South East London Integrated Care System

NHS South East London

South East London 2023/24 Joint Forward Plan

DRAFT - for engagement - to be finalised end Quarter 1 2023

Pre-information for online sessions in May 2023

South East London Integrated Care System

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What is the Joint Forward Plan

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

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

Our Joint Forward Plan provides the following:

- A strategic overview of our **key priorities and objectives for the medium term.**
- A high level summary of the **short term actions** that we will take, working with partners, to ensure the key milestones that support us in meeting these medium term objectives are secured, with further underpinning detail included in our 2023/24 and subsequent operational plans.

This is our first Joint Forward Plan and it will be **refreshed annually** to:

- Take account of implementation and outcomes over the previous year, including any learning to be applied to our future plans.
- Reflect any changes required due to new or emerging issues or requirements, be they related to population health, feedback from our communities and service users or service delivery issues and opportunities.

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What is the Joint Forward Plan

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

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

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

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

How does it all fit together

Overall context of the SEL System plans

The SEL Joint Forward Plan sits within a suite of strategic and operational documents and plans that have been and are being produced from January – June 2023. These represent a potentially confusing set of outputs but are interlinked with a clear golden thread across them.

Overview of our integrated care system

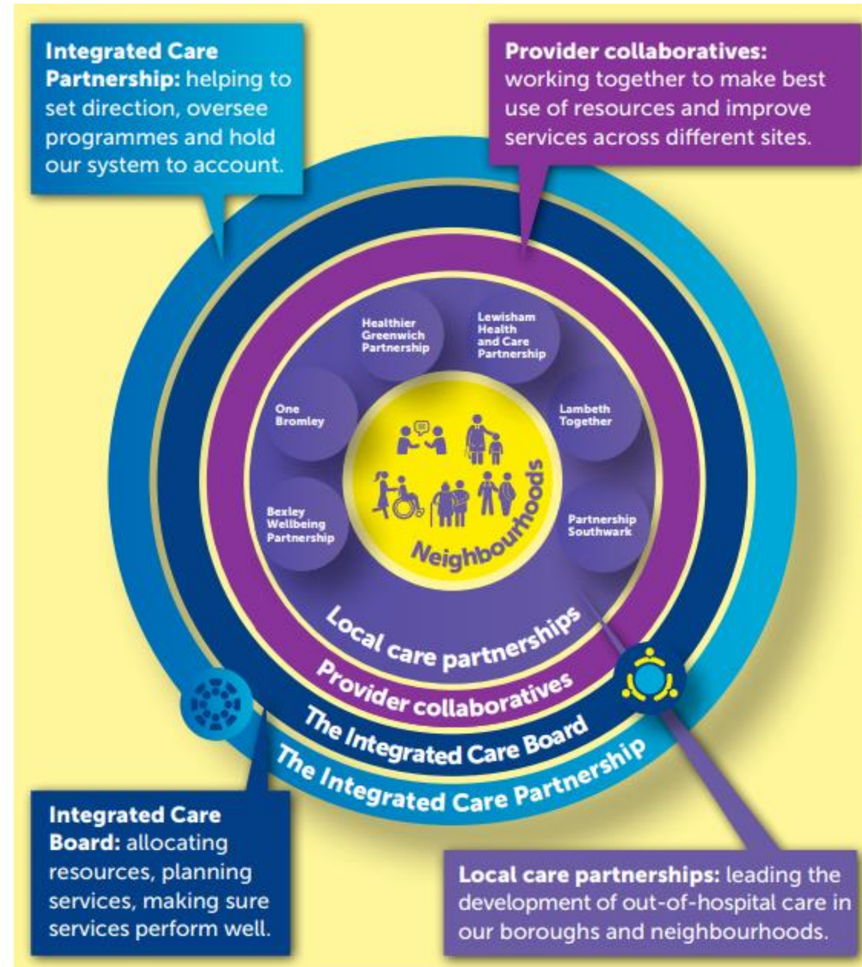
About our Integrated Care System
On 1 July 2022, we set up a new Integrated Care Board and a new Integrated Care Partnership, bringing together the leaders of health and care organisations across South East London to plan services and improve care for our population of almost two mission.

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

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

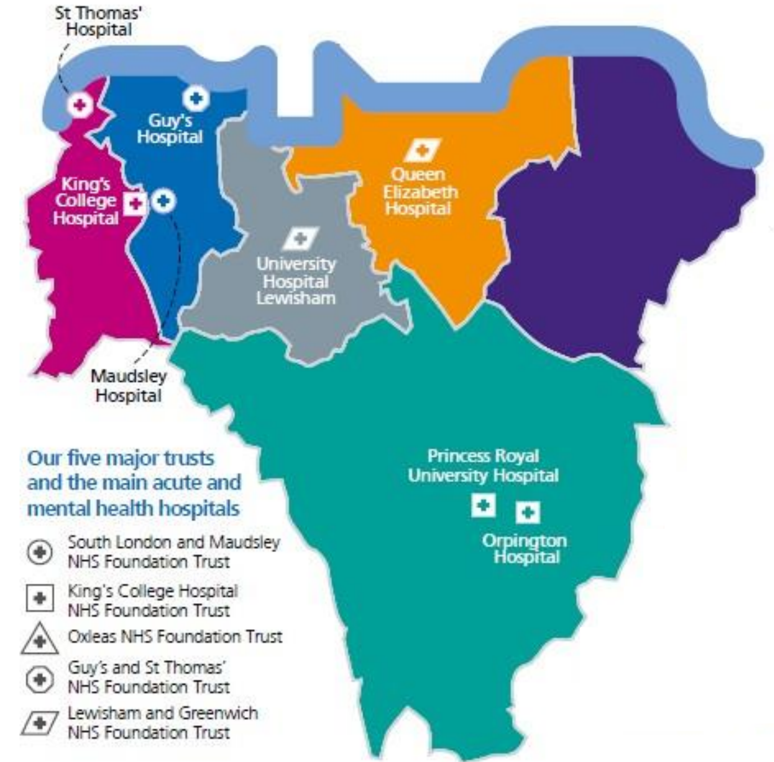
Our new arrangements are based on partnership working, bringing together the range of skills and resources in our public services and our communities, They are also based on the principles of trust, taking decisions at the right level in out system, giving partnerships and organisations within our system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

