Lewisham Local Care Partners Strategic Board
Date: Thursday 18th May 2023, 14.00-16.15 hrs
Venue: MS Teams (meeting to be held in public)
Chair: Pinaki Ghoshal

AGENDA

No	Item	Paper	Presenter	Action	Timing
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes and actions of the previous LCP meeting held on 23 March 2023.**	Enc 1 & 1a	Chair	For Approval	14.00-14.05 5 mins
2.	**Any questions from members of the public** **Question and response from LCPSB on 23rd March:**	Enc 2	All/Chair	For Discussion	14.05-14.15 10 mins
3.	**PEL Report**	Enc 3	Ceri Jacob	To Note	14.15-14:20 5 mins
	Delivery				
4.	**Health Inequalities Funding:** ○ **Ratify decision taken by e-governance** ○ **Discussion on future funding**	Enc 4 & 4a	Dr Catherine	For Ratification	14.20-14.40 20 mins
5.	**Place Executive Group Workshop – update**	Verbal	Jessica Arnold	For Discussion	14.40-14.50 10 mins
6.	**5 Ps**	Verbal	Charles Malcolm-Smith	For Discussion	14.50-15:05 15 mins
7.	**Five Year Delivery plan for Primary Care in Lewisham**	Enc 5 & 5a	Ashley O'Shaughnessy	For Approval	15.05-15.20 15 mins
8.	**Lewisham Health and Care Partnership – Local Care Plan 2023-24 Delivery Plan**	Enc 6 & 6a	Sarah Wainer	For Approval	15.20-15.35 15 mins

9.	**Primary Care Group Chair's Report**	Enc 7 & 7a	Anne Hooper	To Note	15.35-15.40 5 mins
10.	**Risk Register**	Enc 8 & 8a	Ceri Jacob	For Discussion	15.40-15:50 10 mins
	Governance				
11.	**Finance update**	Enc 9 & 9a	Michael Cunningham	For Discussion	15.50-16.05 15 mins
	Place Based Leadership				
12.	**Any Other Business**		All		16.05-16.15 10 mins
	Papers for information				
Next Meeting: - Thursday 27th July 2023, 14:00pm					

Lewisham Local Care Partners Strategic Board

Minutes of the meeting held in public on 23 March 2023 at 14.00 hrs

Via MS Teams

Present:

Dr Jacky McLeod (JMc) (Chair except agenda item 10a)	Clinical Care & Professional Lead
Pinaki Ghoshal (PG) (Chair agenda item 10a only)	Executive Director of CYP. LBL
Ceri Jacob (CJ)	Place Executive Lead, Lewisham, SEL ICS
Michael Kerin (MK)	Healthwatch Lewisham representative
Anne Hooper (AH)	Community Representative Lewisham
Dr Simon Parton (SP)	Primary Care representative (LMC)
Dr Helen Tattersfield (HT)	Primary Care representative
Tom Brown (TB)	Executive Director for Community Services (DASS), LBL
Dr Catherine Mbema (CMb)	Director of Public Health, LBL
Sandra Iskander (SI)	Acting Chief Strategy, Partnerships & Transformation Officer, LGT
Vanessa Smith (VS)	Chief Nurse, SLaM
Dr Prad Velayuthan (PV)	Chief Executive, OHL

In attendance:

Lizzie Howe (LH)	Corporate Governance Lead, Lewisham, SEL ICS (Minutes)

Steve James (SJ)	Comms & Engagement Manager, SEL ICS
Michael Cunningham (MC)	Associate Director Finance, SEL ICS
Kenny Gregory (KG)	Director of Adult Integrated Commissioning
Sarah Wainer (SW)	Director of Transformation, SEL ICS
Ashley O'Shaughnessy (AOS)	Associate Director of Primary Care Lewisham, SEL ICS
Simon Whitlock (SWh)	Head of Service – Joint Commissioning
Cheryl Smith	Corporate Governance Lead Lambeth, SEL ICS
Dr Emma Nixon	GP
Simon Morioka (SM)	PPL
Rebecca Manzi	Project Officer, Lambeth Together
Meera Nair (MN)	Chief People Office, Lewisham & Greenwich Trust (LGT)
Charles Malcolm-Smith (CMS)	People & Provider Development Lead, SEL ICS

Apologies:

Fiona Derbyshire, CEO Citizens Advice Lewisham, voluntary sector representative

		Actioned by
1.	**Welcome, introductions, declarations of interest, apologies for absence & Minutes from the previous meeting held on 26 January 2023** Dr Jacky McLeod (Chair) welcomed everyone to the meeting. Housekeeping matters were given by the Chair. One question had been submitted in advance from a member of the public.	

	Members of the public were advised they were welcome to ask any questions at the end of the meeting under agenda item 13. There were no apologies for absence. COI (conflicts of interest) reminder given to the meeting regarding agenda item 10a. JMc would temporarily stand down as chair and PG would be chairing that agenda item to ensure a COI was managed. Declaration of Interests – There were no new or amended declarations of interest. Board members were reminded to submit their online declaration for the SEL ICS if not already completed. Minutes of the Lewisham LCP Strategic Board meeting held on 26 January 2023 – these were agreed as a correct record. **The Board approved the Minutes of the Lewisham LCP Strategic Board meeting held on 26 January 2023.**	
2.	**PEL (Place Executive Lead) update** Ceri Jacob presented the agenda item. The PEL update was taken as read. There are continued pressures across the system. Trade Union agreements noted, but not with junior doctors. Acknowledged the amount of work underway to keep services running. Discharge summit across SEL recognised the importance of discharge to A&E performance and handover times. The LAs (local authority) were included in the summit alongside health providers and ICB staff. A range of actions were agreed and are being developed into a SEL wide plan with actions for us locally. Actions from the Mental Health summit last November are being taken forward by the Lewisham All Age Mental Health Alliance. The actions are intended to reduce the number of people attending A&E in an acute mental health crisis.	

	The Lewisham LCP Quality and Assurance group has now started. A seminar session in February with the LCP and key staff from partners agreed the approach the LCP wishes to take. The group is chaired by the Chief Nurse from LGT, Louise Crosby. Work is progressing to develop an integrated programme management approach with LGT for the Lewisham LCP. This will build on the existing LGT PMO and ensure a shared understanding of progress against the LCP four priorities and delivery against the ICS priorities. **The Lewisham LCP Board noted the PEL report.**	
3.	**LCP Forward Plan** Sarah Wainer presented the agenda item. The background of the plan and programmes taking place across Lewisham were discussed. The Lewisham Forward Plan forms part of the SEL ICB Forward View. It is a useful document to show direction of travel across many areas and how they link together. Discussions on key metrics have commenced. The programmes set out in the Lewisham Forward Plan will inform the work of enabler functions such as digital, estates and workforce to ensure Lewisham LCP is able to deliver it's plan. CJ gave a reminder of the Lewisham 4 priorities on page 6, previously agreed collectively as a Board. These priorities were not new. They were drawn from ICS, Trusts and LA existing priorities and are the areas the LCP thinks it can have most impact through a collaborative and integrated approach. There are detailed delivery plans underpinning the four priorities. AH said it was an excellent plan and welcomed the commitment to co-creation. A question was asked if freedom to speak up featured in any priority?	

	SI commented it was a nice clear well laid plan, some actions are more complex than others and we will need to keep prioritising as we go through. SW responded that there are significant links with the community. Meera Nair, Chief People Officer Lewisham & Greenwich Trust, agreed with AH point and described the LGT model for freedom to speak up. JMc noted greater impact would be achieved working together rather than in the historical silos. It was noted we needed to capture voluntary sector input and to develop specific, more detailed actions. SW updated there may be some further tweaks as it goes through a number of programme boards. PG noted the high level outcomes in the document and that a lot of work on family hubs is taking place. Child health and work around obesity noted. Regular progress updates with be brought to the LCP Board. The **Lewisham LCP Plan was approved by the Lewisham LCP Board.**	
4.	**MHIS/SDF Funding for Mental Health** SWh & KG presented the agenda item. Adults Transformation Core Offer which has been agreed across SEL was highlighted. There is now have a full complement of practitioners across the system. The teams are looking to use Health Inequalities funding in the voluntary sector. SWh noted work to reduce waiting times for children. Challenge has been working within the funding and seeing the fuller picture. The presentation today is a snap shot of progress so far.	

