particularly in some areas.
- In October, national changes to the commissioning of evening and weekend services delivered by GP Extended Access Hubs led to reduction in capacity on weekends and Bank Holidays as well as impact on the availability of services through NHS 111. Each Local Care Partnerships has been awarded non-recurrent investment to bridge any gaps over Winter until 1st April 2023, but there is no long term solution in place.
- General practice staffing remains challenging, particularly GP and Nurse staffing. Work continues to maximise the opportunities of the Additional Roles Reimbursement Scheme which is seeing new professions entering the primary care network workforce, but patient confidence in these roles needs time to embed.
- The Fuller Review report sets out reinvigorated vision of integrated neighbourhood based care for patients with complex needs, as well as patients needing same day / urgent care. This requires a new approach to delivery of primary and community services, with greater provider collaboration and different ways of working at its heart.
- The Health and care select committee recently produced a report, with a number of recommendations, to support the sustainability of general practice, which they described as being in crisis.



FTE staff per 100,000 patients in South East London compared to England



Primary care – General Practice

Context

Primary care services provide the first point of contact in the healthcare system and includes general practice, community pharmacy, dental, and optometry services. General Practice services are delivered through a variety of organisations and networks including 198 GP practices, 36 Primary Care Networks and 7 GP Federations and are commissioned through both a nationally set contract and locally commissioned services. General practice services include same day access, long term condition management and preventative care (e.g. health checks, screening and vaccinations).

Narrative overview

- General practice In SEL provided a significant amount of the response required to manage the pandemic, including the vaccination programme with routine primary care services stood down nationally. This has negatively impacted on the proactive management of long term conditions.
- Most practices provide accessible, high quality care but there are some that are not and there is, as there was before the pandemic, unwarranted variation in experience, outcomes and access. Our work on shared standards, local delivery aims to reduce some of this variation.
- PCNs continue to be emergent with variable maturity. Borough collaboration through wider system collaboration is key to delivering change - building leadership capability and new models to better manage workload through integrated pathways with other providers
- Staff morale has been impacted by increased workload, actual/perceived criticism as well as increasingly aggressive and violent patient behaviour.

Challenges & opportunities - areas that we might improve upon/consider are:

- Challenges related to primary care workforce including reducing numbers of WTE GPs, GPNs approaching retirement and low levels of morale.
- Challenges with capacity. Despite general practice activity now being above pre-pandemic levels and capacity being fully utilised, some patients are finding it difficult to access services. National changes to extended access services risk reducing access to primary care services outside of core hours, with particular impact on the UEC system.
- Challenges with supporting infrastructure including an ageing unfit estate, sometimes sub-optimal telephony and digital infrastructure, and poor access to real-time data and analytical tools.
- Opportunities presented by the South East London Clinical Effectiveness model which is being embedded across all boroughs enabling a more effective method of targeting consistent approaches, prevention, early detection and intervention.
- Opportunities presented by the Additional Roles Reimbursement Scheme which could ass value as part of integrated neighbourhood teams.
- Opportunities for PCNs to work together and with federations to provide services at scale and improve resilience, and for the ICS to develop strong primary care leadership at all levels (ICB, LCP, PCN and neighbourhood)
- Opportunities and challenges presented by the Fuller Review, which sets a clear direction for genuinely integrated neighbourhood teams
- Opportunities and challenges presented by the delegation of responsibility for Dental, Optometry and Pharmacy services to Integrated Care Boards from 2023/24

Community care

Context

Community based care covers a range of services delivered out of hospital, providing assessment, treatment interventions and management of long term conditions. The Provider landscape for these services across South East London is a mixture of NHS Trusts, social enterprises and independent provider with services having been historically commissioned at different levels .

The NHS Long Term Plan standard aims to 'boost out-of-hospital care' and accelerate the treatment of urgent care needs closer to home and prevent avoidable hospital admissions

Where are we

- We have a well developed Community Provider Network in place where the main providers work collaboratively to improve standards and drive forward service transformation
- We have urgent community response and recover support (UCR) services established in all boroughs: providing two-hour crisis response care from 8am to 8pm, 7 days a week.
- Patients requiring support following their hospital admission or those deteriorating in the community can receive reablement care within 2 days of referral.

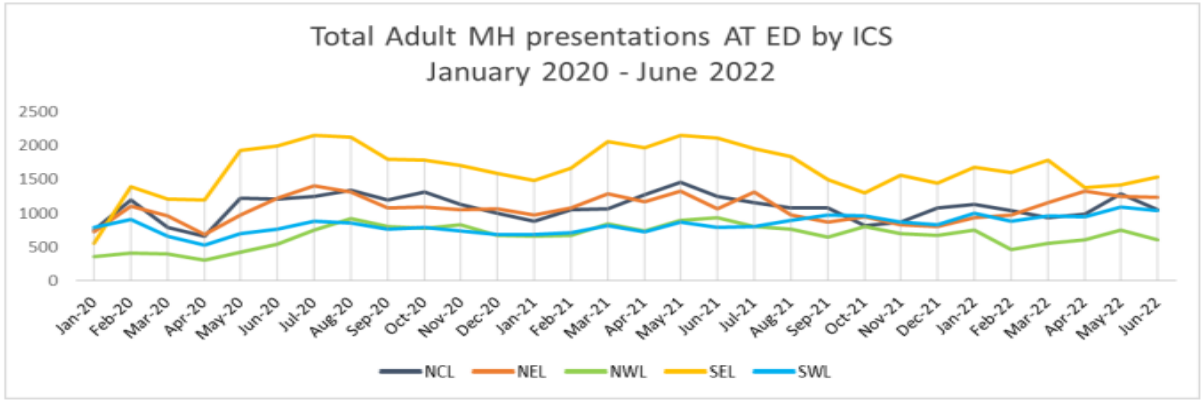
Challenges & opportunities - areas that we might improve upon/consider are:

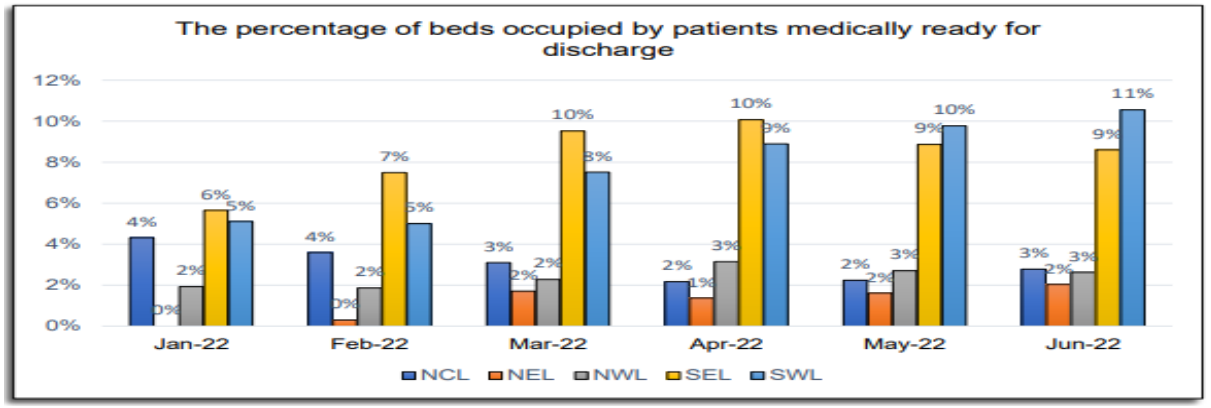
- We are working to reduce variability in the accessibility and level of service delivered at place, establishing core specifications, standards and outcomes for community pathways, such as respiratory, community anticoagulation and enteral nutrition
- We are improving the quality of data being collected in community services by uploading to the CSDS and also increasing the demographic data collected to support work to address health inequalities.
- As a system we are bidding for new funding opportunities to meet the national ambition to boost out of hospital care.
- SEL providers are working towards meeting the 9 standards required for UCR services
- Increasing backlogs of patients waiting for assessment and/or treatment created by community staff being diverted to respond to the COVID pandemic – we are reviewing wait lists and referrals to consider alternative pathways including where appropriate virtual and self management options.
- Recruitment and retention challenges, particularly in specialist nursing and therapies – as a system we are looking at innovative ways to increase workforce by upskilling staff and increasing skill mix, having roles that work across organisations and organisations providing mutual aid.
- Developing posts - we are also looking at optimising clinical staff time by reducing the burden of administrative tasks where possible.