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



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

Our System of Systems



NHS provider landscape in south east London

South East London Integrated Care System

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Joint Forward Plan – challenges & opportunities

System challenges

Opportunities through our Joint Forward Plan

Population Health and Inequalities

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

- Each of our **borough based and care pathway plans** have been part driven by an understanding of population health and inequalities – we are developing an inequalities framework, to enable us to better ensure a systematic approach to population health and inequalities driven actions and outcomes in our planning and delivery.
- Our Medium Term Financial Strategy ringfences funding to support **targeted investment in inequalities** over the next five years – with our year 1 funding (for 2023/24) targeting our five integrated care strategy priorities. These priorities recognise that if we are to **tackle the underlying causes of poor population health, outcomes and inequalities** we will need to secure a genuinely collaborative effort across the NHS, Local Authorities and our communities, given the interplay of health and socio-economic risk factors.
- Our **focussed work on prevention**, in terms of both our overarching prevention priorities but also embedding a prevention, early detection and intervention focus in all our programmes of work will support us in starting to tackle underlying population risk factors.

South East London Integrated Care System

Joint Forward Plan – Challenges & Opportunities

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System challenges

Opportunities through our Joint Forward Plan

Sustainable, high quality services that meet national performance standards

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

- Our JFP sets out our vision and objectives for services, and the **key actions we will take to address the drivers of our challenges and deliver on the opportunities identified** to secure our objective of sustainable, high quality services that meet national performance standards. This includes taking due account of the national planning guidance and delivery expectations for 23/24, in the context of the NHS Long Term Plan and progress towards the longer term targets that have been set. There is therefore a direct read across the ambition set out in our JFP and the **detailed planning for year one contained within our operational plan** and constituent performance trajectories.
- As we take forward our medium term actions we will:
  - Take action to **systematically understand demand and capacity** with a commitment to right sizing our capacity to meet current and forecast demand, after taking account of the productivity and efficiency opportunities available to us.
  - Invest in our **population health management infrastructure and expertise** to ensure our approaches tackle the underlying drivers of our demand, quality and performance challenges and that as we improve our quality and performance outcomes we are also demonstrably improving equity of access, experience and outcome and a focus as much on prevention as treatment.
  - Ensure that we identify and understand the **productivity and efficiency** opportunities available to us and that our plans focus on demonstrably securing these as we tackle our underlying challenges.
  - Ensure that our care pathway redesign work in founded upon **evidence based best practice**, a collective understanding of a **'core service offer'** to address unwarranted variation and an understanding of and ability to secure the **transformation and enabler resource** required to drive and embed delivery.
  - Ensuring a focus on **culture and behaviour** as key to driving change alongside ensuring that we enable and **incentivise change** through our planning and contracting processes.

South East London Integrated Care System

Joint Forward Plan – Challenges & Opportunities

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System challenges

Opportunities through our Joint Forward Plan

Financial sustainability and elimination of our deficit

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

- Our Medium Term Financial Strategy provides clarity as to planned investment for the next five years, including an **allocative approach aligned to our strategic objectives** that **targets inequalities and prevention.**
- Care pathway plans that seek to ensure that we are redesigning services to optimise the opportunities associated with **care pathway transformation,** to improve **productivity and efficiency**, reduce duplication, ensure patients access the right service first time, and have clearly specified outcomes to enable us to collectively assess and secure a return on investment.
- The implementation of our 2022/23 review of **savings opportunities** over the next 2-3 years, with the establishment of associated **efficiency programmes** and the baking in of identified savings in our plans.
- Demonstrable year on year progress, including **delivery of our 2023/24 operational plan** commitments and the **4.5% efficiency target** we have collectively committed to.
- Further work during 2023/24 to assess and **identify the scope for further saving**s, productivity and efficiency and invest to save/return on investment opportunities to underpin our **commitment to a break even recurrent position by end 2027/28.**
- **Risk identification and mitigation for specialised services** delegation.

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

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

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

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

Our mission and vision

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 effective treatment when people become ill, caring for people throughout their lives, taking targeted action to reduce health inequalities, and supporting resilient, happy communities as well as the workforce that serves them.