	HT said it was good news about more funding but that recruitment remained very challenging. Referrals not meeting the threshold continues to be an issue. SWh acknowledged the recruitment challenges and is working with SlaM on this and waiting list support. Swh commented on South London Listens virtual wating rooms. PG agreed yes, recruitment and threshold issue, look at support early on. We need to think about how we deliver slightly differently and be creative, not the same as before. HT commented on working more closely with the schools? PG said a number of schools have mental health support teams and we do have other teams operating across Lewisham. Clarity around referrals to schools is vital. JMc said she approved of the strategy but need to see more spent on the younger people, youth offending work and families, emotional problems before mental health problems arise. We should meet the needs of families in a robust way. PG said there is a wider SEL transformation programme across SEL. Add family thrive service as well. **The proposal was approved by the Lewisham LCP Board.**	
5.	**Workforce** CMS and Meera Nair presented the agenda item. CMS advised this area was already noted within LCP Plan agenda item. Asking for Board support to establish a workforce steering group, identify appropriate membership across the partnership. Report includes the proposed ToR (Terms of Reference). This relates to the LCP Plan and existing priorities and current initiatives. This overarching group will be more ambitious and strategic in our planning for workforce. MN commented on work within each respective organisation and the need to take forward programmes that do not duplicate work elsewhere in the system. A Well-being offer has been developed . There is an opportunity to bring in other areas that have not been	

	considered previously Support requested to identify members to join the group and take to plan forward for 2023/24 and 2024/25. CJ advised the group will support our work as anchor organisations. Workforce recruitment and retention is one of the local systems biggest challenges. MK noted for workforce 2 areas for further study. Firstly communication which is a wide ranging issue across the area needs an effective answer. Secondly, public involvement and engagement with communities, noting this must not be a tick box activity and should be genuine coproduction and design. If board believes in real public engagement it must support the infrastructure to ensure it is there. There needs to be a structure which will engage the voluntary sector properly as the membership voice must be strong. MN stated the group could really have an impact and people will be accountable. MK or a colleague as a member would be useful. JMc commented on educational establishment engagement in the work, well-being of the workforce, and address some of the challenges in a proactive way to change the culture. MN agreed with JMc points. It was agreed there was a need for baseline, comparative data. CMS said the first task of the group is to put together a workforce plan and look at what we want to work towards. TB commented on social care workforce not in a statutory organisation but in the private sector. Also, apprenticeships as this is normally a local workforce. **The Lewisham LCP Board noted the update.**	**ACTION: CMS**
6.	**Community Engagement: People's Partnership Proposals** CMS presented the agenda item. There has been a programme of workshops and shadow running to help shape how the People's Partnership should function. This	

	programme is now at the end with the People's Partnership ready to go live. AH noted that the work with PPL last year had put the LCP in a good position. Have good expertise within our communities. Off to a good start and in a positive place. AH questioned whether the peoples partnership role as a strategic forum for engagement was missing? Also, if there is any way to go back to communities with a three-year sustainability programme of the People's Partnership. Simon from PPL commented on the challenge faced across the country by place-based leaderships. Core engagement principles remain at the heart of this; being inclusive and engaging people in line with the principles. MK said he fully supported the proposals and is keen to be involved in supporting the group with building the culture and the skills to do public engagement well. Funding is good to have settled as we do not want barriers to participation. Papers will be needed in a form which supports engagement as there is a lot to do in 2 hr meetings. CMS advised there will be a handover with PPL. JMc stated she appreciated the hard work. **The Lewisham LCP Board noted the update.**	
7.	**Digital Exclusion** AOS presented the agenda item. AOS spoke about previous Healthwatch work. Updated on primary care work and digital inclusion. The slides detailed where we are now and progress against the key actions underway. In particular, telephone and face to face appointments are available in all practices and practices are encouraged to review the balance of these regularly to ensure the mix is right.	

	Work with GP practices on their websites has ensured most are at Level 3 standardisation (the highest). SP commented on hardware issues and access to devices for patients. AH agreed with SP point, not feasible to sign post to libraries. Would welcome a more detailed look and to have plans for this. MK said HealthWatch welcome on-going attention to this issue as it goes to the heart of health inequalities. Page 4 of the slides, definition of digital exclusion does focus on the kit but poverty is an issue and this work should be seen as part of a wider poverty action approach. Clearly a lot happening in the voluntary sector so helpful to see it as part of the next steps. PG would like more around connectivity. LA also undertaking some of this work which has not been detailed in the presentation. JMc noted the public health champions work and those with LTC and selfcare and self-management. CJ said the new Quality and Assurance Group has digital exclusion as a priority area to work on and this will ensure a broader look at digital exclusion across the whole LCP. AOS advised the next stage is to join all of this up and communicate with the public. JMc asked for an update on a future agenda. **The Lewisham LCP Board noted the update.**	**Action EH**
8.	**Older People's Board** KG presented the agenda item. The group is still testing the vision around the overarching plan. A workshop in January was attended by approximately 60 professionals. Spoke about engagement. Resources, remote monitoring and information sharing. TB stated we need to do justice to our residents and ensure we have the resources to keep people healthier. Co-production with social care, looking to improve our work.	

	JMc noted co-morbidity and managing a number of independent medical conditions and the need to see people as a whole. KG advised it is a phased approach with the focus on immediate priorities at the moment. MDT working will play a part in the work. **The Lewisham LCP Board noted the update.**	
9.	**JTAI Report & Action Plan** PG presented the agenda item. An action plan is to follow. Summary noted and full report. The inspection had taken place over three weeks in November 2022. Feedback was generally positive. As it was a partnership inspection there is no final score. Recommendations were noted. There were no priority actions which is a good sign. CJ agreed, it was very positive and showed how the teams work well together. VS queried SLaM input for the action plan? CJ said there are some actions and these have been to the Quality and Assurance group and through the children's safeguarding group. JMc mentioned schools. PG advised he was with headteachers this morning. **The Lewisham LCP Board noted the update.**	
10.	**Primary Care Group Chair's Report** AH presented the agenda item. The report noted and no questions raised. **The Lewisham LCP Board noted the update.**	
10a	**Lewisham APMS Care Homes Business Case** This agenda item was chaired by PG. AOS presented the agenda item.	

	Following discussions **the Lewisham LCP Board approved the paper.**	
11.	**Risk Register** JMc resumed as chair of the meeting. CJ presented the agenda item. Cover sheet had now been amended to show direction of travel. No red risks for Lewisham. Most are amber. No questions were raised. **The Lewisham LCP Board noted the update.**	
12.	**Finance update** Michael Cunningham presented the agenda item. Report taken as read. Key points noted. Financial position similar to Month 10 YTD, deficit of the ICS is £53.9m, ICS as a whole forecast break even by year end. Efficiency programme work noted. £200m expected to be achieved compared to target of £207m across the ICS. 39% is non-recurrent. ICB and providers are forecast to break even for the current year. Risks are prescribing budget £6.5m Month 10, up to £9m by end of the year, reflecting CAT-M and short supply drug issues. Lewisham slide detailed budget by budget area, details noted. £64k underspend, forecast to be £72k at the year end. LA financial position, there is a forecast overspend on adult social care overspend of £1.4m, and on children's £6.7m. The key drivers are delayed delivery of savings, child transition to adults and hospital discharge costs, cost of placements and complexity of care required and care packages. JMc commented on partnership approach to funding of voluntary sector, previously discussed at the Board. Peoples Partnership committee etc. also variation in budgets for mental health across the	

	boroughs. Big disparity across the six boroughs/SEL. JMc asked for this to be explained. MC commented for the second point, that borough slides are not comparable in this respectas they do not include all mental health expenditure that boroughs make, nor do they reflect the choices boroughs make as to how mental health services are commissioned as between NHS providers or other providers.. The borough table does not include the £30m or so we spend with SLaM for example. Consider funding requests for voluntary sector, prioritised by the borough team with CJ. All parties would be involved. TB commented on voluntary sector funding, £2m LA spend on better care funding. Particularly targeted services, always a challenge, it is a small and finite amount of money with a huge demand. Share investment and align so we do not have duplication. Complexity of demand noted. More proactive to tackle things early on and try to avoid firefighting. **The Lewisham LCP Board noted the update.**	
13.	**Any questions from members of the public** One question had been submitted in advance from a member of the public. Tim Bradley, Lived Experience Member, SE London MSK Programme Board. *Overall ICB ambition to work closely with VCSE is commendable, and particularly the commitment in five priority enablers ' We must fund the VCSE sector appropriately to work with us' (page 66 of the January ICB papers). What are specific Lewisham plans for such funding and also directions for NHS facilities to make available, at low or no extra cost, facilities to support the prevention agenda e.g. Hydrotherapy pools in SE London being used out of hours by VCSE helping those with MSK conditions?* The question was read out and **noted by the Lewisham LCP Board**. CJ advised a response would be sent to Mr Bradley and shared within the next Minutes.	

14.	**Any other business** - Health Inequalities Funding (CJ) ICB decision to increase funding. Programme boards at SEL looking at how best to utilise. Lewisham is represented on all the SEL programme boards. - CJ recognised this meeting as the last Lewisham LCP Board for JMc as she was stepping back from her role with the LCP. CJ and the LCP Board thanked JMc for all of her excellent work for with the LCP and with predecessor organisations and for the population in Lewisham. JMc thanked everyone for their attendance. Meeting closed 16.14 hrs.	