Mental health

Where we are

- Demand for mental health services is growing directly as a result of the COVID pandemic. Of particular note is the increase in demand for children and young people's mental health services. Acuity is also increasing with more people being detained under the mental health act.
- The acute and crisis care pathway remains a key area of focus. Despite investment in home treatment teams and alternative crisis offers, ED attendances and 12 hour breaches remain high. SEL has the highest number of mental health ED attendances across all London ICS' and one of the highest nationally. Despites improvement in Length of Stay, we continue to experience high bed capacity and delayed discharges impacting overall system flow.
- The NHS LTP has a clear focus on expanding access to mental health services including Improving Access to Psychology Therapies (IAPT), perinatal mental health services, dementia diagnosis and physical health checks for people with severe mental illness. Although we have expanded access in these services, supported by investment, an improvement trajectory is proposed for many key performance indicators in 2022/23 and delivery will be a challenge. This is similar to other systems in London.





Performance Measure	Latest Period	Q1 Plan	ICS Position
IAPT Access	2022/23 Q1	11,281	**10,240**
Perinatal Mental Health Services Access	Aug-22	1,913	**1,390**
Dementia Diagnosis	Aug-22	66.7%	**69%**
Physical Health Checks for SMI	2022-23 Q2	8,447	**7,891**
Inappropriate Out of Area Placements	Aug-2022	250	**2,060**

Mental health

Context

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

Narrative overview

- Historically investment into mental health services has been lower than acute services. SEL has fully committed to increase investment through the mental health investment standard (MHIS) and national service development funds (SDF). However, SEL still spends less than national average spend on mental health (per capita for weighted population) with SEL spending £162 compared to the national average of £195 (London average is £158).
- In 2021/22 we launched our community transformation programme, shifting the bulk of new investment from inpatient services into these services to provide early intervention through new integrated teams. Progress with the programme has been slower than anticipated due to workforce constraints and the need to shift culture/ways of working across teams.

Challenges & opportunities - areas that we might improve upon/consider are:

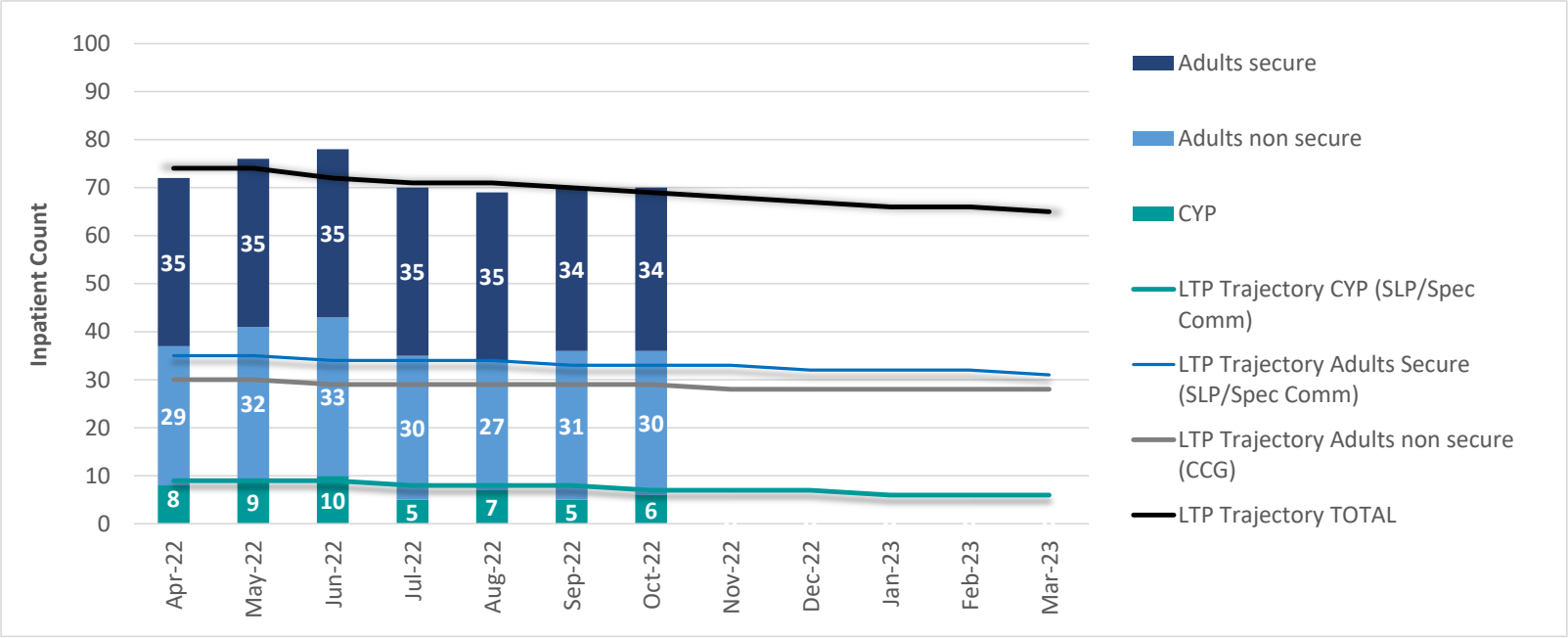
- Early intervention and prevention:- high bed occupancy and presentations to EDs remain a key challenge for SEL, particularly for those unknown to mental health services. Expansion and adoption of community transformation programmes offers the opportunity to intervene earlier in the pathway and provide tailored intervention which meets the needs of the different populations within SEL. There is also an opportunity to focus on early years and family approaches to reduce the burden of mental health during the life course of an individual.
- Social determinants of mental health:- mental illness is strongly influenced by the social determinants of health. Through closer partnership working there is an opportunity to reduce these influences, preventing people from reaching mental health crisis and supporting quicker discharge from inpatient services to less restrictive settings in the community.
- Inequalities in access of services:- there are disparities in access and usage of mental health services across SEL. For example, children from black and mixed heritage backgrounds are poorly represented in CYP mental health services, yet black men are over-represented in adult inpatient services.
- Workforce availability:- as services grow, there is the opportunity to better embed non-clinical and voluntary/community sector roles within services.

Learning disabilities and autism

Where are we

- Nationally the reliance on inpatient bed usage for people with a learning disability or autism has been falling for the last decade. In SEL, we have seen a reduction in inpatient usage in line with the NHS Long Term Plan deliverables, achieving our LTP targets for the number of inpatients in 2021/22 and are on track for delivery for 2022/23. Although placements out of London have reduced, further work is required to repatriate patients back to SEL and for a small number who require bespoke community placements.
- SEL has made significant strides in the provision of annual health checks for people with learning disabilities, carrying out at least 71% of checks against target of 75% in 2021/22. However, the key focus going forward is to ensure these health checks are of good quality and offer the appropriate sign-posting and intervention to improve outcomes for people with a learning disability.
- Waiting times for autism diagnosis for both adults and children are recognised as a challenge nationally. Despite the availability of additional funding for waiting list reduction and clearance in 2021/22, we continue to have long waiting times for assessment and diagnosis.

2022/23 Inpatient Trajectory & Actuals



Learning disabilities and autism

Context

Nationally, people with a learning disability (LD) can have a 14-18 year lower life expectancy than the general population and up to 40% of people with a learning disability in England report difficulties in using health services (versus just 18% of the general population). In SEL, the Transforming Care Programme for learning disabilities and autism (LDA) has been running since 2015/16 after Winterbourne View, became the Learning Disability and Autism Programme in 2020, to support people to live healthier and longer lives, and in line with the priories set out in the NHS Long Term Plan (LTP), the programme is focused on three key areas: (i) early intervention and preventing admission; (ii) delivering co-ordinated care for people with a learning disability or autism; and (iii) increasing community-based support and capacity.

Narrative overview

- Delivery of the ICS' inpatient trajectory has been supported by multiple workstreams including completion of Care and Treatment Plans (CTRs) aimed at avoiding admission and supporting discharge from hospitals, and a focus on use the dynamic support registers in primary care to identify those with a learning disability and at risk of admission. SEL has also successfully expanded its key worker workforce to provide better support children and young people in the community. However, generally the provision of a whole wrap around offer in the community for adults and children with a learning disability or autism remains limited.
- In 2021/22, an adult community support service aimed at reducing admissions, focusing on those individuals with both a learning disability and/or autism and a concomitant mental health illness was piloted. However, the spread of this service was limited and models of care varied across the two mental health trusts.

Challenges & opportunities - areas that we might improve upon/consider are:

- Developing community-based services to further support admission avoidance:- expanding the provision of community-based, wrap around offers for people with learning disabilities and autism through developing a core offer for service provision across SEL and greater collaboration across the ICS partners including across health and social care, and building voluntary and community sector partners.
- Use of Population Health Management:- there is an opportunity to embed population health management approaches into the delivery of annual health checks for learning disabilities, improving the quality of these checks with a view to reduce the disparity in life expectancy.
- Workforce availability:- workforce remains a key challenge for learning disability and autism services, impacting the ability of the system to quickly take forward initiatives and improvements for implementation (e.g. waiting list clearance).

