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

How we have engaged with local people and stakeholders

The Integrated Care System has carried out a range of engagement activities during summer and autumn 2022 as part of the ICS strategy development process and the development of the Working With People and Communities Strategic Framework. This included webinars, face to face events, online chat forums and outreach with organisations supporting marginalised groups and communities. A review of insight gained through this engagement supplemented by other insight gained across the system was also carried out, and is now published (see What we've heard from local people and communities - South East London ICS (selondonics.org)). Key themes are summarised over the next few slides and have informed the development of our Joint Forward Plan. Additional insight from borough level engagement has further informed the development of Local Care Partnerships' health and care plans.

Going forward the JFP will be updated annually and ongoing engagement and feedback from our communities and stakeholders will inform the updates made, whilst also taking account of implementation and outcomes over the previous year and any changes required due to new or emerging issues or requirements.

During April - June 2023 we carried out further engagement activity specifically on the Joint Forward Plan as detailed below. Themes from this engagement are summarised on slide 17 and have been shared with programme leads to inform the final version of the plan.

- Held local engagement activities in each of our boroughs, building on the engagement that has previously taken place and giving people the opportunity to comment on specific borough plans, as well as input to further development of SEL programme sections.
- Engaged with a range of key stakeholders and forums including:
    - Each of our six Health and Wellbeing Boards. Borough Health and Wellbeing Boards have provided feedback on and endorsed the Joint Forward Plan. Health and Wellbeing Board statements can be found on the South East London ICS website.
    - The South East London Integrated Care Board and Integrated Care Partnership
    - NHS England London Regional team
    - SEL ICS Workforce Programme
- Engaged and discussed the draft plan with the following groups to inform the development of relevant sections of the plan:
    - Mental health voluntary sector steering group
    - Learning disabilities and autism user, parent and carer forum
    - Maternity Voice Partnership chairs
    - The Council for Disabled Children
- Held two webinars for local people and communities 19 and 23 May to engage local people on a south east London basis and have focussed discussions on areas that are not covered by the ICS strategy including planned care, urgent and emergency care, cancer, ageing well and end of life care.
- Held discussions with the South East London VCSE Sector Strategic Alliance, Healthwatch Chief Officers and the South East London Healthwatch Reference Group
- Published a Joint Forward Plan project on our online engagement platform with a short survey Developing our Joint Forward Plan in south east London | Let's Talk Health and Care South East London (letstalkhealthandcareselondon.org) enabling the public to feedback views.

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

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 'seldom heard', and we need to change how we involve them in our services.
- **Wider causes of health and social issues**: Wider causes of health and social issues can make it difficult for people to take up services, particularly prevention services, but these causes are often underestimated by health and care services. We heard that what are often viewed as basic needs such as feeling safe, having somewhere to live and secure employment have a significant effect on people's health and wellbeing.

South East London Integrated Care System

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

NHS South East London

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 Voluntary, community and social enterprise sector (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.

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

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

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

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.