	LCPSB Action Log			Start Date					
	Coordinator: Lizzie Howe			10.03.2023					
REF	Issue *(description)*	Action	Latest Update	Action Owner (s)	Date Added	Date to be Completed By	Open/Closed	Status	Week start FY Week
# # # # # #	**Workforce Recruitment and Retention** Discussion around educational establishment and engagement in the work place, well-being of the workforce, and address some of the challenges in a proactive way to change the culture. CMS to establish a task and finish group to develop a workforce plan and look at what we want to work towards.			**CMS**	23.03.23	14.07.2023	Open	Pending	
# # # # # #	**Quality and Assurance Group** Digital Exclusion is on the next agenda for the Quality and Assurance Group. Agreed to present outcomes and provide an update at a future LCP meeting.			**EH**	23.03.23	14.07.2023	Open	Pending	

South East London
Integrated Care System

NHS
South East London

Tim Bradley
Lived Experience Member, SE London MSK Programme Board
SENT BY EMAIL

Thursday 4th May 2023

Dear Tim

My sincere apolgies for the delay in responding to you regarding your question submitted for our Local Care Partnership Strategic Board meeting held on Thursday 23rd March 2023, via our Lewisham Question's inbox.

You had asked what specific Lewisham plans are in place for such funding and also direction for NHS facilities to support with the prevention agenda e.g. hydrotherapy pools in South East London being used out of hours by VCSE to assist those with MSK conditons.

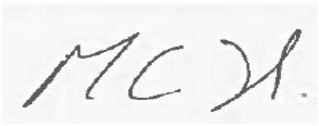
In response, I can confirm that we recognise the valuable contribution that VCSE sector can make to our planning and decision-making and are making provision for appropriate remuneration within the arrangements for the Lewisham People's Partnership. The recommendations that are contained within the paper being presented to the Strategic Board include allowance for the size of different VCSE organisations and for preparation time as well as participation, and they follow the policies and principles adopted by a number of other organisations.

As a partner of One Public Estate and on the use of estates generally, our local care plan states "As partners we want our estate to support service transformation and collaboration and integration across the health and care system. Our buildings should enable us to work smarter and more effectively in delivering community-based care and contribute to the improvement of patient experience and satisfaction."

The management and planning around estates is complex and the LCP will continue to work with colleagues elsewhere to help us achieve our aims for the use and development of the local estates. Through the Lewisham Estates Forum, which brings together partners from across the system, including the local authority, we will continue to seek opportunities to improve the use of our estates and to identify opportunities to improve health and care outcomes.

I do hope this has answered your question. If, however, you would like to discuss further please do not hesitate to contact me. In the meantime, our next Local Care Partnership Strategic Board public meeting is taking place on Thursday 18th May, 14:00 and as you are aware, you are welcome to attend to hear about the latest development in Lewisham.

Yours sincerely,



Ceri Jacob
Place Executive Lead
Lewisham ICB

Lewisham Local Care Strategic Board

Item 3
Enclosure 3

Title:	**PEL Update Report**
Meeting Date:	**18 May 2023**
Author:	Ceri Jacob
Executive Lead:	Ceri Jacob

Purpose of paper:	**To provide a general update to the Lewisham Care Partnership Strategic Board**	Update / Information	*x*
		Discussion	
		Decision	

Summary of main points:

This report provides a brief summary of areas of interest to the LCPSB which are not covered within the main agenda.

Place Executive Group
The Place Executive Group (PEG) reports to the LCP Strategic Board and was originally intended to provide oversight of key programmes of LCP work and includes representation from all partners across the LCP.

As noted in the last PEL report, work has been underway to develop an integrated programme management approach for Lewisham LCP which is intended to work through the PEG. To support this move to an integrated programme management approach, a workshop to review how the PEG should function in the future was held on 11 May. A range of suggestions were made to improve how the PEG functions and to secure its role as the "engine room" of the LCP within an integrated programme management approach.

It is anticipated that the first report from this new system and refreshed PEG will be available to the Board at its next meeting.

Management Cost Reductions
All ICBs are required to reduce their running costs by 30% by April 2025. 20% must be released by April 2024 with the remaining 10% released by April 2025. A programme of work is underway to identify how this reduction can be best achieved.

The intention is to shape the workforce in a way that delivers the statutory duties of the ICB and the priorities of the ICS in a manner that maximises the opportunities of working as part of an Integrated Care System.

	An all staff in person event was held on the 26 April with over 400 staff to begin engagement with staff and to address questions as far as possible at this point. Further updates will be provided to the Board as the process progresses.			
Any Potential Conflicts of Interest	**Nil**			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**x**	**Southwark**	
	Equality Impact	Nil		
	Financial Impact	Nil		
Other Engagement	Public Engagement	**Not required for this paper**		
	Other Committee Discussion/ Engagement	**NA**		
Recommendation:	**To note the update**			

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 4
Enclosure 4

Title:	**South East London (SEL) Integrated Care System (ICS) Health Inequalities Funding 2022/23 - Summary and Review of Lewisham projects/initiatives**
Meeting Date:	**18th May 2023**
Author:	Dr Catherine Mbema
Executive Lead:	Ceri Jacob

Purpose of paper:	To ratify the decision made by e-governance to agree the proposal for ongoing funding of existing health inequalities initiatives in Lewisham for the next financial year. To discuss potential health inequalities project areas for any additional funding allocation for 23-24.	Update / Information	
		Discussion	x
		Decision	x

Summary of main points:	In 2022, Lewisham submitted proposals to receive health inequalities funding from SEL ICS to fund projects/initiatives that aim to address health inequalities in Lewisham. The projects/initiatives fell into two broad categories: - Community Assets - Health Services In line with a review process being conducted across SEL ICS, each Lewisham project/initiative has been assessed according to a number of review areas to provide assurance around the funding allocation. Following review of the existing areas of funding by one of the workstream groups for the Lewisham Health Inequalities and Health Equity Programme (Workstream 1 – Equitable preventative, acute and community physical and mental health services), it is proposed that the funded projects/initiatives continue into the 23/24 financial year to allow full implementation and evaluation of impact
Potential Conflicts of Interest	**Nil of note**

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Will be assessed through evaluation of the initiatives and projects.		

	Financial Impact	Full year funding for all of the Lewisham initiatives and projects is £764,000.
Other Engagement	Public Engagement	Will take place for a number of the funded initiatives and projects.
	Other Committee Discussion/ Engagement	Update report on the Health Inequalities and Health Equity Programme is to be taken to the Lewisham Health and Wellbeing Board in July 2023.
Recommendation:	It is proposed that the funded projects/initiatives continue into the 23/24 financial year to allow full implementation and evaluation of impact. A reassessment of this investment will be planned towards the end of the 23/24 financial year. Following clarification of any additional funding available for 23/24, proposals for new initiatives/projects will be considered via Workstream 1 of the Health Inequalities and Health Equity Programme.	

South East London (SEL) Integrated Care System (ICS) Health Inequalities Funding 2022/23

Summary and Review of Lewisham projects/initiatives

April/May 2023

1. Overview

In 2022, Lewisham submitted proposals to receive health inequalities funding from SEL ICS to fund projects/initiatives that aim to address health inequalities in Lewisham. The projects/initiatives fell into two broad categories:

- **Community Assets**
- **Health Services**

The proposals were approved, and funding was allocated. A summary of the projects/initiatives and funding allocation can be seen below in Table 1.

Table 1. Summary of funded health inequalities projects/initiatives

Project category	Project name	Funding allocation (part-year)	Project aim
Community Assets	Community based preventative health outreach programme	£55,820.47	To make the community-based outreach more sustainable and will work to establish a programme of preventative outreach that will focus on libraries and faith settings in the first year of implementation.
	Implementation of opportunities for action from the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)	£83,730.71	To co-produce the implementation of opportunities for action from the BLACHIR report.
	Community Connections Lewisham (CCL) Hospital Outreach project	£42,423.56	To bring the experience and benefits of a social prescribing service to a secondary care setting. Providing more holistic support to patients, empowering them to take control of their health and wellbeing to tackle health inequalities that will ultimately affect their medical treatment.
Health Services	Lewisham Health Equity Fellowship Programme - develop clinical leadership to address health inequalities	£131,736.31	To develop local system leaders to address health inequalities – a local network of clinicians to lead neighbourhood-level community engagement (co-design, community development, prevention, and health promotion).
	HEE Population Health Fellows - addressing inequalities in clinical outcomes	£50,238.43	To use the integrated data set to work with clinical teams across Lewisham to prioritise clinical services for review to identify differential clinical outcomes.
	Addressing inequalities in elective surgery waiting lists	£83,730.71	To reduce waiting lists for surgery, whilst embedding an approach to reduce inequalities in access, experience, and outcomes from surgery.
	Improving recording of special category data	£47,230.82	To improve access to accurate and up to date data, the recording of special category data (including ethnicity and sexual orientation) across the health system.
	Specialist Smoke Free Pregnancy Midwife	£14,422.33	To commission a tri-borough Specialist Smoke Free Pregnancy Midwife to be responsible for the delivery of 'Smoke Free Pregnancies'. To facilitate training, provide support for non-specialist staff and performance management, and engage with external stop smoking services.

*Review currently excludes the Health Equity Fellow Programme that will be running for 2 years until October 2024.

2. Review of funded projects/initiatives

In line with a review process being conducted across SEL ICS, each Lewisham project/initiative has been assessed according to the following review areas to provide assurance around the funding allocation:

- Goal
- Anticipated reduction in health inequalities
- Implementation plan
- Population health management (PHM) approaches
- Engagement
- Outcomes achieved to date
- Challenges, issues and barriers faced
- Learnings
- Successes to date
- Patient feedback
- Outcome metrics

Findings of the assessment by review area can be seen in Appendix 1.