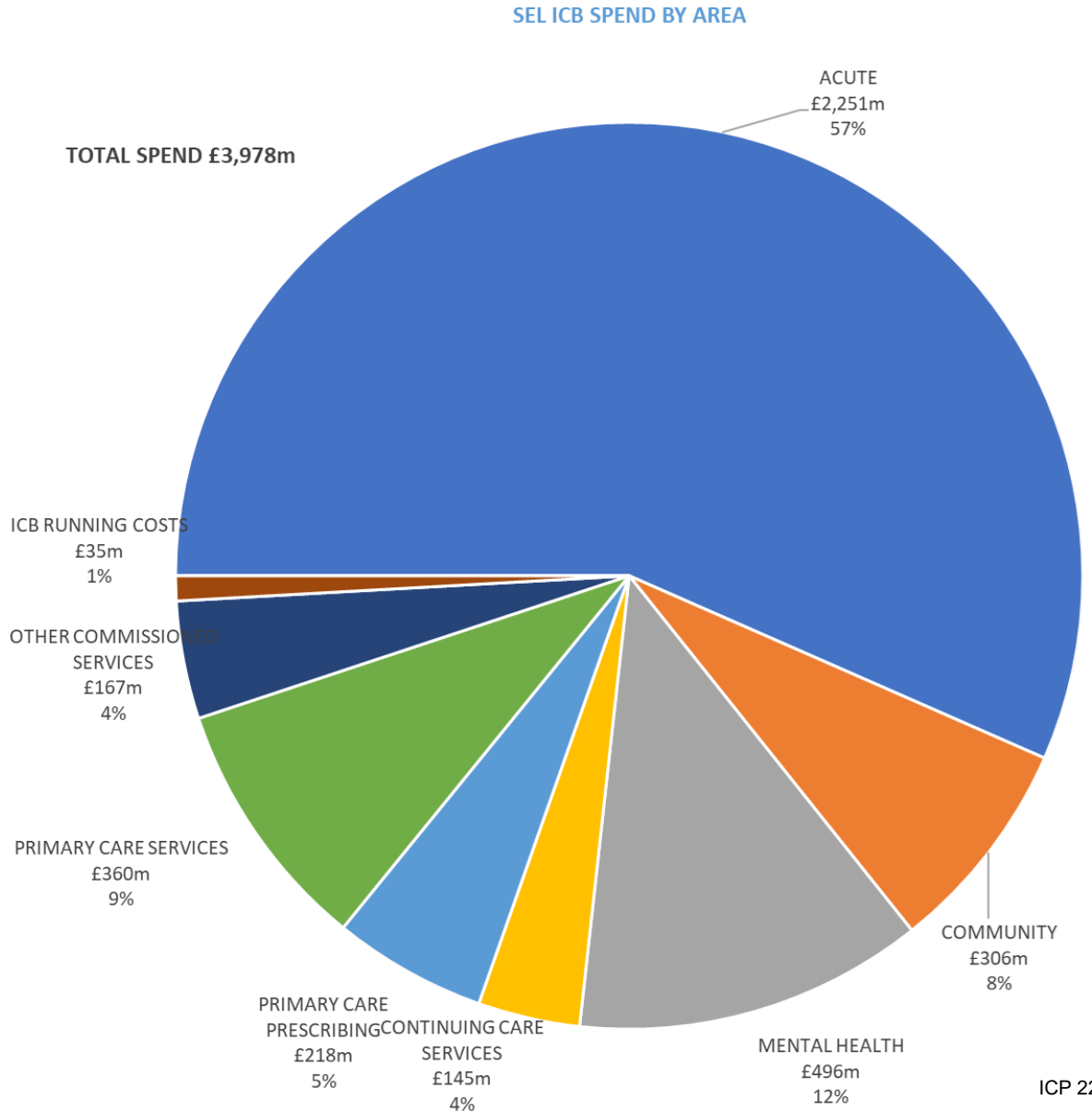
SEL ICS financial position

- Figures on the next three slides indicate planned ICB and ICS spend for 2022/23.
- Figures provided are NHS funding figures, and as such do not include information from Local Authority (LA) partners on LA spending.
- The ICB will be working with LA partners to develop a view on health spending for future meetings. An initial estimate from reviewing LA publicly available outturn reports/draft accounts suggests that the total 2021/22 spend for adult social care and public health was c. £478m across south east London. However, this figure needs further refining with LA partners, and should be taken as a broad estimate only.

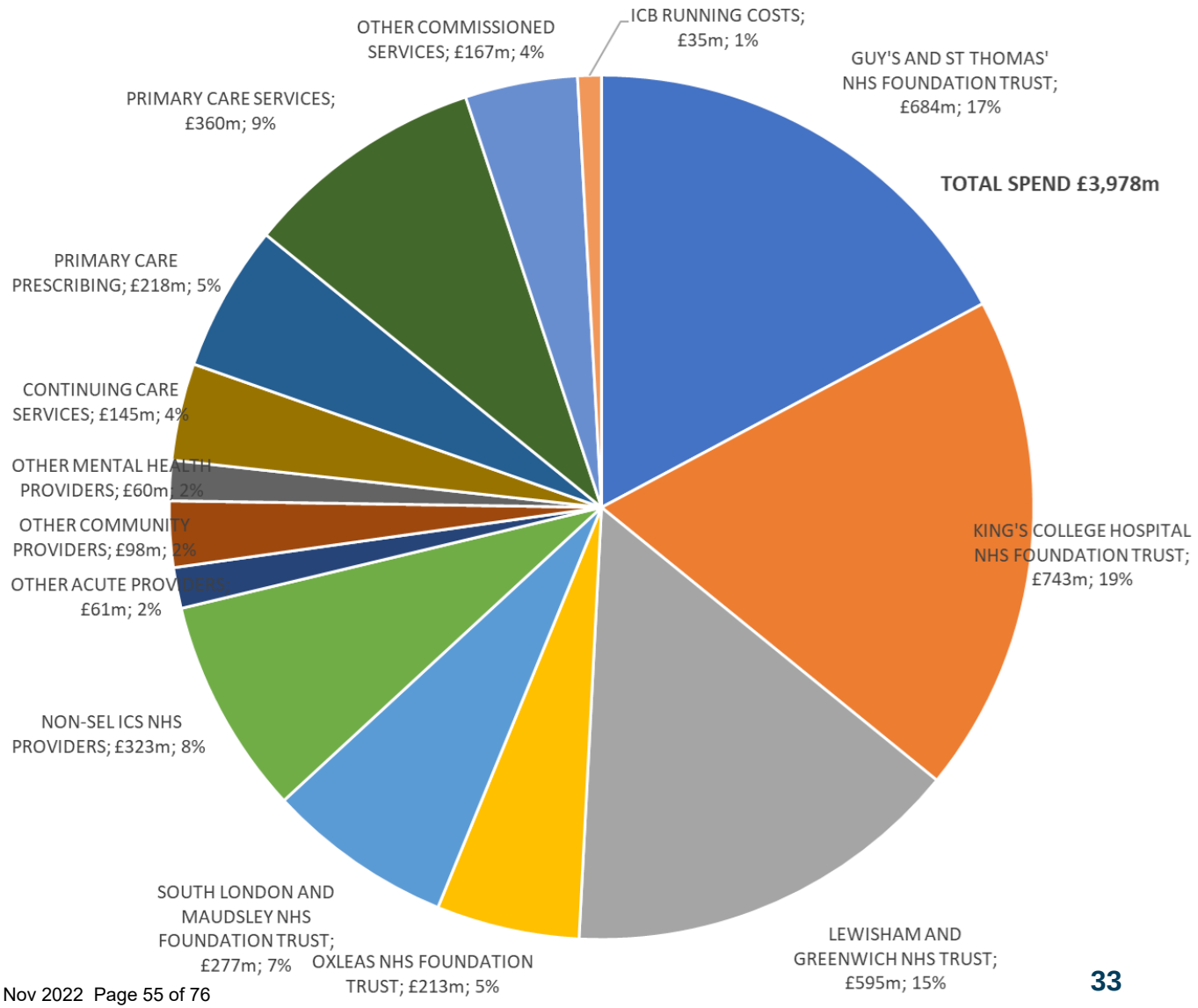
SEL ICB 2022/23 planned spend

South East London Integrated Care System

SEL ICB SPEND BY AREA



SEL ICB SPEND BY PROVIDER



SEL ICS 2022/23 planned spend

TOTAL SEL ICS SPEND, £7,344m

SEL ICS underlying financial position

- As a system, SEL plans to breakeven in 2022/23, however this is supported by non-recurrent income such as a Covid allocation of £100m (1.5% of SEL ICS income), which is expected to reduce significantly in 2023/24.