The principles set out in our vision:

1. Health and wellbeing
2. Convenient and responsive care
3. Whole-person care
4. Reducing health inequalities
5. Partnership with our staff and communities
6. Protecting our finances and the environment

Our priorities

Prevention and wellbeing	Early years	Children's and young people's mental health	Adults' mental health	Primary care and people with long-term conditions
Improving prevention of ill health and helping people in South East London to stay healthy and well.	Making sure that children get a good start in life and there is effective support for mothers, babies and families before birth and in the early years of life.	Improving children's and young people's mental health, making sure they have quick access to effective support for common mental health challenges.	Making sure adults have quick access to early support, to prevent mental health challenges from worsening.	Making sure people have convenient access to high-quality primary care, and improving support and care for people with long-term conditions.
Pages 112-117	Page 141	Page 134	Page 133	Pages 187-190 Pages 194-198

Creating the conditions for change

- How we plan to work together as a system
- How we plan to allocate our resources
- Innovation and service transformation
- Working in partnership with our communities
- Developing our leadership and our workforce
- Developing our digital capability and our buildings

South East London Integrated Care System

Engagement informing the South East London Joint Forward Plan

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

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

South East London Integrated Care System

Engagement informing the South East London Joint Forward Plan

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

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

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

Summary of our approach to personalisation

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

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

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

South East London
Integrated Care System

SEL Care Pathway Programmes

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

South East London Integrated Care System

Urgent and Emergency Care

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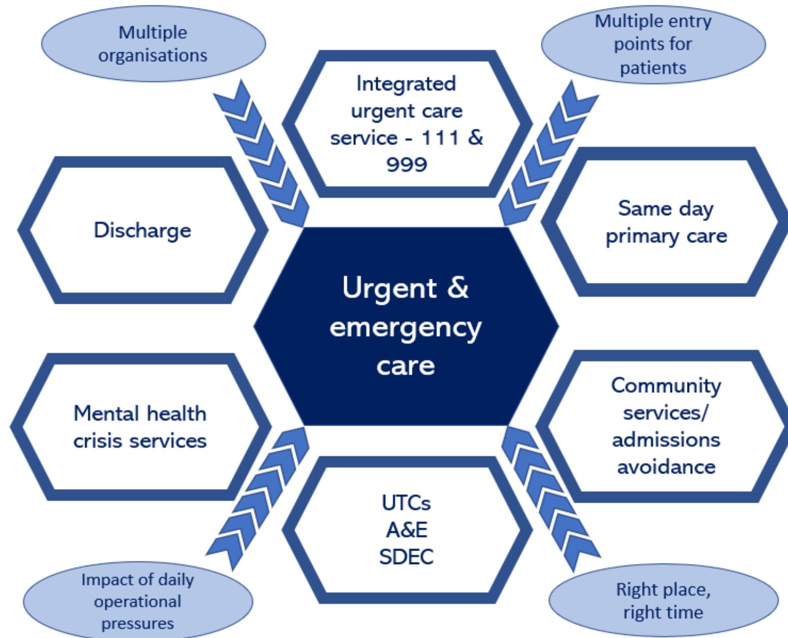
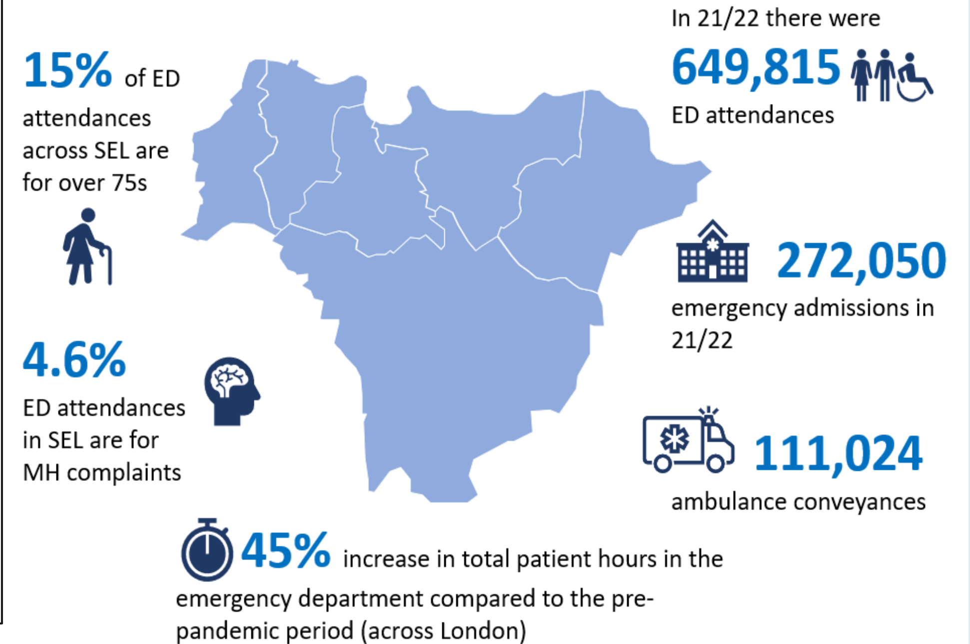
Overview of our current system

Overview of UEC system



Health inequalities:

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



What we've heard from the public

Access to urgent care and long waits is a key issue for local people (SEL ICS working with people and communities strategy engagement, 2022). Local people have previously reported that difficulty accessing primary care appointments led to them seeking help and care at Emergency Department (ED) and other urgent services, and whilst many people were aware of and had used urgent care alternatives to A&E (such as urgent care centres) there is a need for increased publicity, information and signposting on different urgent care and out of hours services and where to access them (Our Healthier South East London engagement on the NHS Long Term Plan, September 2019). Our Friends and Family Test Results for SEL Emergency Departments in October showed feedback that was a Positive 70% Negative 20% (National comparison Positive 74% Negative 17%).