3. Areas for future development

Following review of the existing areas of funding by one of the workstream groups for the Lewisham Health Inequalities and Health Equity Programme (Workstream 1 – Equitable preventative, acute and community physical and mental health services), the following areas have been identified for future development of the funded initiatives/projects and any further health inequalities funding coming to the borough:

- Consideration of building in work to address wider health inequalities linked to the social determinants of health through funded projects/initiatives.
- Use of population health data initiatives to make neighbourhood/PCN profiles that capture information on health inequalities more accessible to Lewisham stakeholders, including those in voluntary and community sector organisations.
- Developing the community-based prevention model around existing work with Lewisham libraries as part of the 'Warm Welcome' initiative.

4. Next steps

It is proposed that the funded projects/initiatives continue into the 23/24 financial year to allow full implementation and evaluation of impact. A reassessment of this investment will be planned towards the end of the 23/24 financial year.

Following clarification of any additional funding available for 23/24, proposals for new initiatives/projects will be considered via Workstream 1 of the Health Inequalities and Health Equity Programme.

*Review currently excludes the Health Equity Fellow Programme that will be running for 2 years until October 2024.

Appendix 1: Review findings*

1. Review area

1.1. Goal

Project/Initiative	Finding
Community Connections Lewisham (CCL) Hospital Outreach Project	To bring the experience and benefits of a social prescribing service to a secondary care setting. Providing more holistic support to patients, empowering them to take control of their health and wellbeing to tackle health inequalities that will ultimately affect their medical treatment.
Implementation of opportunities for action from BLACHIR	To co-produce the implementation of opportunities for action through the appointment of a community partner and recruitment of dedicated project officer.
Community based prevention health outreach programme	To make the community-based outreach more sustainable and will work to establish a programme of preventative outreach that will focus on libraries and faith settings in the first year of implementation
HEE Population Health Fellows	To use the integrated data set to work with clinical teams across Lewisham to prioritise clinical services for review to identify differential clinical outcomes.
Addressing inequalities in elective surgery waiting lists	To reduce waiting lists for surgery, whilst embedding an approach to reduce inequalities in access, experience and outcomes from surgery
Improving recording of special category data	To improve access to accurate and up to date data, the recording of sexual orientation and other special category data across the health system
Specialist smoke free pregnancy midwife	To commission a tri-borough Specialist Smoke Free Pregnancy Midwife to be responsible for the delivery of 'Smoke Free Pregnancies'. To facilitate training, provide support for non-specialist staff and performance management, and engage with external stop smoking services.

1.2. Anticipated reduction in health inequalities

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	The service will contribute towards reducing health inequalities. Patients will benefit from engaging with the Five ways to wellbeing model. Evidence suggests that the model improves a person's health and wellbeing. This in turn has a significant impact on physical health and treatment outcomes. CCL will help connect patients to services, activities, groups and more to held redress the balance of health inequalities and ensure that patients are receiving the support they require to complete treatment.
Implementation of opportunities for action from BLACHIR	The opportunities for action identified in BLACHIR will be implemented and address a range of health inequalities faced by Black African and Black Caribbean communities in Lewisham.
Community based prevention health outreach programme	The community-based health outreach programmes will focus on vaccination, health promotion and the vital 5 among other topics and will target communities experiencing health inequalities.
HEE Population Health Fellows	These roles will enable other projects to reduce health inequalities, through the development of tools such as Core20Plus5 which will be able to be applied to other pop health projects. Specific projects to reduce health inequalities will also be identified according to the data when the posts are filled. Previous examples of projects worked on by fellows include identifying people with undiagnosed COPD for spirometry clinics, and developing culturally appropriate dietary advice for women with gestational diabetes.
Addressing inequalities in elective surgery waiting lists	A reduction of inequalities in access, experience and outcomes from surgery. The desired outcomes are a reduction in cancellations, a reduction in the number of patients not ready for pre-operation, a reduction in inappropriate referrals, improved patient experience and a reduction in length of stay in hospital.

*Review currently excludes the Health Equity Fellow Programme that will be running for 2 years until October 2024.

Improving recording of special category data	This will enable analysis of data to identify any inequalities in access and outcomes of care, providing the opportunity to immediately act on this data to improve care for people who are face significant health inequalities.
Specialist smoke free pregnancy midwife	The project aims to reduce the Smoking at Time of Delivery (SATOD) rate and reduce inequalities faced by those that smoke during pregnancy.

1.3. Implementation plan

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	The Project is being overseen by the Social Prescribing Manager at CCL and delivered by two frontline staff. A steering group will be established who will create a Theory of Change, with clear aims reporting and evaluation processes, to provide strong direction and a framework to the process.
Implementation of opportunities for action from BLACHIR	BLACHIR opportunities for action have been mapped to projects, initiatives and responsible organisations/teams. BLACHIR EOI process undertaken and contract for a community partner has been awarded to a Black-led community group. Mobilisation meeting with the organisation to support implementation commences April/May 2023.
Community based prevention health outreach programme	Model of outreach has been agreed, is being developed and will be finalised by May 2023 with rollout thereafter
HEE Population Health Fellows	Advert out to recruit currently.
Addressing inequalities in elective surgery waiting lists	An MDT approach is being adopted. Care plans will be developed to improve the health of patients while waiting for and undertaking surgery. Process charts and data analysis are complete and the project is moving to delivery.
Improving recording of special category data	A temporary role will be recruited to triangulate data from the PHM system to ensure data is recorded across Trust EPR systems. A task and finish group is being established to develop and embed approaches to improve ongoing recording of data.
Specialist smoke free pregnancy midwife	Permanent post recruited to in November. 2 Midwifes sharing post. Action plan for work complete. Training on behaviour change, e-cigarettes and brief interventions complete. Audit on carbon monoxide monitoring complete. Training on carbon monoxide during pregnancy being delivered in groups and 1 to 1. Training to continue. Targeted work to take place in specific areas according to data.

1.4. Population health management (PHM) approaches

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	The targeted model of outreach in communities will be conducted according to data. PHM approaches will be employed accordingly. The Project Steering Group including people with lived experience will help to further develop the approach.
Implementation of opportunities for action from BLACHIR	PHM approaches will be employed throughout and have been used in gathering intelligence in BLACHIR to date.
Community based prevention health outreach programme	The targeted model of outreach in communities will be conducted according to data. PHM approaches will be employed accordingly.
HEE Population Health Fellows	PHM approaches will be central to the Population Health Fellows and will be employed in everything that they do.
Addressing inequalities in elective surgery waiting lists	We will be taking a population health management approach, making use of the elective waiting list dashboard. Using more complete information on patients, a multi-disciplinary approach will be taken, involving a Consultant, GP, and other relevant staff (e.g. LD nurse), to review patients at risk of inequalities. Data analysis has been completed by the project team and forms the basis of the adopted approach.

*Review currently excludes the Health Equity Fellow Programme that will be running for 2 years until October 2024.

Improving recording of special category data	The improvement of data will enable and improve the effectiveness of PHM approaches employed in other projects.
Specialist smoke free pregnancy midwife	Targeted work taking place in specific areas according to data.

1.5. Engagement

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	CCL has built relationships with key teams at UHL through the Social Prescribing Winter Funded project. This has provided a stronger footing for developing the engagement plan for this scheme. The Steering Group will include key reps from across the hospital and community settings, VCSE and will include people with lived experience.
Implementation of opportunities for action from BLACHIR	Virtual and in person engagement events were offered by the Public Health Commissioning Team to support community organisations with the EOI process. Feedback sessions following the award of contract also offered.
Community based prevention health outreach programme	The commissioned community groups and the Community Champions will be engaged to understand the best approach to outreach and where best to conduct the outreach in communities.
HEE Population Health Fellows	The fellows will work with patients, community groups, healthcare professionals and other key stakeholders to understand what the data is telling us, co-produce solutions to address any inequalities identified, and take a learning approach to test the solutions.
Addressing inequalities in elective surgery waiting lists	We will develop a co-production approach that will work with patients to develop interventions that meet the needs of the patients we are aiming to support. A bid to the Health Foundation has been made to support this work.
Improving recording of special category data	Work with staff and patients will be undertaken to understand reasons and co-develop solutions utilising a quality improvement approach.
Specialist smoke free pregnancy midwife	Engaged with local stop smoking services. Aiming to increase engagement.

1.6. Outcomes achieved or when will they be achieved

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	The theory of change will help to design a relevant and achievable reporting structure for the project. These will include but are not limited to: Warwick Edinburgh Scale. Ability to manage conditions (e.g attending appointments, medication adherence etc). Ability to maintain contact with others, family, friends, local community. CCL will also set up Peer Support Groups for clinics, as part of this work.
Implementation of opportunities for action from BLACHIR	Outcomes will be monitored throughout the cycle of the process. Full programme evaluation occurs end of FY 23/24
Community based prevention health outreach programme	Outcomes will be recorded once model of outreach implemented in FY 23/24
HEE Population Health Fellows	Outcomes will start to be achieved once posts are filled.
Addressing inequalities in elective surgery waiting lists	Project is moving to delivery now so outcomes will begin to be seen in 23/24.
Improving recording of special category data	Improvement in data completeness by March 2024
Specialist smoke free pregnancy midwife	Outcomes will be monitored throughout FY 23/24

1.7. Challenges, issues and barriers faced

Project/Initiative	Finding
Community Connections Lewisham Hospital Outreach Project	A key challenge will be to engage secondary care medical teams with preventative approach. Receiving appropriate referrals has been a challenge in the previous secondary care social prescribing scheme.