- Furthermore, as a system we are considered to receive more income annually than national target shares would suggest. This support is expected to reduce over time as additional convergence savings adjustments are applied to allocations. The 2022/23 SEL ICS system convergence adjustment was £46.5m (0.7% of the ICS income) and we would expect further additional savings adjustments to be applied in future years.

- Our plans will need to address both our underlying financial deficit and the future convergence adjustments to deliver a sustainable financial position over the medium term.

Integrated Care Partnership

Item 3
Enclosure C

Title:	Development of the South East London Integrated Care Strategy
	22 November 2022
Authors:	Ben Collins, Director of System Development
Executive Lead:	Jonty Heaversedge (Joint medical director)

Purpose of paper:	To update Partnership members on our analysis and engagement to date and to seek steers on our draft vision and potential strategic priorities.	Update / Information	X
		Discussion	X
		Decision	X
Summary of main points:	Following extensive discussions with senior leaders from Spring 2022 onwards, we have developed proposals for an ambitious strategy that should deliver tangible improvements for people in South East London, identifying a small number of areas where action across our system could deliver a step change in health and care. The paper summarises our analytical approach and engagement on the strategy, sets out a draft vision for future health and care services, and discusses a possible set of strategic priorities for collective action across South East London.		
Recommendation:	Partnership members are asked to: • Review our draft vision for our future system and services (section 4) and indicate whether they can support it; • Review our proposals for possible strategic priorities (section 5) and advise on whether they represent the right initial focus and a coherent set of priorities for cross-system action; • Review and comment on our proposals for what it should mean for an issue to be selected as a priority in this strategy (section 6).		

South East London Integrated Care System

Development of South East London's Integrated Care Strategy

Integrated Care Partnership - 22 November 2022

1. Introduction

1.1. One immediate responsibility for our new Integrated Care Partnership is to oversee the development of an integrated care strategy setting out our priorities for improving and joining up care across our health and care system for the five years from 2023-24 to 2027-28. Like other Integrated Care Systems, we have committed to an initial publication on our strategy by end of 2022.

1.2. As you know, our ambition is to develop a different type of strategy to traditional NHS approaches. We are not attempting to develop an all-encompassing strategy describing all the important work that will need to happen within our Boroughs and our providers over the next five years, because recent experience has shown that these types of strategies have limited effectiveness in driving transformative change.

1.3. Instead, we have agreed with leaders across our system to develop a tightly focused strategy, starting with an appraisal of the needs of our populations (as set out in our Boroughs' Joint Strategic Needs Assessments), and homing in specifically on those areas where we believe collective action at South East London level will help us achieve a step change in health and care and address health inequalities, while helping to address our financial challenges. We also agreed on the need to use this process to help develop effective partnership working across and capabilities in delivering cross-system change and improvement.

1.4. We believe that this targeted approach will be much more effective in driving transformative change across our system. It should help our Board and Partnership to focus on the most important cross-system issues while respecting the concept of subsidiarity. It will help us to pursue cross-system change effectively in a period when the resources available for transformation will be limited. It will also help us to ensure transparency and accountability for progress, something which is easily lost in strategies with hundreds of commitments and objectives. The aim is to produce a strategy that leads to action, rather than sitting on a shelf once published.

1.5. An additional reason for this approach is that our strategy will sit alongside a much more detailed NHS five-year system plan, which will describe in more detail the work across our local care partnerships, provider collaboratives and providers to improve access, quality and outcomes across a wide range of health and care services, as well as how we plan to address significant financial challenges in the next five years.

2. Purpose of this paper

2.1. This paper provides a summary of our analysis and engagement with system leaders and our communities on the strategy over the last few months. It seeks Partnership members' steers on a draft vision for our future health and care system, and a set of potential cross-system priorities for improving care. It also asks for Partnership members' views on what it should mean for an issue to be selected as a priority for action at South East London level in our strategy. Partnership members' comments on these issues will allow us to develop an initial statement on our vision and strategic priorities by end of 2022 and help us to focus immediate future work on our strategic approach to selected priorities, objectives for improvement and implementation plans.

3. Our engagement and analysis so far

3.1. Since early summer 2022, we have been completing analysis and engagement to inform our vision, potential priorities for our strategy and cross-cutting themes. This started in June 2022 with a review of our data on service user experience and the performance of our services and a review of previous CCG strategies, our Boroughs' Joint Strategic Needs Assessments, our Local Care Partnerships' strategies and our providers' strategies to identify common themes. We also reviewed previous feedback from our communities on our strategic focus and invited residents to comment online on the issues they were most interested in discussing in the process.

3.2. In light of this review, and the feedback we received, we identified seven initial high-level areas as a starting point for discussion on potential strategic priorities. In July 2022, we invited the public and staff to complete an online survey to inform our vision and give views on potential strategic priorities. We also invited the public and partners to attend two online events. As well as the vision, we asked participants to comment on the biggest potential problems or opportunities within the seven areas that we might address in our strategy. (We also asked whether any important areas were missing.)

3.3. Based on our initial analysis, discussions with leaders and experts and what we had heard from these events, we developed a longlist of 30 potential strategic priorities within these seven areas where cross-system working could significantly improve health and care. We engaged 100 leaders and partners across our system in a face-to-face workshop at end July 2022 to help refine and test these potential priorities. We asked participants to help us make an initial assessment focusing on the size of the opportunity to improve care and the need for system-wide collaboration.

3.4. From August to September 2022, we completed a more detailed analysis of our initial thirty potential priorities. We drew from our performance data and existing strategies and the results of the engagement described above and feedback from our local care partnerships and providers to make an assessment of each of the thirty potential priorities against three agreed criteria: the size of the opportunity to improve care (in particular the opportunity to improve outcomes, improve efficiency and address health inequalities); the need for cross system collaboration to address the issue; and the feasibility of making progress in the next 3 to 5 years (see appendix).

3.5. Through this process, we narrowed and regrouped our initial seven areas to four areas. From our initial list of thirty, we identified a shortlist of fourteen particularly strong potential strategic priorities within these four areas that scored highly against our criteria for further consideration (see appendix).

3.6. We tested our vision and our 14 potential strategic priorities with our Integrated Care Board in a workshop in September 2022. From October to November, we also tested the vision and potential priorities and discussed cross-cutting themes with our future

Integrated Care Partnership members in group meetings of Local Authority Leaders and Trust Chairs and in one-to-one discussions.

3.7. Throughout this process, we have also regularly tested our analytical and engagement approach, our emerging findings at each stage and our proposed next steps with a strategy steering group of leaders from across our system (including Directors of Strategy in our Trusts and the Directors of our Local Care Partnerships), our Integrated Care Board and Executive Team and our Local Authority Leaders and Trust Chairs. We have held discussions with Local Care Partnerships and our Primary Care Leadership Group and our Local Medical Committees. There have also been discussions of the strategy at our Local Authorities' Health and Wellbeing Boards, with further discussions planned for the remainder of the year.

3.8. We have also held discussions with many organisations representing disadvantaged groups, who have consistently highlighted the importance of more convenient and tailored primary prevention, easy access to primary care, communication with health services, and the need to combine support for physical health, mental health and social challenges such as debt, housing and keeping children in school.

4. Our draft vision for health and care

4.1. In light of our engagement, we have developed a draft vision for the evolution of our system which highlights six particularly important aspects of how we want to deliver care. Our ambition here is to paint a picture of the broad direction of travel for our system, so that we ensure a broad alignment in the development of many different services and empower staff across our system to deliver change (see summary and long version in the appendix). We have proposed to focus on: (i) preventing ill health and protecting wellbeing; (ii) delivering convenient and responsive care; (iii) whole person care; (iv) improving care for all our communities; (v) partnership with our service users; and (vi) empowering our staff. ***Can Partnership Members support the draft vision as a high-level statement on the future we are aiming for?***

Figure 1: Our mission and draft vision for health and care services

Our mission is to help people in South East London to live the healthiest possible lives. We will do this through helping people to stay healthy and well, providing the right treatment when people become ill, caring for people throughout their lives, taking targeted action to address health inequalities, and supporting resilient, happy communities as well as the workforce that serves them.

If we are to deliver this mission, we know that we will need to make far reaching changes to our current system. These are our most important principles for developing our services:

1. Health and wellbeing

We want to become as good at protecting health and wellbeing as at treating illness. Like other local health and care systems, we have inherited a set of services focused primarily on treating people when sick rather than supporting health. We will need to invest in more coherent and effective preventative health services, and more proactive services that go out and find people and intervene earlier to avoid serious illness. We will need to work in partnership to create healthier environments and harness the power of our voluntary sector and communities to support healthier living and happier lives.