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Urgent and Emergency Care

Strengths / opportunities	Challenges
Collaboration SEL has a well-established and effective system approach to operational pressures providing real-time mutual aid across the system (e.g. daily surge calls). The formation of the Acute Flow Improvement Group and the Discharge Solutions Improvement Group has also enabled engagement of local system leaders in the longer-term and most systematic and consistent improvement of UEC pathways. **Community and integrated urgent care** As early adopters of Urgent Community Response (UCR) provision, we have developed an effective UCR service across all of SEL. SEL is also the lead commissioner for NHS111 for London and so plays a pivotal role in developing integrated urgent care. **Governance** Established Place-based UEC Boards are in place to support local development and delivery working alongside the SEL Board to secure agreed common standards and approaches delivered locally. Board include representation from the wide range of stakeholders involved in planning and delivering UEC. **Communication & Engagement** There is strong engagement and communication in some Boroughs with the opportunity of achieving more consistency by way of a SEL UEC communication strategy that aligns with the recommendations in the Fuller Report. Whilst there is some good local engagement, for example in local UTC procurement, more work is required to engage with our residents on UEC service design and in communicating what services are on offer. **Service Redesign** There is a wealth of service improvement expertise across the system and a huge opportunity to funnel this expertise into spreading existing pockets of good practice. Using UEC/health/111 data sets together will help us to understand the way the population uses UEC services, the changes in acuity seen across the UEC pathway and highlight areas for opportunity. We will maximise the opportunity of innovative digital solutions as well as improving consistency and alignment across the system where this is beneficial for the population.	**Collaboration** Emerging collaborations and partnership are in their infancy with individual partners often having to concentrate on their own pressures and constraints, resulting in variation across systems. There is also scope to better join up work across UEC and other key programmes (primary care, pharmacy, community services, CYP, etc.). **Demand, capacity and flow** We need to better understand and address demand, capacity and flow constraints including considering how we better tackle challenges related to demand and capacity together and improve transfers of care across the UEC care pathway. **Balancing operational pressure and long term improvement** System solutions for UEC often require behaviour and culture change which can take a long time and a sustained effort; this can be challenging when immediate operational pressures often take focus away from more medium term sustainable change. **Service design** We need to be better at evaluating improvement initiatives and stopping initiatives that cannot evidence positive outcomes. As a system we also need to agree an approach to resourcing initiatives that have shown positive outcomes where these often have short-term/pilot funding arrangements in place. **Communication & Engagement** We need to improve our meaningful patient and front-line staff engagement in UEC service design. Again the short-term interactions with patients and operational pressures on front line teams make this challenging to overcome. **Inequalities** We know that there are a number of factors driving behaviours that increase pressure on UEC services, such as increasing patient expectation of immediacy of care, damaged trust between the public and health care provision, and other factors such as the cost of living crisis. Social factors such as deprivation rates may also indicate more complex home and care needs which impact on discharge requirements and flow through our acute hospital sites. We need to prioritise patients with the greatest need to better influence health outcomes and ensure we are shifting the curve for those population groups that are over reliant on urgent and emergency care services for their care.

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UEC - Our vision and objectives

Our vision

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

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

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

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

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UEC - Our priority actions

Our priority actions – what we will do

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

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

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

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

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

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

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Planned Care

Overview of our current system

Following the pandemic, we have been working hard to reduce the backlog of patients awaiting specialist appointments and procedures. Whilst steady inroads have been made, particularly in respect of reducing the number of patients waiting a very long time for treatment, there is still a lot to do. Even before the pandemic, waiting lists were growing, so we knew that just going back to historic levels of activity would not be enough. Our focus has therefore been to try and increase our capacity to diagnose, see and treat patients, work more collaboratively to pool resources, and become more productive by improving the efficiency of our services.

Strengths / opportunities

Collaboration – The formation of the Acute Provider Collaborative (APC) has resulted in closer working than ever before between our hospitals. Specialty teams now routinely work together to provide mutual aid, develop joint pathways and share staff and expertise

Community provision – We have developed some of the most comprehensive out of hospital services in the country for specialties such as Ophthalmology and Dermatology. We are thus in a good position to build on these foundations for services such as ENT and for diagnostics

Challenges

Physical capacity – In order to manage the backlog, and to make sure we have sustainable services in the longer term, we know we are going to need additional physical resources. This includes, beds, theatres and diagnostic equipment, in order that we can balance emergency demand with planned outpatients and procedures

Staffing – There are a number of specialties where there are significant staffing challenges. To mitigate this we have tried to use the Independent Sector, and insourcing companies, but we want to ensure that we have sustainable staffing models and offer good jobs, to local people. We are exploring alternative ways of working and cross site working as part of our collaborative solutions to these challenges

Inequalities – We know that waiting times and access to care varies across SE London. We need to make sure that we prioritise those in the greatest need, but that this is done equitably across the ICS

What we've heard from the public

People have told us that increased waiting times has placed significant burden on their physical and mental health and wellbeing, work and financial stability and relationships (Joint Programme for Patient, Carer and Public Involvement in COVID recovery, 2022, and SEL ICS working with people and communities strategy engagement, 2022). Whilst they wait people want to be kept informed, supported to manage their conditions, and access to support services and peer support.