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	People going through treatment may have a lot of medical, illness and treatment specific questions that are team are not trained to answer or support with. It will be important to set clear boundaries and expectations for the clients so they can understand what our staff can support with, and work closely with the teams who can support with this. Although we think that going through a diagnosis and treatment plan can be a good opportunity for patients to want to engage with health and wellbeing activities, we also acknowledge that for certain individuals the stress of their circumstances won't allow for them to take the time for themselves to engage with a service like ours. Lastly, the potential degenerative nature of the illnesses our cohort will be facing has the potential to skew the results in terms of happiness and wellbeing. Even though clients may benefit greatly from our intervention, their overall wellness would decline as their illness progresses.
Implementation of opportunities for action from BLACHIR	Maintaining the goodwill and positive relationships with communities that were built through the process of creating BLACHIR.
Community based prevention health outreach programme	Deciding upon a model of outreach has been difficult as pros and cons to all. No perfect model exists and so the project delivery group has agreed upon a model for vaccinations and a model for wider health outreach in communities which can be more ambitious, targeted and embedded in communities
HEE Population Health Fellows	Some delays in the recruitment process but the job descriptions have now been confirmed and are out to advert.

1.8. Learnings

Project/Initiative	**Finding**
Community Connections Lewisham Hospital Outreach Project	With this project we want to encourage our cohort to share their Lived Experiences and Expertise of diagnosis, treatment and recovery with their community to raise awareness of signs of illnesses, the reality of treatment course and positive outcomes. We will facilitate this through our Peer Support groups, compiling the information gained throughout our reporting.
Addressing inequalities in elective surgery waiting lists	Meetings with partners in public health and primary care has highlighted the need to focus on the interventions available to support patients with health optimisation and recognition that existing services may not be meeting our target patients needs at the moment and work to co-produce solutions will be needed.

1.9. Successes to date

Project/Initiative	**Finding**
Implementation of opportunities for action from BLACHIR	A community partner organisation has been appointed to work with the partnership on implementing the opportunities for action.
Addressing inequalities in elective surgery waiting lists	Clinical lead is in place and is developing the project with good engagement from system partners.
Specialist smoke free pregnancy midwife	The midwives have delivered multiple modules of training. Improvements seen in ongoing assessment, referral and recording of smokers and the monitoring being undertaken by the wider team. Increase in the accurate documentation of CO monitoring in past 4 months.

1.10. Patient feedback

Project/Initiative	**Finding**
Community Connections Lewisham Hospital Outreach Project	Patient Feedback will be integral to the project, with service-user experience shaping and influencing the direction of the service as our experience progresses. The Lived Experience and Expertise of the patients taking part in the project will only add greater understanding and richness, and ultimately benefit the future planning and direction of

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	all our services. We will aim to set up a Patient Steering Group to create further empowerment of the individuals involved. We will also collect feedback throughout in other ways, such as conversations with trusted CCL staff, with particular consideration for staff who have their own Lived Experience and will be best placed to facilitate these kinds of conversations. There will also be surveys which can be filled in anonymously and without the need to speak to an involved staff member, allowing the patients the opportunity to input and feedback in the ways they feel the most comfortable
Implementation of opportunities for action from BLACHIR	None yet but this will form a key part of the project evaluation.
Community based prevention health outreach programme	
HEE Population Health Fellows	
Addressing inequalities in elective surgery waiting lists	
Improving recording of special category data	
Specialist smoke free pregnancy midwife	

1.11. Outcome metrics developed to date

Project/Initiative	**Finding**
Community Connections Lewisham Hospital Outreach Project	We have identified the following milestones for the project, influenced by our existing work and experiences in the Hospital, as well as the more defined parameters of this Project: - Getting engagement from at least one of the Hospital Clinics with buy-in from medical staff - Having a data sharing agreement in place with the Clinic/s, in order that we can monitor clients' medical outcomes; i.e., are they attending medical appointments, is their condition improving etc - Receiving enough, appropriate referrals into our service to build a group dynamic within the cohort of patients - Patients feeling the value of the support we have provided being engaged in a Patient Steering Group, which allows them to take ownership of the service and positively influence it for both themselves and future service users. It will allow their Lived Experience on their treatment to be at the forefront of decision making for the service The outcomes to patient health and wellbeing mentioned above in point 6 will contribute to successes of the project, including: - Improved self-reporting of wellbeing - Improved management of their treatment - Improved connection to others
Implementation of opportunities for action from BLACHIR	To be developed with community partner that has been appointed.
Community based prevention health outreach programme	To be developed as the programme is developed.
HEE Population Health Fellows	To be developed based on the projects that the Fellows develop.
Addressing inequalities in elective surgery waiting lists	- Improved clinical outcomes (HbA1c, Blood pressure, Haemoglobin) - Fewer patients identified as not-fit for surgery at pre-operative assessment - Reduction in length of stay in hospital post-op - Improved patient experience
Improving recording of special category data	Improved data completeness for patient special category data, specifically related to: -ethnicity -sexual orientation -disability
Specialist smoke free pregnancy midwife	- Reduced prevalence of smoking in pregnancy - Reduction in SATOD rates - Increased quit rates

*Review currently excludes the Health Equity Fellow Programme that will be running for 2 years until October 2024.

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 7
Enclosure 5

Title:	**Five year forward view delivery plan for Primary Care in Lewisham**
Meeting Date:	18th May 2023
Author:	Ashley O'Shaughnessy
Executive Lead:	Ceri Jacob

Purpose of paper:	The purpose of this paper is to seek the approval of the Five year forward view delivery plan for Primary Care in Lewisham	Update / Information	
		Discussion	
		Decision	**X**

Summary of main points:

The Five year forward view delivery plan for Primary Care in Lewisham articulates the proposed articulates the proposed direction of travel and outlines the priority areas for focus over the next 5 years.

The vision for primary care in Lewisham is the provision of high quality, integrated primary care services to support our local communities to equally live and remain well throughout their lives.

The plan aligns with and complements;

- national policy,
- the South East London Integrated Care System strategy,
- the Lewisham Health and Care Partnership priorities
- the Fuller Stocktake report and associated actions.

The plan highlights the main areas where primary care is an enabler to wider system change and delivery of improved outcomes, especially regarding the four identified local partnership priorities.

The objectives of the Five year forward view aligns with the recommendations of the Fuller Stocktake report which are;

- To streamline access to care and advice for people who get ill but only use health services infrequently: providing them with more choice about how they can access care and ensure care is available in their community when they need it.

- To provide more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions.

- To help people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

In order to achieve the main objectives and deliver high quality care the plan details actions which focus on 6 priority areas:

1) **Proactive and preventative care**
   Supporting people to stay well for longer by enabling them to make healthier lifestyle choices and treating avoidable illnesses early on

2) **Accessible care**
   Supporting timely access to care (including face to face and remote), in line with patient need, for same day urgent care and routine care.

3) **Coordinated care**
   Supporting person centred and co-ordinated care to improve quality through effective shared decision making for and with those experiencing the greatest need

4) **Sustainable primary care**
   Supporting all primary care providers to deliver the highest quality care and enable transformation by remaining resilient and sustainable both now and in the future

5) **Partnership/collaborative working**
   Supporting general practice to work cohesively together and effectively with wider local partners including the population, Lewisham People's Partnership, LGT, SLAM, the council and increasingly with the wider primary care family

6) **Inequalities**
   Supporting primary care to identify and reduce the disparity in outcomes and lived experiences between different population groups

The plan also describes priority actions in the supporting enabler areas of Workforce, Digital, Estates and Data.

Detailed delivery plans will sit beneath the Five year forward view and will be underpinned by an investment plan.

Governance for the oversight and delivery of the plan will sit with the Lewisham Primary Care Group with regular update reports submitted to the Lewisham LCP Strategic Board.

Potential Conflicts of Interest	There are no immediate Conflicts of Interest, however this may occur for primary care providers on the board including One Health Lewisham and GPs as a result of the commissioning of services and use of funding to support delivery of the plan - any such conflicts will be identified and managed accordingly.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Delivery of the plan should support a reduction in health inequalities and indeed this is one of the specific priority areas included as part of the plan		
	Financial Impact	Much of the financial resource that will support the delivery of the plan is associated with national contracts and programmes which come with dedicated funding sources. The plan will also be underpinned by an investment plan which will help inform how we prioritise any locally available discretionary funding.		
Other Engagement	Public Engagement	Although much of the plan is informed by broader national and local public engagement and feedback, we have not had the opportunity to directly engage with the local public around the plan. We intend to have more formal engagement with the public to further inform the plan, particularly working with the Lewisham People's Partnership.		
	Other Committee Discussion/ Engagement	▪ Lewisham Primary Care Group ▪ Lewisham Primary Care Leadership Forum ▪ Lewisham LMC ▪ Lewisham Clinical Care and Professional Leads Meeting ▪ Lewisham Place Executive Group ▪ Lewisham Senior Management Team ▪ Lewisham Local Care Partnership Board seminar (April 23)		
Recommendation:	The Lewisham Local Care Partnership Strategic Board is asked to: ▪ **Note the priority areas for primary care.** ▪ **Approve the Primary Care Development Plan.**			

South East London Integrated Care System

Five year forward view delivery plan for Primary Care in Lewisham

Version 1.0

12th May 2023

FINAL

Introduction

- This Five year forward view delivery plan for Primary Care in Lewisham articulates the proposed direction of travel and outlines the priority areas on which we will focus over the next 1 – 5 years.