2. Convenient and responsive care

We need to make it as easy as possible for people to interact with our services, tackle the long waiting times for some services and offer more convenient and responsive care. Local people continue to tell us how difficult it is to communicate with us, access our services and navigate our system. We need to develop high quality online consultations for people who want them, without excluding people, and deliver more care in or close to people's homes. We need to dismantle models of care that consumer service users' time and impose avoidable travel or other costs, while increasing carbon emissions. We will need to harness the power of technology and simplify our services so that they are easier for people to understand and navigate.

3. Whole person care

We need to continue the process of bringing together professions and services to deliver coherent team-based care. In our system, people rely on separate, disconnected teams for support with different physical health, mental health and social needs, rather than joined up, responsive services that can address all the issues that matter to them at the right time. Local people should be able to rely on a single small team of staff who they know and trust to provide most of their care. Wherever possible, those teams should draw in specialist expertise when needed, rather than automatically asking service users to go to separate services for aspects of their care. In making these changes, we will also lay the foundation for stronger relationships between service users and their core teams of care givers and more compassionate, trusting and person-centred care.

4. Improving care for all our communities

We know that some minorities and people from deprived communities are less likely to be enrolled with a GP practice, find it harder to access services, suffer poorer overall health and have worse outcomes from care. We need to target resources at those most in need to tackle gaps in access, quality of care and health outcomes for different social groups. We also need to develop more tailored and culturally appropriate services to better meet the needs of women, minorities and the most disadvantaged people in our society, for example finding new ways to connect with these service users, adapting our existing services and developing different types of care where required to deliver convenient and effective care.

5. Partnership with our service users

We want to continue the shift to a model of genuine partnership working between health and care professionals, communities and service users, where professionals work with service users to understand what really matters to them and support them in managing their health and care. During the Covid 19 pandemic, we demonstrated the power of partnership working between health services, social services, the voluntary sector and our communities to improve people's health and care. As in the pandemic, we want to harness the strengths of our service users and communities to improve health and wellbeing.

6. Empowering our staff

We rely on the creativity and commitment of our brilliant, diverse staff to continue adapting and improving care. While we plan a small number of programmes of work across our system, we will depend on our 100,000 staff to deliver most of the changes to deliver our vision. We want to encourage our staff to go out and improve services, without waiting for permission, but to do so in line with these principles: thinking in particular about how we can improve prevention, connect with other services to offer more convenient, whole person care, tailor services for deprived groups, and harness the power of service users and communities.

5. Strategic priorities for cross system action

5.1. As above, from September to November 2022, we have been testing with senior leaders and partners our four proposed strategic areas and our shortlist of fourteen potential priorities. There is broad agreement that the four areas we have identified capture the most important areas for cross system working to integrate care.

5.2. There was also broad agreement that the shortlist of fourteen potential priorities captured major opportunities to work together at system level to improve care. System leaders did however ask us to strengthen the emphasis on particular issues such as supporting older people and addressing inequalities within some potential priorities.

5.3. Most importantly, there was agreement that we need to narrow down our list of priorities if we are to resource and oversee them effectively as major collective projects involving partners across our system. There was also recognition that we will need to narrow our focus within selected priorities, some of which are intentionally broad at this stage, as we develop our overall approach to addressing them.

5.4. In the sections below, we provide some reflections on what a good final selection of strategic priorities might look like. In doing so, we have revisited our initial assessment of how our shortlisted priorities score against our criteria for a good South East London strategic priority, reflecting on comments from Partnership members and other system leaders in October and November (described in paragraph 2.6).

5.5. As well as the merits of each potential priority on its own, we also considered at this stage what might amount to a coherent and balanced set of four to six cross-system strategic priorities. In doing so, we sought to construct a proposal that includes priorities in each of our four areas of focus (prevention & wellbeing, children & young people etc), would engage staff and organisations across our system and would allow us to develop our capabilities in cross-system working to improve care.

Prevention and wellbeing

5.6. Over the last few months, we have been discussing three potential areas of focus to prevent ill-health and support wellbeing: delivering prevention and early identification of health conditions as effectively as possible, including for our most disadvantaged groups; closer joint working to support people to live healthier lives; and further joint work across our partnership to tackle the underlying social determinants of ill health (see table below).

5.7. From our analysis and engagement, there are strong arguments in the first instance for a cross-system priority to deliver proven prevention and early detection of disease (such as screenings, health checks and vaccinations) as effectively as possible across South East London, with a particular focus on groups who are least likely to receive care. This is an area where we know that relatively simple interventions, delivered much more effectively than at present, could save thousands of lives.

5.8. This is also an area where there are benefits in pooling expertise across South East London to help shape our overall approach. We will be able to pool resources to understand and test the range of options for more effective delivery models and the most effective approaches for connecting with disadvantaged groups (for example, support for more effective delivery within primary care, prevention hubs, partnerships with pharmacies, other forms of high street access, VCSE-led delivery).

5.9. It is an area where partnership working between the NHS, Local Authorities and the Voluntary, Community and Social Enterprise Sector could help us overcome significant

challenges, such as failure to connect effectively with some groups. We saw in the pandemic how much we could increase the take up of prevention opportunities through joint working partners and harnessing the power of our communities. It is also an area where more systematic benchmarking and sharing of learning might help us to address longstanding variation in uptake of services across South East London.

5.10. There are of course good arguments in favour of our other two potential priorities: supporting healthy lives and addressing social determinants. But there are limits to how much we can bite off in one go. There is of course lots of work already in progress on all these issues within our Local Care Partnerships, our Local Authorities, and our new South East London Anchors Programme (which is focusing initially on access to good employment for local people and procuring goods and services in ways that support our local communities). We would value Partnership members' reflections. ***Given the need to target our initial cross-system action in this complex area, do you agree that an initial focus on prevention is the right place to start?***

Figure 2: Our longlist of potential strategic priorities for prevention and wellbeing

Potential strategic priorities: Prevention & Wellbeing	
Ensuring that everyone in SEL receives convenient and effective primary and secondary prevention services	Many people in South East London (in particular those from deprived groups) do not receive the full range of proven primary and secondary health prevention services including vaccinations, health checks and screenings. We know that if we were to systematically deliver proven interventions to a high standard, this would have a significant impact on health outcomes and health inequalities. There is an opportunity for us to review our current approaches, test against approaches in other systems, potentially develop new delivery models for preventative care, and benchmark progress across SEL.
Supporting people in South East London to live the healthiest possible lives.	Many people in South East London are living unhealthy lives, with poor diets, low levels of physical activity and high alcohol and drug use, alongside loneliness and other social factors that drive poor health. We know that achieving even modest changes in people's lifestyles, though difficult to achieve, would translate into better health outcomes, particularly for children and people from deprived groups. We also know it should in time help to reduce avoidable health and care costs. We might pool insight and expertise to develop a more coherent and effective approach to supporting healthy living across South East London with clear metrics for success.
Using our combined resources to improve the socio-economic conditions driving poor health in SEL and address environmental sustainability.	People in our most deprived communities are struggling with poor housing and living environments, air pollution, access to affordable healthy food, poor jobs and unemployment, poverty, debt and other socio-economic factors that are driving poor health and wellbeing. As a collective, we are the largest employer in SEL and one of the largest purchasers, property owners and investors. We could harness our collective political and economic power to influence poverty and inequality more directly, for example expanding current work on living wage and employment, investing in job creation and social enterprise or investing in housing. We could pursue environmental sustainability while creating healthier places for people to live

Children and young people

5.11. Within the children and young people category, we have been discussing the potential for joint action to ensure a good start in life, to improve early support for children with mental health challenges, to develop more convenient and effective models of primary care for adolescents and young adults, and to develop more proactive and joined up

support for children with ongoing conditions (see table below).

5.12. From our analysis and engagement, there is a strong case for taking forward a priority to help ensure children have a good start in life. This reflects the extensive evidence on the impact of foetal health and early years on people's future health and broader life chances. It would also allow us to address together challenges in the resourcing, targeting and integration of early years support across South East London. It would allow us to pool expertise and insight across health, Local Authorities and the VCSE on a coherent and effective model and identify opportunities to make more effective use of our staff and resources.

5.13. There is also a strong case for working together at South East London level to improve early support for children and young people with mental health challenges such as anxiety, depression and eating disorders. At present, we have long waiting lists for a limited range of traditional early support services, leading to avoidable suffering, worsening of children and young people's conditions, and greater demand for more specialist services. There are opportunities for health, local authorities, the VCSE and schools to work together on alternative approaches and partnership models, that could help to break the cycle of high demand, waits and rationing, while providing children and families with a broader range and in some cases more effective support (for example, group support, peer support, services and combining VCSE and NHS staff and their approaches).