South East London Integrated Care System

Planned care - Our vision and objectives

NHS South East London

Our vision

We want our elective services to be equitable, deliver high quality care and be responsive to the needs of our population. Our aim is to work as a system to ensure that patients have better access to specialist advice when they need it and that we reduce the number of times patients need to come to hospital, offering care close to where patients live whenever possible. We will also ensure that through system working we speed up the time to treatment and adopt new ways of working and best practice pathways, to ensure our services offer patients the highest quality care.

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

- **Reduce waiting times and sustainable waiting lists** - By working together, we have made good progress in seeing and treating the patients with the longest waits. Whilst this is a good start, we want to go much further. To achieve this, we need to maximise the amount of activity we undertake, make best use of our collective resources and capacity, and maximise our productivity and efficiency in both non-admitted and admitted care pathways. We need to make sure that every appointment genuinely adds value and that we look to streamline pathways wherever possible
- **Be much more patient-centric** – Our patients consistently tell us that they find long waits for appointments and treatment incredibly frustrating, and that not knowing what is happening can be frustrating and isolating. We will redouble efforts to communicate much more effectively, and invest in portals to allow patients to access advice when they need it – including being able to contact their clinical team.
- **Ensure patients are seen in the most appropriate setting, by the most appropriate professional** - we will build on successful community services, such as those in Dermatology and Ophthalmology, to bring more services closer to home. This should reduce waiting times, and also free up capacity at our hospital sites. There is significant potential in this area to deliver services such as ENT and Gynaecology as well as diagnostics. As part of ensuring patients are seen in the most appropriate setting we will also continue to explore the potential to move appropriate procedures from day surgery to outpatients.
- **Improve equality of access to timely and high quality services** - by working together as a system make best use of our collective capacity and ensure we are working together to align pathways, protocols and processes that deliver consistent and high quality care for our patients

South East London Integrated Care System

Planned care - Our priority actions

NHS South East London

Our priority actions – what we will do

1. Implement **personalised outpatients**, ensuring patients can access care conveniently and in a way that best meets their needs. This will be achieved through optimising models such as Patient Initiated Follow-up (PIFU) and virtual appointments. Patient portals will also become widely available giving patients convenient, 24-hour access to personal health information and allowing them to message their care teams, (re)schedule appointments and update contact information.

2. Ensure patients are seen in the **right place, first time, by the right professional**. We will do this by improving the quality and timeliness of advice and guidance; implementing clinical triage of referrals across a wide range of specialties; improving the systems within primary care to make it easy for referring clinicians to follow the latest guidance and pathways; and further developing our planned care community services offer.

3. **Implement and maximise our use of treatment hubs** across SEL, to increase our capacity for high volume low complexity surgery. This will reduce and equalise waiting times for treatment, and ensure we can protect capacity so operations can continue when there is significant operational pressure in the system (e.g. during winter and other periods of high emergency demand). It will also ensure we can make better use of existing capacity for more complex treatment.

4. **Use our collective capacity to minimise waiting times for patients.** In the first instance this will involve planning how we use our capacity on a system basis – rather than by organisation. This will be a precursor to moving to single points of access where appropriate, to distribute demand coming into the system and equalise waiting times for our patients.

5. Continue to improve quality of our services **and work towards achieving GIRFT standards and best practice pathways,** through the work of the elective clinical networks. The networks bring together services across sites to align pathways, protocols and processes and design and implement new ways of working that improve care for our patients.

6. **Implement the SEL Community Diagnostic Centre (CDC) rollout programme** to create additional diagnostic capacity through an initiative that straddles all four key objectives – contributing to reducing waiting times; ensuring patients can be seen in the most appropriate environment through the provision of more local services and the development of 'one stop shop' diagnostic services; and improving equity of access to diagnostic services.

South East London Integrated Care System

NHS South East London

Cancer

Overview of our current system

Cancer services are structurally complex and involve a number of teams and programmes working together, supported by SEL Cancer Alliance. The Cancer Programme covers the whole patient pathway from prevention and screening to timely presentation through early diagnosis and treatment and on to living with and beyond cancer and personalised care. Within SEL, cancer patients often experience a shared pathway between acute providers, with GSTT or KCH providing complex specialised treatment. Our providers are also tertiary centres of excellence for key tumour groups and receive a significant number of referrals from outside London. SEL, compared to other parts of the UK, has areas of high deprivation, and a younger and more ethnically diverse population, which shapes priorities for cancer services and transformation, for example, responding to higher incidence of prostate cancer among black men. SEL has 45,000 patients living with and beyond cancer, our early diagnosis rate (54.8%) is in line with London and England but, as with the rest of the country, well below the Long term plan (LTP) ambition of 75%. Our 1 and 5 year survival rates (75.2% and 54.1% respectively) are both in line with the national and London, we receive around 89,000 suspected cancer referrals a year and conduct around 8,700 first treatments for cancer per year. Demand into our services has been growing by between 5-10% year on year.

Strengths / opportunities

- **Relationships**: Strong relationships between a number of tertiary and specialised services with a Cancer Alliance on the same footprint as the ICB. An engaged clinical workforce in primary and secondary care and the ability to share resources / work together, such as with joint appointments.
- **Patients**: The ability to work closely with patients and ensure co-production of key projects.
- **Data**: We are able to understand our performance drivers and inequalities at a granular level through data available to us and have been one of the first systems in the country to produce Best Practice timed pathway information.
- **Funding**: Confirmed national transformation funding specifically for cancer over the next few years, overseen by SEL Cancer Alliance.
- **Innovative Pathways**: A number of key pathways in development or early establishment such as Rapid Diagnostic Clinics (RDC), Telederm, Targeted Lung Health Checks (TLHC), Feacal Immunochemical Testing (FIT), new diagnostic models.
- **Community Diagnostic Centres (CDC):** Offer an opportunity to the system to increase diagnostic capacity, a key aspect of cancer pathway delays.