- The plan aligns with and complements national policy, the South East London Integrated Care System (ICS) strategy, the Lewisham Health and Care Partnership (LHCP) priorities and the Fuller Stocktake report and associated actions.

- The plan highlights the main areas where primary care is an enabler to wider system change and delivery of improved outcomes, especially regarding the four identified local partnership priorities - we will need to ensure that there are clear expectations of what each part of the system will need to achieve to contribute to this, including primary care.

- The plan identifies 6 priority areas which will be the focus of our work and details specific actions for 23/24 and 24/25 as well as intended outcomes in 5 years time.

- The plan also describes priority actions in the supporting enabler areas of Workforce, Digital, Estates and Data.

- More detailed plans will sit beneath this Five year forward view as needed which will also be underpinned by an investment plan.

- Governance for the oversight and delivery of the plan will sit with the Lewisham Primary Care Group with regular reports submitted to the Lewisham LCP Strategic Board to provide update.

South East London Integrated Care System

Lewisham borough

NHS South East London

Our population

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

We have a significantly younger population compared with national averages, with more adults aged between 25-44 and more children aged between 0-4. There is a smaller population of those aged 65+. However, it is thought our population growth won't be evenly spread across the ages and we will see an increase in the older population and a slight decrease in the younger population and working age population. Almost half (48.3%) of our population are from an ethnic minority community. Between 2011 and 2031 it is projected that the size of the population of children and young people between 0-19 in ethnic minorities will grow faster than the rate of children from white ethnic groups

Health outcomes for our population

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

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

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

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

Inequalities within our borough

Lewisham is the 63rd most deprived Local Authority in England and within the 20% most deprived Local Authorities in the country. Bellingham, Downham, Rushey Green and New Cross are the most deprived local wards in the borough.

Lewisham's Black and Minority Ethnic communities are at greater risk from health conditions such as diabetes, hypertension and stroke. In addition, Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, including psychotic disorder and Post-Traumatic Stress Disorder (PTSD), and experience inequalities in access to services. In the borough we also see late presentations of lung and colorectal cancers.

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

Primary Care overview - Lewisham

Overview of our current system

- There are **27 GP practices** in Lewisham with a combined registered patient list of approximately **330,000** patients delivering services out of **36 sites**.
- Lewisham's 27 GP Practices are grouped into **6** geographically coherent **Primary Care Networks (PCNs)**
- Lewisham has **2 super-practices** which are also PCNs in their own right
- Lewisham also has a single **borough wide GP Federation**, One Health Lewisham Ltd who provide a range of primary and community care services
- Practices range in size; **2 with <5000 patients, 10 with >5000<10000 patients, 8 with >10000<15000 patients and 7 with > 15000 patients**. The largest **practice has over 55,000** registered patients.
- **CQC ratings** of Lewisham practices are generally good with 25 **practices rated 'Good' and 2 as 'Requires Improvement'** (as of April 2022)**.**
- Lewisham has **52 community pharmacies (CP)** (as of April 2022). **This is an average of 17.0 pharmacies per 100,000 population,** lower than the London (20.7) and England (20.5) average**.** There are two "100-hour a week" pharmacies across the borough and at least one pharmacy provides Sunday opening from 7am to 9pm.
- Provision of current pharmaceutical services and locally commissioned services is well distributed, serving all the main population centres. As part of the 2022 published Needs Assessment, no gaps were identified in provision either now or in the future for pharmaceutical services

Strengths / opportunities

- **Clear sense of place**
- Strong local **primary care leadership**
- Established **local partnerships** – both within and across primary care providers
- **Innovative culture,** ready to embrace the benefits of new ways of working, including through the use of digital tools
- The **delegation** of community pharmacy, optometry and dental commissioning and contracting from NHS England to the ICB

Challenges

- **Demand** - Increasing workload including potentially inappropriate/unnecessary work generated across the system
- **Complexity** - Increasingly more complex care is being delivered in the community
- **Workforce recruitment and retention** – Ageing workforce (GPs and nurses), challenging to attract and retain new staff including GP Partners
- **Estates –** Varied GP estate with increasing challenges to accommodate an expanding workforce (particularly PCN staff)
- **Inequalities –** Significant variation in health outcomes based on geography and demography
- **Covid backlog –** Management of Long Term Conditions, immunisations, screening and onward referrals

What we've heard from the public

Through the GP Patient Survey, our local Healthwatch teams and from direct feedback, our patients have told us they trust their clinicians and generally have a positive experience once contact is made, but can be frustrated by the perceived difficulties in accessing general practice services in a convenient manner and especially in making contact via the phone.

Our vision and objectives

Our vision

The provision of high quality, integrated primary care services to support our local communities to equally live and remain well throughout their lives

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

How the model of primary care needs to change to improve our population's health and wellbeing

The publication of 'next steps for integrating primary care: Fuller Stocktake report' creates a new vision and case for change for integrating primary care. The report recommends Integrated Care System (ICS) leadership at every level to support and enable local care partnerships (LCPs) to deliver three key changes to the way in which primary and community care services are delivered at neighbourhood / Primary Care Network (PCN) levels of the system. At the heart of the report is a new vision for integrating primary care and improving access, experience and outcomes for our communities, which centres around three essential offers:

1. **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it;
2. **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions;
3. **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

This five year forward view for primary care in Lewisham aligns with the recommendations of the Fuller Stocktake report and indeed much of this work was already planned and underway.

Primary care as an enabler

Primary care as an enabler

In several areas, Primary care is an enabler to wider system change and delivery of improved outcomes and we will need to ensure that there are clear expectations of what each part of the system will need to achieve to contribute to this. Specifically in relation to the four Lewisham Health and Care Partnership priorities, the table below describes the main considerations in regards to primary care:

LHCP priorities	Primary care considerations
Strengthening the integration of primary and community based care and achieving financial sustainability across the system by working together and in collaboration as organisations and with the communities we serve.	The integration of primary and community based care is fundamental to support the delivery of improved outcomes in many areas including prevention, Long Term Condition identification and management, Mental Health, urgent and emergency care, planned care and anticipatory care especially for our older adult, frail population. We will particularly need to be clear on the role primary care will need to play as part of the integrated neighbourhood teams approach, working with their local communities and within MDTs to support the delivery of high quality care and improved outcomes.
Working to build stronger, healthier families and providing families with integrated, high quality, whole family support services.	Primary care has always played a key role in providing holistic care to families (in many cases, several generations) and we will need to build on this to make every contact count. In particular we will need to be clear how Primary care can best support the development and delivery of integrated family hubs and also the planned new Integrated Child Health Model.
Addressing inequalities throughout the Lewisham health and care system and tackling the impact of disadvantage and discrimination on health and care outcomes.	Primary care will need to support the identification of inequalities and seek to reduce variation at every opportunity. This will include working at scale, largely through PCNs, as part of the wider integrated neighbourhood approach.
Being a compassionate employer and building a happier, healthier workforce by creating a range of employment opportunities for local people and creating an environment that fosters wellbeing in our staff.	Although primary care is largely a collection of smaller organisations, we will still need to ensure that they are supported to be fully part of our workforce initiatives so that they can equally benefit from opportunities and experiences.