5.14. Again, there are good arguments for the other priorities we have discussed together so far. But there are limits to the number of cross system initiatives we can attempt in tandem in this area. There is work in progress to improve primary care for adolescents and children with long term conditions, which will continue. ***Do Partnership Members agree that ensuring a good start in life and early support for mental health challenges are the right immediate focus for cross system action?***

Figure 3: Our longlist of potential strategic priorities for children and young people

Potential strategic priorities: Children and Young People	
Ensuring children and young people can access effective early intervention services for mental health challenges.	Some children and young people in South East London are struggling with emotional wellbeing, anxiety, depression and eating disorders post pandemic, with long waiting times and a limited range of services. We could work together to break the cycle of overwhelming demand, rationing, delays, exacerbation of conditions, and pressures on more specialist services. For example, we might explore new community-led support and new partnerships with the VCSE.
Ensuring that mothers, children and families receive effective pre-natal, postnatal and early years support.	Many babies, young children and their families in South East London do not receive effective pre- and post-natal support, healthy eating and nutrition, mental health, and social support/parental interventions. We have the opportunity to review our range of services spanning primary, community, social care and the hospital system to develop a more coherent and effective model.
Ensuring that young people can access tailored primary and community services to meet their needs.	Our traditional models of primary and community care are not designed to meet the needs of adolescents and young adults. There is some evidence that some struggle to access convenient and appropriate physical health, mental health and sexual health services and support for health and wellbeing. We could work together on tailored models of care for adolescents and young adults, harnessing digital tools or expanding the wellbeing hubs in some boroughs.

Ensuring that children with long term conditions in SEL can access proactive, joined up and effective care to manage their conditions.	Children with long term conditions such as asthma, epilepsy and sickle cell disease in SEL do not systematically receive proactive, joined-up care. There is scope to intervene earlier, support prevention, deliver more coherent packages of health care, social support and support, and develop team-based models that make better use of staff and resources, including hospital specialists.

Adult mental health

5.15. In adult mental health, our analysis and engagement highlighted particularly strong arguments for a priority focusing on early support for people struggling with mental health challenges including g across South East London to improve early support for people struggling with mental health challenges including people with anxiety, depression and in crisis.

5.16. As for children, there are long waiting lists for a limited range of early intervention services, with evidence that people's conditions worsen as they wait for care. For people in crisis, we know that failure to provide the right help at the right time can lead to rapidly worsening mental health with huge knock-on effects for individuals and families such as losing your job or home.

5.17. Again, this is an area where pooling insight and working in partnership across our system could unlock major opportunities for innovation. There are low cost and effective alternatives to traditional services worth exploring. One message from our engagement with disadvantaged groups is the need to bring together adult mental health services with local authority and VCSE services so we deliver joined up support for many people with interrelated mental health and social challenges.

5.18. In adult mental health, we also discussed a possible cross-system priority focused on more effective preventative support for good mental health and wellbeing. There are clearly very good arguments for doing so, although it may be possible to make faster progress through focusing collectively on early intervention at this stage. ***Do Partnership Members agree that that we should focus initially as a system on early support for adults with mental health challenges, rather than the huge opportunity, but complex issue of primary prevention for mental health?***

Figure 4: Our longlist of potential strategic priorities for adult mental health

Potential strategic priorities: Adult mental health and learning disabilities	
Ensuring that adults across South East London can access effective support to maintain good mental health and wellbeing.	At present, adults in South East London have access to limited and variable support to maintain good mental health and wellbeing, with variable preventative support in primary care and a patchwork of voluntary sector services, more focused on people who already have significant needs rather than prevention. There might be scope for concerted cross-system action to raise awareness of opportunities to maintain good mental health and avoid problems developing, for example through supporting healthy lifestyles and social networks.

Ensuring that adults in SEL have rapid access to a broad range of effective early intervention services for mental health challenges.	Adults in South East London are struggling to access timely and effective early support for mental health issues, emotional wellbeing and broader health, care and social challenges. This is leading to the development of more severe mental health problems, avoidable exacerbation (e.g. psychosis) and increasing demand for urgent care and more specialist mental health services at significant cost. There is scope for partnership and innovation to develop a broader range of early intervention services, working across health, social care and the VCSEE, to achieve the impact seen in other local systems.
Ensuring that people with learning disabilities in SEL receive proactive, holistic and tailored care to support them to protect their physical and mental health	Many people with learning disabilities have a complex set of physical health, mental health and social needs but do not receive sufficiently proactive, holistic, and joined up care to protect their health and maximise their independence and quality of life. People with learning disabilities struggle to access preventative services and appropriate treatment services, with scope to improve quality of life and life expectancy. We could pool expertise and work together on a new model of joined-up, team-based support for people with learning disabilities to deliver much more proactive, whole person care.

Primary care, long term conditions and people with multiple needs

5.19. In this final area, we have been discussing four potential priorities: ensuring that people receive convenient and high-quality episodic care from the primary care and urgent care system; ensuring that people receive high quality, joined up and convenient care for long term conditions; developing effective models of primary care for people from disadvantaged groups; and providing joined-up, whole person care for people with multiple physical health, mental health or social needs (see table below).

5.20. There are particularly strong arguments for joint work at system level to help ensure both access to high quality episodic care and to join up care for people with continuing health needs, in particular older people and the frail elderly. There are advantages in pursuing these priorities together given the interrelationships between the problems and solutions. One particularly important area of focus would be reconfiguring our primary and community workforce in neighbourhood teams to release GP time, make better use of resources and deliver more joined up, team-based care.

5.21. We will need to take action across primary and urgent and emergency care in these areas in response to Claire Fuller's review for NHS England on integrating primary care[1]. However, we know that it will be challenging to implement the models outlined in Fuller (for example team-based care) in ways that secure the full benefits. There are advantages in ensuring an element of cross-system working as we implement these models, for example to share learning and benchmark progress. There are benefits to working together as a whole system on the interface between primary care and the wider urgent care and hospital system. We can also explore the potential benefits of working together on data and digital solutions. There may be cross system options to take pressure off primary care so there is more capacity for both episodic care and care for people with long term conditions.

5.22. There were two other potential priorities in our shortlist: providing effective primary care for disadvantaged neighbourhoods and communities; and providing joined-up whole person care for people with multiple health and social needs. Our proposal would be to seek to tackle these issues in the first instance through the proposed collaborative work outlined above to implement the Fuller recommendations. There will be very significant opportunities to tailor our approach to these groups in work on

[1] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report

access to good episodic care and care for people with continuous health needs. **Do Partnership Members agree this represents a coherent approach to cross system work on access to primary and urgent care, alongside other work across our system?**

Figure 5: Our longlist of potential strategic priorities for primary care, people with long term conditions and people with complex needs

Potential strategic priorities: primary care, long term conditions, complex needs	
Ensuring that people across SEL can access easily and conveniently appropriate primary care services	People are struggling to access primary care services conveniently and in the ways they would like, with frustration about waiting times, and ability to choose between online and face to face appointments. Potential for joint working to harness technology and make better use of the primary and urgent care workforce across our system.
Ensuring that people with long term conditions receive high quality joined up and convenient care spanning the primary, community and hospital system.	People with long term conditions don't consistently receive joined-up care, reporting that their care is often from many disparate teams, with frequent travel to services on different sites. This fragmentation also leads to duplication between different teams and poor use of staff and resources across primary and secondary care. We could pool expertise to develop a more coherent team-based model of care for these groups, based in the primary and community system, but also focusing on improving joint working and coordination with hospital specialists.
Ensuring that people with multiple physical health, mental health and social needs in SEL have access to joined-up, team-based care close to home.	Many people in South East London with multiple physical health, mental health and social needs do not receive sufficiently proactive health and social support to help them cope with challenges and live good lives in their communities. The result is poorer outcomes and also avoidable use of urgent care services, hospital stays and residential care, as well as pressures on other public services. We could pool resources to develop an effective model of intensive, wrap around care for these groups.
Ensuring that people from the most deprived groups in SEL can easily access tailored and effective primary care services	People from the most deprived groups are less likely to be registered with a primary care practice and, even when they are, appear to face particular challenges in securing high quality preventative care, treatment for care, and support for long term conditions. We might pool expertise to develop more effective models of primary care for our most deprived neighbourhoods or groups of service users, drawing on established approaches such as those developed by the deep end network.