Challenges

- **Population**: Challenges in ensuring accessible and equitable services responding to the needs of the diverse SEL population, for example, addressing inequalities in cancer screening uptake.
- **Workforce**: Shortages in key areas that impact cancer pathways such as radiology.
- **Demand & Capacity**: Long term capacity shortfalls in some key tumour pathways and in a number of diagnostics which cancer pathways are reliant on. Increasing demand on systemic anti-cancer therapy (SACT) services
- **Competing Demands**: Cancer pathways touch on many aspects of the healthcare system and utilise the same workforce to drive improvements required and supporting services – e.g. imaging and pathology. System pressures also reduce capacity of organisations to focus on improvement.
- **Inter Trust pathway transfers**: The SEL system has been designed for a large number of pathways to require shared care across multiple providers. This requires pathways and transfer processes to be highly efficient to avoid additional delays.

What we've heard from the public

Patient Experience events are held across the year with patients and staff to review patient feedback data and agree areas of focus and priority. Patients are also key participants in the following groups: Patient involvement and experience steering group, Patient Involvement Community of Practice, Tumour specific patient advisory groups, SACT Patient working group, Inequalities sub committee, Prostate Cancer awareness raising working group. Communication and information are key themes identified. SEL performed less well compared to the national average in the 2021 CPES around: information around long term side effect of cancer treatment and support available, opportunities to discuss worries or fears, fully understanding the referral for diagnosis, ease of contacting and involvement in decision making around their treatment. Patient experience improvement initiatives for the coming year are based on this feedback, and co-design is a key feature of this work. Teams will work collaboratively across SEL to codesign quality improvement work.

South East London Integrated Care System

NHS South East London

Cancer - Our vision and objectives

Our vision

To work in a collaborative model to deliver high quality cancer services across community, primary, and secondary care in South East London. Our aim is to ensure that patients receive timely diagnosis, high quality treatment, excellent experience, and improved clinical and quality of life outcomes.
South East London ICS and the South East London Cancer Alliance bring together a range of local organisations – including NHS bodies, local government, charities, and patient groups – with shared goals of: Fewer people getting cancer; More people surviving cancer; More people having positive experience in their treatment and care; Ensuring everyone receives the same high quality services, no matter who they are or where they live; More people being supported to live as well as possible after their treatment is over.
Underlying all objectives of the SEL Cancer Programme are the principles of improving patient experience, reducing health inequalities, encouraging innovation and involving patients in service improvement and transformation and ensuring national & local data and evidence underpins the work programme.

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

- Support the national ambitions to **improve early stage (stage 1 and 2) diagnosis and survival rates** in SEL.
- **Reduce variation and inequity in access** to cancer services and treatment and waiting times within SEL, through collaborative working in the sector to improve and standardise cancer pathways and close working with other referring regions and pan London.
- Faster Diagnosis and Cancer Waiting Times Standards **– improving 28 day diagnosis and 62 day treatment** performance from current levels.
- **Improve productivity** through pathway change (e.g. procedures under local anaesthetic rather than general)
- Improved clinical workforce productivity, e.g. **optimising non-clinical roles** in cancer and allied healthcare roles, **implementing stratified follow up pathways** (reducing outpatient appointments), training, shared roles.
- Accelerate implementation and further **development of innovative pathway**s such as Non Specific Symptoms (NSS) pathways (also known as Rapid Diagnostic Clinics) and Telederm.
- **Support innovation** across the whole cancer pathway, including **pathway redesign**, reviewing workforce skill mix, and exploring **use of technology** to mitigate capacity and workforce risks and working with the national team on delivering innovations, such as the NHS-Galleri Trial.
- **Improve patient experience of cancer services** and engagement with people on cancer pathways (as reported in the National Cancer Patient Experience Survey).
- **Improve quality of life outcomes**, through supporting initiatives for personalised care.
- **Involve patients and carers** in our service transformation work.
- **Use of data** to identify variation and inform population level decisions / priorities for cancer in SEL including targeted interventions to address equity gap

Cancer - Our priority actions

Our priority actions – what we will do

1. **Early Diagnosis and Prevention**
   Design and deliver interventions to improve awareness of cancer symptoms and screening programmes, support timely presentation and effective primary care pathways, targeted cancer screening uptake interventions, targeted case finding and surveillance and delivering Targeted Lung Health Checks across South East London.

2. **Faster Diagnosis and Improved Performance**
   Implement best practice timed pathways for priority tumour groups, improve front-end processes leading to diagnosis, and further developing Non Specific Symptom pathways. As well as Implementing actions to support wider pathway recovery including all key performance metrics through to treatment.

3. **Personalised Cancer Care and patient experience**
   Supporting acute providers and primary care to implement stratified follow up, implement the key personalised care interventions for all cancer patients, support improvement in the national Quality of Life and National Cancer Patient Experience survey response among SEL cancer patients, and respond to findings.