Our objectives and priority actions

Our priority actions

The key actions we will take to deliver the plan have been categorised into the following areas:

- **Proactive and preventative care**
  - Supporting people to stay well for longer by enabling them to make healthier lifestyle choices and treating avoidable illnesses early on
- **Accessible care**
  - Supporting timely access to care (including face to face and remote), in line with patient need, for same day urgent care and routine care.
- **Coordinated care**
  - Supporting person centred and co-ordinated care to improve quality through effective shared decision making for and with those experiencing the greatest need
- **Sustainable primary care**
  - Supporting all primary care providers to deliver the highest quality care and enable transformation by remaining resilient and sustainable both now and in the future
- **Partnership/collaborative working**
  - Supporting general practice to work cohesively together and effectively with wider local partners including the population, Lewisham People's Partnership, LGT, SLAM, the council and increasingly with the wider primary care family
- **Inequalities**
  - Supporting primary care to identify and reduce the disparity in outcomes and lived experiences between different population groups

Priority action – detail

Name of priority action

Proactive and preventative care

- Supporting people to stay well for longer by enabling them to make healthier lifestyle choices and treating avoidable illnesses early on

How we will secure delivery

Actions for 23/24

- Working with public health colleagues, ensure clarity of accountability, leadership, delivery and metrics in supporting residents to live healthily in key areas such as immunisations, screening, weight management, smoking, sexual health and substance misuse
- Continued improvement of early identification of LTCs (particularly hypertension) and management/mitigation as needed
- Continued focus on the delivery of patient Health Checks, in particular for serious mental illness (SMI), learning difficulties (LD) and other vulnerable groups
- Return to pre-pandemic levels as a minimum for cervical screening
- Continued focus on social prescribing including full implementation of the Joy IT system

Actions for 24/25

- Implement our coordinated local approach to supporting residents to live healthily
- Develop approaches with the wider primary care family to further improve early identification of LTCs
- Review of social prescribing data to inform approaches to social determinants of health and impacts on primary care service delivery

Intended outcomes in 5 years time

Downward trend in emergency admissions for preventable illness stemming from undiagnosed chronic disease

Achieving at least at the same level as the London average for cervical screening rates

Achieving the expected prevalence levels for the main LTC areas

Consistently achieving above the nationally set targets for SMI and LD health checks

Priority action – detail

Name of priority action

Accessible care

- Supporting timely access to care (including face to face and remote), in line with patient need, for same day urgent care and routine care

How we will secure delivery

Actions for 23/24

- Implementation of the national access recovery plan
- Work with PCNs to develop and implement their "Capacity and Access payment" plans
- Specific focus on ensuring that all general practice activity data (including that which is PCN related) is accurately captured and coded and so forms part of the local baseline
- Review PCN Enhanced Access arrangements to ensure patient benefits are being delivered consistently and safely
- Development and evaluation of options for same day urgent care services
- Review of the GP home visiting service to confirm long term arrangements
- Embed the Community Pharmacy Consultation Service (CPCS) pathway

Actions for 24/25

- Implementation of same day urgent care services including clear communication to the public and wider system partners
- In-line with national policy, continue to work with PCNs to refine their Enhanced Access offer
- Implementation of new arrangements for the GP home visiting service
- Continue to strengthen links with the wider primary care family to support patients to access the right services at the right time, first time

Intended outcomes in 5 years time

Reduced variation in access across Lewisham

The right balance of care to support individual patient needs – for example, continuity of care for patients with long term conditions and timely care for those with episodic or urgent needs

All patients have access to a range of appointments (in person or remote) to meet their needs and service locations are convenient if a face to face consultation is required

All patients know how to access the most appropriate service to ensure they receive the right care at the right time

Improved patient experience of all aspects of access

Priority action – detail

Name of priority action

Co-ordinated care

- Supporting person centred and co-ordinated care to improve quality through effective shared decision making for and with those experiencing the greatest need

How we will secure delivery

Actions for 23/24

- Procurement of a single provider model for enhanced support to older adult care homes
- Re-procurement of the High Intensity User service
- Ensure primary care input into the design and development of the local Integrated Neighbourhood Teams model and approach, including MDTs
- Continued focus on effective LTC management including implementation of the 2nd year of the PCN diabetes outcome scheme
- Working with the population health team and system partners, continued focus on risk stratification (including core20plus5) and care planning, particularly end of life care planning

Actions for 24/25

- Implementation of the new single provider model for older adult care homes
- Implementation of the agreed local Integrated Neighbourhood Teams model and approach
- Implementation of the 3rd and final year of the PCN diabetes outcome scheme

Intended outcomes in 5 years time

Integrated and coordinated neighbourhood teams in place and primary care clear on their role within these

Effective multidisciplinary working/teams in place following best practice

Improved outcomes for our patients with LTCs, particularly the diabetes 3TTs and 8 care processes

Reduced avoidable use of unplanned care and avoidable exacerbations of ill health

Embedded population health management approach in care delivery, using data and evidence to identify need and how to address it

At least 80% of patients who have an expected death to have a “universal care plan” in place

Priority action – detail

Name of priority action

Sustainable primary care

- Supporting all primary care providers to deliver the highest quality care and enable transformation by remaining resilient and sustainable both now and in the future

How we will secure delivery

Actions for 23/24

- Review local PMS premium to support delivery of wider LHCP objectives into 24/25
- Continue to support PCN development (i.e. governance, infrastructure) including specific support for Clinical Directors in their expanding roles
- Development and evaluation of options for the future of general practice to ensure it remains fit for purpose, resilient and sustainable
- Support continuous Quality Improvement (QI), in particular by maximising the support from the Clinical Effectiveness SEL programme (CESEL)
- Consider how best to create protected learning time for primary care to develop and transform whilst still supporting patient needs

Actions for 24/25

- Implementation of the revised PMS premium
- Continue to support PCN development including support for Clinical Directors in their expanding roles, building on learning from 23/24
- Continue to support the evolution of general practice to ensure it remains fit for purpose, resilient and sustainable
- Review and refine protected learning time arrangements to ensure that these are working for both primary care providers and patients

Intended outcomes in 5 years time

All primary care providers rated as a minimum at Good overall by the CQC or equivalent body

Reaffirming the importance of primary care as the corner stone of the NHS

Reduce variation between patient experience and outcomes irrespective of which practice/PCN a patient is registered with

Priority action – detail

Name of priority action

Partnership/collaborative working

- Supporting general practice to work cohesively together and effectively with wider local partners including the population, Lewisham People's Partnership, LGT, SLAM, council and increasingly with the wider primary care family

How we will secure delivery

Actions for 23/24

- Reform the PCN forum into the Primary Care Leadership forum (including a formally appointed independent chair) to provide a unified primary care voice for Lewisham
- Work with system partners to better understand interface issues and their impacts and develop an action plan to address both in the short, medium and longer term
- Work with the Lewisham People's Partnership to support the development of a clear set of expectations of what patients can expect of primary care and what primary care can expect of patients (a local charter)
- Design and implementation of a public engagement campaign to make every contact count with primary care
- Consider how we best engage with local pharmacy, dental and ophthalmic services

Actions for 24/25

- Fully established Primary Care Leadership forum which is representative of the wider primary care family i.e. pharmacy, dental and ophthalmic services
- Review progress against the local "interface" action plan to evaluate impact of short term actions and ensure that medium/longer term actions are on track
- Review of the local charter to ensure appropriate and working for all parties
- Evaluation of the impact of the public engagement campaign and incorporation of any changes/additions as needed
- Proactively work with local pharmacy, dental and ophthalmic services to improve outcomes for the population

Intended outcomes in 5 years time

Seamless pathways between services for patients and providers (including self referral options where appropriate) with reduced duplication, a clear understanding of each others services/roles/responsibilities and effective lines of communication

A well informed population who are clear on how to best utilise the whole range of local services and their roles and responsibilities as part of this

A truly unified primary care voice for Lewisham with clear lines of accountability, responsibility and decision making authority

The whole primary care family of general practice, pharmacy, dental and ophthalmic services working together collaboratively to improve outcomes for the local population

Priority action – detail

Name of priority action

Inequalities

- Supporting primary care to identify and reduce the disparity in outcomes and lived experiences between different population groups

How we will secure delivery

Actions for 23/24

- Development and implementation of PCN level inequalities plans, led by PCN health equity fellows
- Continuation of enhanced primary care homeless services
- Review and refine enhanced primary care services for local migrants and asylum seekers including dedicated support for local intermediate accommodation centres
- Continued focus on digital inclusion, supporting patients who might struggle/prefer not to use digital tools so that they are not disadvantaged
- Ensure that opportunities for action highlighted through the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) are taken forward in primary care as appropriate

Actions for 24/25

- Continued delivery of the PCN level inequalities plans and consideration of how to mainstream the PCN health equity fellow roles once the current 2 year programme ends in September 2024
- Continued involvement in the wider local heath inequalities programme led through public health
- Development and implementation of a joined up approach to digital inclusion with all system partners

Intended outcomes in 5 years time

A reduction in inequalities in key areas led by primary care including screening, immunisations and LTC identification and management

Levelling up outcomes and lived experience for those at highest risk of health inequalities / our most vulnerable population cohorts

Minimise patient digital exclusion in accessing and using services and ensure equitable alternatives for those who are not able/prefer not to utilise these tools and systems

Enabler requirements

Workforce

- Data-led workforce planning; understanding workforce profile (including ageing workforce) and developing practice, PCN and system plans in response
- Additional Roles Reimbursement Scheme (ARRS) – fully utilise PCN budgets, integrate staff within the system, ensure high quality and review the impact of these new roles
- Ensure continued links to the local Training Hub so available funding and opportunities are clearly promoted and maximised
- Support primary care to effectively manage violence and aggression towards staff from the public
- Working with system partners, support the recruitment and retention of staff, making Lewisham an attractive place to work and striving to keep those who train locally to stay in Lewisham
- Continue the work of our local practice nurse adviser team to support our local practice nurses to effectively undertake their roles including Continuing Professional Development (CPD)
- Launch a Lewisham primary care staff awards programme to recognise and celebrate excellence

Digital

- Facilitating improved patient access/experience by supporting practices to fully embed online/video consultation systems
- Supporting practices to optimise telephony systems to provide a high quality experience to patients
- Further improving on the utilisation of the NHS App across primary care
- Improving the quality and consistency of practice websites
- Supporting practices and PCNs to optimise access to patient records in a safe and robust way and so empowering patients to take control of managing their own health
- Working with system partners to integrate digital systems where possible and as a minimum ensure interoperability
- Efficient scaling and adoption of digitally sustainable solutions across the system