6. What it means to be a strategic priority

6.1. As well as discussing our shortlist of priorities, we have also discussed with system leaders what it should mean to be selected as a priority within our integrated care strategy. As discussed above, we have not simply sought to identify the most important issues for our system. (Work will continue on many important issues not covered in detail in the strategy.) Instead, we have focused on identifying priorities where collective action across our system will help to accelerate progress.

6.2. In light of this, we envisage that the Integrated Care Partnership and our Integrated Care Partnership should play a particularly active role in overseeing the delivery of these priorities, that there should be a South East London wide process of developing our overall approach to selected priorities (leading to action at different levels in our system depending on the solutions identified) and that resources should be allocated

to support the cross-system change required to deliver the priorities (for example, for service redesign and collaborative improvement as required). We are also eager to involve the public actively in developing and implementing solutions.

6.3. Given that we are homing in on areas that will require concerted action involving organisations across our system, we also envisage that partners will need to take account of these strategic priorities in their own strategies, plans and investment decisions and that the Integrated Care Partnership should hold its constituent organisations to account for their role in supporting delivery of shared priorities. ***Do Partnership Members agree with this articulation of what it should mean for a problem or opportunity to be selected as a South East London priority?***

7. Cross-cutting themes and enablers

7.1. We have also been engaging with leaders, partners, staff and the public on cross cutting strategic themes for our strategy, including the ways of working, capabilities and enablers we will need to deliver our vision and strategic priorities.

7.2. Drawing on this engagement, we propose to include a set of cross-cutting strategic themes which will recognise the four purposes of an ICS (improving outcomes, ensuring financial sustainability, addressing health inequalities and supporting socio-economic development) within our local context. These themes will act as a lens through which to view delivery of the priorities of our strategy and the broader set of objectives in our five-year NHS system plan. For example, our engagement on the strategy sheds further light on the outcomes and the quality of care the public want us to focus on across our services. Our engagement with disadvantaged groups provides more information on principles to address inequalities.

7.3. Regarding our ways of working and capabilities, we propose to set out at a high level how we will work together as a system on our strategic priorities to deliver substantial change. This is likely to cover our ability to work effectively across boundaries, our innovation capability, and the activities that might take place at different levels in our system, respecting both the need for a degree of cross-system collaboration on our priorities but also our commitment to respecting subsidiarity.

7.4. On our enabling infrastructure, we have separate strategies which will need to be refreshed on enablers such as data and digital, workforce and estates. We don't propose to duplicate that work in this strategy. Instead, we plan to highlight some key implications of our vision and priorities for these enablers. For example, we need to support our workforce in playing cross-system leadership roles, leading cross-system transformation and in working in cross-system teams. We need our data and digital infrastructure to better support our ambitions for prevention, convenient care, team-based care and working in partnership with our service users.

8. Next steps

8.1. We will refine our vision and strategic priorities and develop our cross-cutting strategic themes, ways of working and enablers reflecting the Partnership's advice. From late November, we will hold further online and face-to-face events and invite the public to provide further comments online, focusing on how we frame our strategic priorities, the ambitions and outcomes we should set ourselves and the solutions we should explore. We plan to circulate a draft initial publication for Partnership Members to review in the second week of December, in time for revision and publication by end of 2022. We envisage a concise document setting out our vision, our four strategic areas and the

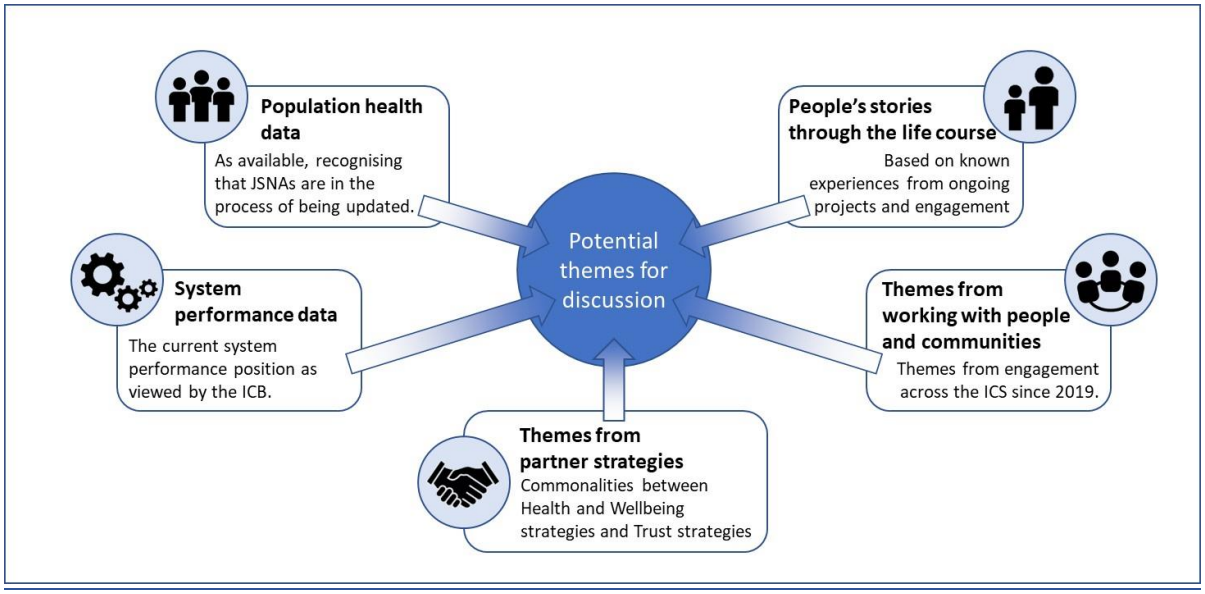
strategic priorities within them, and our approach to developing capabilities and priorities for enablers such as digital and workforce.

8.2. We are also convening expert groups from across our system (including the VCSE and Healthwatch) to review the evidence and propose an overall strategic approach and outcomes for each of our priorities. This work should start before Christmas and inform our initial publication, but much of the critically important thinking on our overall strategic approach to addressing our priorities will need to continue in early 2023.We propose to develop a more detailed strategy setting out our overall approach to delivering strategic priorities and implementation plans before the end of 2023-24.

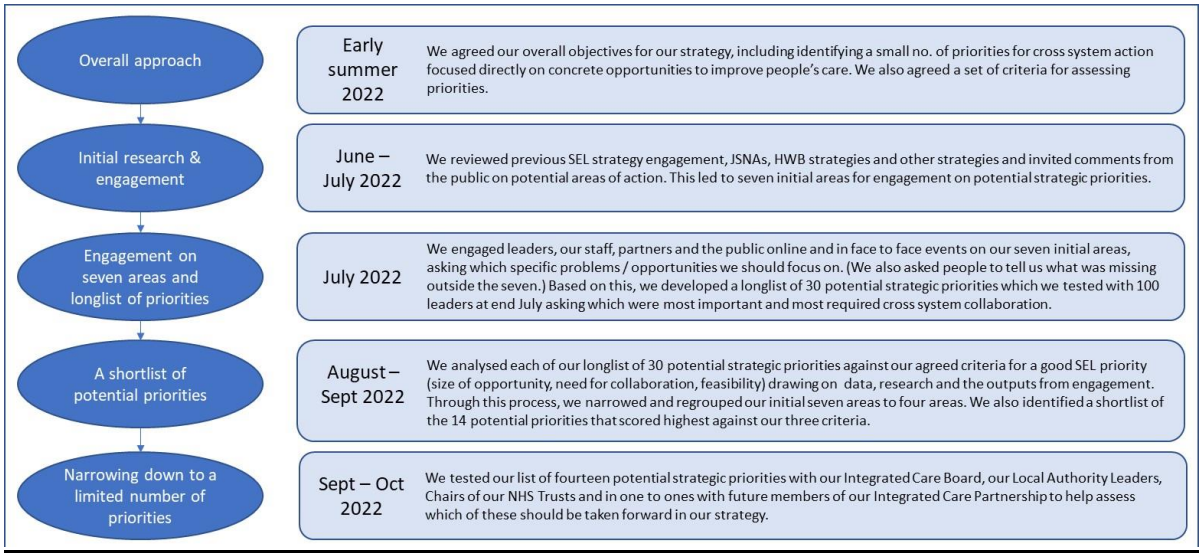
November 2022

Appendix

Our initial analytical process to identify themes for engagement on the straetegy



Our engagement and analytical process for developing potential strategic priorities



Our criteria for assessing potential strategic priorities

Test 1: Size of the opportunity	Would addressing this problem or pursuing this opportunity deliver substantial improvements in health and care for our communities?	For example could we significantly improve outcomes, efficiency and address inequalities?
Test 2: Need for collaboration	Is this a problem or opportunity where different parts of our system would really benefit from working together?	For example, are there substantial benefits in pooling knowledge and expertise and joint working? Do different parts of our system need to redesign care together? Do we need to build some shared infrastructure?
Test 3: Feasibility	Is it realistic to believe we could make tangible progress on this area within the next 3 to 5 years?	For example, can we envisage a strategic approach that would allow us to make significant progress? Could we find the will, capabilities and resources to implement it?
Test 4: Strategic coherence	Put together, do our selected priorities add up to coherent consistent, and coordinated approach?	For example, does one priority support another. Do they add up to more than the sum of their parts?