4. **Clinical Outcomes and Treatment variation**
   Ensuring the system implements key Getting it Right First Time (GIRFT) and national recommendations to improve survival outcomes as set out in the LTP and reduce variation across the Cancer treatment Pathway.

5. **Research and innovation**
   Facilitate and promote research to ensure that national funding is utilised to embed key national innovations and enable specific local research and innovation supported by partnership working including with industry e.g. the Small Business Research initiative.

South East London Integrated Care System

NHS South East London

Palliative and End of Life Care (PEOLC)

Overview of our current system

Death and dying are inevitable.
In 2022 10,211 people died in South East London. 5,121 of these people died in hospital, for many, if they had been asked where they would want to die, they would have chosen a setting outside of hospital. It is estimated that around 50-75% of deaths are 'amenable to palliative care', but at present it is not clear what proportion of people are referred for support. At any one time, nationally, it is estimated that one third of people who are in hospital today will die in the next year, many of these admissions might have been avoided with proactive open communication and personalized care planning.
Palliative and end of life care must be a priority across services and care pathways. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preference and wishes.

Strengths / opportunities

- We have a well established PEoLC group and CCPL leads in most boroughs
- New London universal care plan (UCP) well utilized in many parts of the system and opportunities to further embed this.
- Bexley in particular has had success in 'finding their 1%' of people likely to die in the next year. Of these patients, almost 70% have a personalized care plan. There is scope to learn from this work and achieve similar results for the relevant % across other boroughs
- We have almost completed work to define a core offer for community Specialist Palliative Care providers;
- Pilot project to support patients and their families transitioning from CYP to adult EoL services
- Significant opportunity to address inequalities in many areas, starting with people with LD
- Projects started to implement End of Life Care virtual wards into wider acute/community pathways
- We have excellent services locally and a world leading PEoLC research institute

Challenges

- There are significant gaps in workforce across generic EoL (GP, DN, hospital, care home) and specialist palliative care (SPC) services. Where we have workforce, they may lack confidence on EoLC.
- Local SPC provision is reliant on significant charitable funding which may present problems in the current cost of living crisis (also a strength)
- There are significant inequalities in access to care – and much work to be done, e.g. moving away from a white-European approach to death and dying
- Our data is not joined up and so we are not able to fully understand pockets of excellent or weak performance.
- Outcomes in PEoLC are not well documented at present

What we've heard from the public

Most engagement with patients, families and carers has been through individual services. We have heard that the priorities for our patients are "to manage and choose the support" they need and to be empowered to begin planning at an earlier stage. We have also heard the need to better integrate care between services and to ensure seamless access to advice, care and treatment out of hours, including access to medications. We are keen to progress more integrated engagement with our communities building on best practice across the UK, such as compassionate communities and death literacy.

South East London Integrated Care System

NHS South East London

PEOLC - Our vision and objectives

Our vision

Our vision is to ensure that people of all ages at the end of their lives* are identified early so that they can be supported to make informed choices, receive 24/7 care in the place of their choice and that they receive the best quality, personalised care, with people close to them supported by people who are empowered, skilled, confident and timely.

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

Our key objectives align to the National Palliative and End of Life Care 22-25 strategic priorities of accessibility, quality and sustainability.

Accessibility

- People likely to be in the last year of life are identified as early as possible
- All patients in the last year of life are offered a Personalised Care and Support Plan (PCSP)
- High quality care and advice is accessible 24 hours a day, 7 days a week for patients, family, carers and professionals in all settings
- There is equitable access to PEOLC for all, focusing on underserved populations

Quality

- Patients receive standardized and high-quality Palliative and End of Life Care irrespective of age, condition or diagnosis
- There is a confident workforce with the knowledge, skills and capability to delivery high quality Palliative and End of Life Care
- End of Life Care is seen as everyone's business, with patients identified and support through effective multi-disciplinary teams

Sustainability

- Specialist palliative care services, including hospices, are sustainable in the longer term, with sufficient NHS investment to achieve this.
- We have sufficient SEL specialist palliative care workforce to meet patient need and future demand, and non-specialist staff supporting end of life care patients feel confident and supported to deliver effective end of life care.
- We have thriving neighbourhood-based support which maximises the role of neighbourhood and third sector organisations in delivering support to patients, families and carers (e.g social prescribing and compassionate neighbours)

** n.b: Although we are generally talking about 'last year of life' there will be some people where a palliative care approach may be earlier. For others, they may be identified in the very last weeks, days or hours.*

South East London Integrated Care System

NHS South East London

PEOLC - Our priority actions

Our priority actions – what we will do

1. **Proactive and personalised care** - We will improve early identification of people approaching end of life and ensuring proactive, personalized care and support planning.
2. **Improve our service offer** - We will ensure PEoLC services are accessible 24/7 for patients, carers and professionals in all settings that are rated as 'good' or above across all areas of SEL
3. **Improve access** - We will identify groups who are marginalized and improve access for these groups
4. **Workforce** - We will support our workforce to have the confidence and skills they need to provide end of life care and work with the People programme to ensure that has End of Life Care is integrated into all health and care career pathways in SEL.
5. **Population Health Management** - We will use population health management approaches to ensure that EoLC is integrated into the model of care for all population groups, starting with the frail elderly and those with long term conditions.
6. **Compassionate communities** - We will work alongside our communities to support the development of compassionate communities with citizens who have a growing confidence and understanding about death, dying and loss.

South East London Integrated Care System

NHS South East London

Glossary

Abbrev	Description	Abbrev	Description	Abbrev	Description
A&E	Accident and Emergency Department	BAU	Business As Usual	CPES	Cancer patient experience survey
ACP	Advanced Care Practitioners	BCF	Better Care Fund	CQC	Care Quality Commission
AHC	Adult Health Check	BFI	Baby Friendly Initiative	CVD	Cardio Vascular Disease
AHSN	Academic Health Science Network	BP	Blood pressure	CYP	Children and Young People
AI	Artificial Intelligence	CAMHS	Children and Adolescent Mental Health Services	DASS	Director of Adult Social Services
ALD	Adult Learning Disability	CDC	Community diagnostic centre	DES	Directory of Enhanced Services
AHP	Allied Health Professional	CETR	Care Education Treatment Review	DSR	Dynamic Support Register
APC	Acute Provider Collaborative	CESEL	Clinical Effectiveness South East London	ECH	Eltham Community Hospital
ARI	Acute Respiratory Infections	CHC	Continuing Health Care	ED	Emergency Department
ARRS	Additional role reimbursement scheme	CHD	Coronary Heart Disease	EDI	Equality Diversity and Inclusion
ASC	Adult Social Care	CKD	Chronic Kidney Disease	EHCNA	Education Health Care Needs Assessment
ASD/ADHD	Autistic Spectrum Disorder / Attention deficit hyperactivity disorder	CMHS	Community Mental Health Services	ENT	Ears Nose and Throat
BAME	Black, Asian and minority ethnic	COPD	Chronic Obstructive Pulmonary Disease	EPEC	Empowering Patients Empowering Communities

South East London Integrated Care System

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Glossary

Abbrev	Description	Abbrev	Description	Abbrev	Description
FIT	Feacal Immunochemical Testing	ICP	Integrated Care Partnership	LBL	London Borough of Lambeth
G&A	General and Acute hospital beds	ICS	Integrated Care System	LCP	Local Care Partnership
GIRFT	Getting it right first time	INT	Integrated neighbourhood teams	LDA	Learning Disability and Autism
GLA	Greater London Authority	IPC	Infection prevention and control	LeDeR	Learning from the lives and deaths of people with learning disability and autistic people
GSTT	Guys and St Thomas' NHS Foundation Trust	IUC	Integrated Urgent Care	LFPSE	Learn From Patient Safety Events
HCAI	Healthcare associated infections	JFP	Joint Forward Plan	LGA	Local Government Association
HGP	Healthier Greenwich Partnership	JLHWS	Joint Local Health and Wellbeing Strategy	LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and other sexual identities
HVLC	High volume low complexity	JSNA	Joint Strategic Needs Assessment	LGT	Lewisham and Greenwich NHS Trust
HWB	Health and Wellbeing	JWA	Joint Working Agreement	LHCP	Lewisham Health and Care Partnership
HWS	Health and Wellbeing Strategy	KCH	Kings College Hospital NHS Foundation Trust	LIP	Local Implementation Plan
IAPT	Improving Access to Psychological Therapies	KCL	Kings College London	LMHS	Local maternity and neonatal system
ICB	Integrated Care Board	LA	Local Authority	LOS	Length of Stay
ICHM	Integrated Child Health Model	LARC	Long Acting Reversible Contraception	LTC	Long Term Condition

South East London Integrated Care System

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Glossary

Abbrev	Description	Abbrev	Description	Abbrev	Description
LWNA	Living Well Network Alliance	OD	Organisational Design	PTL	Patient tracking list
MH	Mental Health	PCN	Primary Care Network	PTSD	Post Traumatic Stress Disorder
MDT	Multi-disciplinary Teams	PEOLC	Palliative and end of life care	QEH	Queen Elizabeth Hospital
MHMDS	Mental health minimum dataset	PHB	Personal Health Budget	QMS	Queen Mary's Sidcup
MMN	Maternal medicines network	PHC	Physical Healthcare Check	QOF	Quality Outcomes Framework
MSP	Market Sustainability Plan	PIFU	Patient Initiated Follow Up	SACT	Systemic anti-cancer therapy
MSK	Musculo Skeletal	PHM	Population Health Management	SDEC	Same Day Emergency Care
MSW	Maternity support worker	PMO	Programme Management Office	SEL	South East London
MTFS	Medium Term Financial Strategy	PODs	Pharmaceutical, general optometry and dental services	SELCA	South East London Cancer Alliance
MVP	Maternity voice partnership	PReP	Pre-exposure prophylaxis	SEND	Special Educational Needs and Disabilities
NAPC	National Association for Primary Care	PROMS	Patient reported outcome measures	SLAM	South London and Maudsley NHS Foundation Trust
NVQ	National Vocational Qualification	PRS	Private Rented Sector	SLP	South London Partnership
NWL	North West London	PSIRF	Patient Safety Incident Response Framework	SMI	Serious Mental Illness

South East London Integrated Care System

NHS South East London

Glossary

Abbrev	Description	Abbrev	Description	Abbrev	Description
STI	Sexually Transmitted Infection				
SWL	South west London				
TBC/D	To be confirmed / determined				
TLHC	Targeted lung health check				
UCR	Urgent Community Response				
UEC	Urgent and Emergency Care				
UKHSA	UK Health Security Agency				
UTC	Urgent Treatment Centre				
VCS	Voluntary and Community Sector				
VCSE	Voluntary Community and Social Enterprise				