Our four strategic areas and our longlist of fourteen potential strategic priorities

Prevention & wellbeing 	How can we become better at preventing ill-health and helping people to live healthy lives?	Ensuring that everyone in SEL receives convenient and effective primary and secondary health prevention services, including children and adults from our most deprived groups.
		Supporting people in South East London to live the healthiest possible lives, including people from our most deprived communities and groups
		Using our combined resources to improve people's socio-economic conditions including reducing poverty and deprivation and improving access to good jobs, housing and opportunity.
Children and Young People 	How can we ensure that children and young people in South East London get the best possible start in life?	Ensuring that children and young people in SEL can quickly access a broad range of effective early intervention support when facing mental health challenges.
		Ensuring that mothers, children and families receive effective pre-natal, postnatal and early years support so that all children in South East London have a healthy start in life.
		Ensuring that young people can access tailored primary and community based services specifically designed to meet their needs
		Ensuring that children with long term conditions in SEL can access proactive, joined up and effective care to manage their condition
Adult mental health 	How can we ensure access to convenient, high quality primary care with our available staff and resources?	Ensuring that adults in SEL have rapid access to a broad range of effective early intervention services for mental health challenges, avoiding long waits and reducing the need for more specialist services.
		Ensuring that adults across South East London can access effective support to maintain good mental health and wellbeing and avoid suffering mental health problems.
		Ensuring that people with learning disabilities in SEL receive proactive, holistic and tailored care to support them to protect their physical and mental health and to live good lives in their homes or in the community.
Primary care, long term conditions, complex needs 	How can we deliver convenient primary care and well-coordinated, joined up and whole person care for older people and others with long term conditions and complex needs?	Ensuring that people with long term conditions in South East London receive high quality joined up and convenient care spanning the primary, community and hospital system.
		Ensuring that people with complex physical health, mental health and social needs in SEL have access to joined-up, person centred and effective care close to home.
		Ensuring that people across SEL can access easily and conveniently appropriate primary care services in ways that make best use of technology and our workforce.
		Ensuring that people from the most deprived groups in SEL can easily access tailored and effective primary care services to support prevention, early intervention and management of conditions.

Integrated Care Partnership

Item 4
Enclosure D

Title:	**Approach to allocation of resources in South East London – development of a strategy driven medium term financial strategy.**
Date:	22 November 2022
Authors:	Mike Fox – Chief Financial Officer Sarah Cottingham – Executive Director for Planning and Deputy CEO
Executive Lead:	Jonty Heaversedge (Joint medical director)

Purpose of paper:	A paper to enable a discussion on a strategy driven medium term financial strategy.	Update / Information	
		Discussion	X
		Decision	
Summary of main points:	This paper sets out some areas for consideration by the Integrated Care Partnership as we undertake our medium term planning - to trigger discussion and to help inform our work and next steps in developing a proposed financial planning process and approach.		
Recommendation:	The members of the ICP are asked to consider / provide a steer on the approach they would like to see with regards a financial framework for our integrated care strategy and the ambition around different approaches to a system medium term financial strategy.		

South East London Integrated Care System

A Strategy-driven Medium Term Financial Strategy

A discussion paper to help inform development and next steps

Integrated Care Partnership 22 November 2022

1. Context

1.1. A key first task of our new Integrated Care Partnership will be the development of an Integrated Care Strategy, a five year forward strategic look that articulates our strategic vision, priorities, objectives and outcomes and associated flagship programmes.

1.2. The expectation is that members of the Integrated Care Partnership will ensure that the action required to meet these agreed objectives and outcomes is secured through the respective delivery plans of partners, acting individually, on an aligned basis or collectively - with the Integrated Care Partnership overseeing progress.

1.3. Our work to develop the integrated care strategy over the summer has been focused on engagement to determine the type of strategy we are seeking to secure and a potential long list of priorities for consideration and prioritisation, with work underway since then to refine and prioritise the outputs of the summer engagement.

1.4. We have not to date considered in any detail our underpinning approach to enablers and specifically the financial framework within which we will implement our strategy. We therefore need to consider our approach, to ensure that we are able to concurrently develop an agreed medium term financial strategy that will operate alongside our health and care strategy.

1.5. Specifically, we will need to consider and develop an agreed financial framework and set of principles associated with a Medium Term Financial Strategy (MTFS). This would enable us to align our allocation and investment approach to our strategic objectives.

1.6. At the same time our Medium Term Financial Strategy will need to support the ICS (the system) in securing financial sustainability. Our context is challenging: an underlying recurrent deficit, significant planned changes to the allocation framework and associated financial uncertainty in the NHS and extremely constrained local authority budgets across care and public health services along with planned national changes for adult social care.

1.7. This paper sets out some areas for consideration by the Integrated Care Partnership as we undertake our medium term planning - to trigger discussion and to help inform our work and next steps in developing a proposed financial planning process and approach.

2. Financial Framework for our Integrated Care Strategy

2.1. We have said finance should be an enabler, demonstrably supporting the delivery of agreed strategic priorities. Demonstrating such an approach is challenging to achieve in reality and alongside enabling, finance will also represent a constraint. We will need to consider:

- **How might we best balance our approach across these two factors?**
- **Whether we are prepared to commit to a set of principles around an allocation framework and investment decisions that are demonstrably driven by a consideration of our strategic priorities?**
- **If so, what might this look like and how would we enshrine these commitments in the context of an uncertain forward environment and significant current and future financial challenge?**

2.2. The ICB will be responsible for allocating NHS resources across the ICS and the Local Authorities clearly hold responsibility across services for which they are responsible. We know that our current investment is not driven by population need in all cases but rather by historic spend and commissioning decisions. A good example is relative under investment in mental health services.

- **What is our appetite for making concrete changes that ensure we allocate funds in a way that addresses inequity in investment across service areas whilst also taking due account of relative efficiency and opportunity for improvement?**

2.3. The Integrated Care Partnership (and within it the ICB's allocative role) gives a real opportunity to do things differently. In the past we have committed as a system to shift resource and care along the care pathway to support community-based care, invest in prevention and inequalities. In reality however we have made limited progress in these areas with relatively marginal changes.

- **How might we use this opportunity to do something different with the resources available to us, in terms of both how we manage and allocate incremental growth but also the utilisation of core funding?**
- **How can we achieve a shift in resource allocation from treatment to prevention?**

2.4. We describe ourselves as a system of systems founded on the principle of subsidiarity and delegation with borough based Local Care Partnerships and horizontally focused Provider Collaboratives representing the key components of our system architecture.

- **How might we better lever opportunities from these Partnerships and Collaboratives to do things differently, take collective responsibility for resource and manage it across organisational and service boundaries?**

- **What is the right balance across a system or more local approach to these issues and challenges?**

2.5. The ICB has an allocative responsibility relating to NHS resources. However, the Integrated Care Partnership strategy will span health, care and wider local authority areas of influence. Within the ICS we have a number of pooled budgets such as the Better Care Fund and Section 75 agreements, but our financial planning is conducted separately with limited visibility of our respective positions or application of innovative solutions that effectively blur the boundaries across health and care.

- **How do we better join up our planning across health and care? Is there appetite to go further, for example, in considering a wider ICP approach while reflecting the funding constraints of all parties?**
- **How might we incentivise pathway changes that shift the cost of care across health and care boundaries but which benefit the system as a whole and our residents?**

2.6. All parts of our system are facing significant financial challenge with spend that is greater than the level of funding we receive. It will be important that we focus not just on allocative approaches but also that we ensure value for money, productivity and efficiency and a return on investment across the totality of our spend. As a system we currently default to organisation-based cost reduction planning and a delivery focus that is over reliant on short term, non-recurrent or unsustainable solutions that may also impact costs or efficiency in other parts of the system.

- **How might we challenge ourselves and each other to push the boundaries in terms of signing up to ambitious commitments around more effective resource utilisation, improved productivity and efficiency and reduced spend?**
- **How do we secure better balance across recurrent and non-recurrent solutions, collaborative / organisational approaches?**

3. Discussion and Consideration

3.1. The members of the ICP are asked to consider / provide a steer on the approach they would like to see with regards a financial framework for our integrated care strategy and the ambition around different approaches to a system medium term financial strategy.