Estates

- Ensure a clear and prioritised plan for local primary care estates developments particularly in regard to our large multi-occupancy health centres
- Ensure primary care estates plans are fully integrated with wider system estates plans and strategies
- Ensure sufficient space is available to accommodate the growing number of PCN ARRS staff and that clear financial agreements are in place to underpin this
- Support practices and PCNs to centralise back office functions where beneficial to do so
- Ensuring a pipeline of prioritised schemes for the London Improvement Grant (LIG) and other capital funding opportunities
- Continue to support practices to digitise their patient records and reconfigure freed up space for clinical / service use as able

Data/business intelligence

- Accurate reporting of primary care activity - working with practices and PCNs to analyse, diagnose and facilitate how appointments should be mapped and coded to ensure accurate reporting in-line with the National Slot Categorisation
- Use of demand and capacity tools to improve insight at practice and PCN levels to ensure workforce and systems are optimised
- Use of local population health tool to help risk stratify and identify population cohorts for targeted support and intervention
- Robust data sharing arrangements in place to facilitate integrated care – including clear communication to patients to explain the benefits of data sharing

Metrics to track delivery

Metrics to track delivery

In order to track progress against delivery of the plan, there are a number of both quantitative and qualitative metrics that will be reviewed. Some of these outcome measures will be directly related to actions undertaken in primary care and some will be a result of wider work across the whole local partnership. As well as considering overall achievement against metrics, we will review the underlying data to understand if there are any inherent inequalities that need to be addressed. A summary of the key metrics is as below:

Quantitative	Qualitative
• CQC ratings • QOF outcomes • PCN Investment and Impact Fund (IIF) outcomes • Annual GP Patient Service results • Friends and Family Test • Immunisation rates • Cancer screening rates • LTC prevalence rates • Health check uptake rates (SMI/LD) • Workforce numbers in general practice • Appointment numbers in general practice • Referrals to the Community Pharmacy Consultation Service • End of life care plans in place • NHS App download numbers and utilisation statistics	• CQC reports • Healthwatch reports and feedback • Feedback from the Lewisham People's Partnership • Feedback directly from the public • Formal complaints • Stakeholder surveys (within primary care and with wider system partners) • Quality Alerts • QOF Quality Improvement (QI) domain reports

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Plan on a page

Lewisham Primary Care Development Plan (SUMMARY)

Context

SEL ICS Strategy / Lewisham place-based priorities / Next steps for integrating primary care: Fuller Stocktake report / PCN DES

Vision

The provision of high quality, integrated primary care services to support our local communities to equally live and remain well throughout their lives

Delivering High Quality Care

How the model of primary care needs to change to improve our population's health and wellbeing

The publication of 'next steps for integrating primary care: Fuller Stocktake report' creates a new vision and case for change for integrating primary care. The report recommends Integrated Care System (ICS) leadership at every level to support and enable local care partnerships (LCPs) to deliver three key changes to the way in which primary and community care services are delivered at neighbourhood / Primary Care Network (PCN) levels of the system. At the heart of the report is a new vision for integrating primary care and improving access, experience and outcomes for our communities, which centres around three essential offers:

1. **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it;
2. **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions;
3. **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

This structure broadly aligns with the previous Lewisham Primary Care Development strategy 2016-21 which described the three pillars of proactive, accessible and coordinated care. It is suggested that we keep with this categorisation to maintain consistency and it is also felt that this is a easily understandable language that will help when engaging with wider stakeholders.

Key elements on these three pillars are as below:

Proactive Care

Including:
- Co-ordination of vaccinations, screening and health checks
- Early identification (eg LTCs)
- Supporting healthy lifestyles and self-management

Accessible Care

Including:
- Choice of access options (face to face, telephone, virtual)
- PCN Enhanced Access
- Integrated primary and urgent care including same-day access

Co-ordinated Care

Including:
- Integrated neighbourhood working & MDTs
- Risk stratification
- Care planning & review

Sustainable Primary Care

To include:
- GP Practices
- Super-partnerships and "multi-practice" partnerships
- Primary Care Networks (PCNs)
- GP Federation
- Need to also consider increasing direct engagement and collaboration with local pharmacy, dental and ophthalmic services

Need to focus on unwarranted variation and support leadership development and protected time for team development

Partnership/collaborative working

- Within and between all primary care partners
- With the wider Lewisham system (e.g. council, LGT, SLAM)
- With the local population
- Existing PCN Forum has a key role to support a credible and coordinated united primary care voice

Inequalities

- Link to public health programme to identify and address inequalities especially in regard to vaccinations, screening and LTC management
- Mitigate any digital exclusion at every opportunity
- Provide specialist services where indicated i.e. enhanced support to the homeless, migrants/asylum seekers

Enablers

IT & data

- Online consultations / remote monitoring
- Population Health Management (Cerner)
- Data sharing across partners

Estates

- Plans at both individual practice and PCN level
- Support consolidation of back office functions
- Maximise opportunities through one public estate (OPE) programme

Workforce

- Maximise opportunities through the ARRS scheme
- Continue close working with the Lewisham Training Hub
- Focus on recruitment and retention

Monitoring and evaluation

- Patient feedback including GPPS and Healthwatch
- Quality dashboards (practice/PCN)
- QoF and other outcome measures

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 8
Enclosure 6

Title:	**Lewisham Health and Care Partnership – Local Care Plan 2023-24 Delivery Plan**
Meeting Date:	18 May 2023
Author:	Sarah Wainer
Executive Lead:	Ceri Jacob

Purpose of paper:	On 23 March, Lewisham's Local Care Plan (Forward View) 2023–2028, was presented to members of the strategic board. The plan included the priority areas on which partners have agreed to work together to achieve improvements in health and care outcomes and address inequalities. The agreed priority areas are: 1. **Strengthening the integration of primary and community based care** by establishing the model, infrastructure and approach required to achieve effective integrated working at a neighbourhood level; establishing local models of care for at least two long term conditions and older people. 2. **Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services** by establishing family hubs across Lewisham and delivering integrated pathways. 3. **Addressing inequalities throughout Lewisham health and care system** by implementing an agreed infrastructure through which initiatives to address health inequalities and achieve health equity in the borough can be delivered. 4. **Maximising our roles as Anchor Organisations, being compassionate employers and building a happier, healthier workforce** by identifying opportunities for joint apprenticeship programmes, implementing joint initiatives to promote health and care careers, and developing tools and approaches to inform workforce planning and address workforce issues. Members are asked to note the summarised delivery plans for the four priority areas attached to this report.	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	Lewisham's Local Care Plan (FV) set out the agreed direction of travel for Lewisham's health and care partnership and outlined the priority areas on which partners will focus and work together over the next five years.		

	To underpin the LCP (FV), delivery plans on the agreed priority areas have been developed. Attached to this report are summarised versions of those delivery plans which set out the actions that will be taken in 2023/24 to achieve LHCP's objectives.			
Potential Conflicts of Interest	None. The delivery plans have been developed with partners and reflect the LHCP's commitment to improving health and care outcomes and reducing health inequalities.			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	A key focus of the delivery plans for 2023/24 is on addressing inequalities throughout the local health and care system.		
	Financial Impact	Although there are no specific financial implications arising from this report, delivery plans are dependent on adequate resources being available and being identified in financial plans.		
Other Engagement	Public Engagement	Programme boards and delivery partners will undertake engagement where necessary on the development of their plans.		
	Other Committee Discussion/ Engagement	N/A		
Recommendation:	Members are asked to note the summarised delivery plans for the four priority areas attached to this report.			

LHCP Priority Areas – Delivery Plans for 2023 -2024

Delivery Plan 2023/24

Priority Area: Strengthening Primary and Community Based Care

Programme/Delivery Board: Integrated Neighbourhood Network Alliance

Chair: Dr Taj Singharo Programme Lead: Fiona Kirkman

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
MDT working: Supporting the organisation, efficiency and processes surrounding multi-disciplinary team meetings.	❑ Identify challenges and barriers to effective MDT working ❑ Design a model and methodology to improve MDT working, including identifying enablers such as funding, workforce and pathway re-engineering ❑ Review and update standard operating procedures, incentive schemes as appropriate, lines of accountability and SMART success measures	➢ Mapping of all existing MDTs across the borough ➢ Review of best practice and examples of MDTs happening elsewhere, and how these might be applied in Lewisham **July 2023** ➢ Develop a proposal for MDT working and gain approval of our recommendations through LCP governance ➢ Implementation through contracts, PMS Premium, enacting enablers, etc. **September 2023** ➢ Ongoing review, evaluation and adjustment	• Streamlined MDT meetings and improved processes (e.g. access to records) • Complex patients are supported with fewer hand offs and improved outcomes • Patients are identified proactively before their needs become complex • Teams work better together with increased understanding of	Exact metrics to be agreed through Task and Finish group – first task and finish group to be established by June 2023.	Jessica Arnold, Director of Delivery	• Primary Care • Adult Social Care (Neighbourhood Coordinators) • Lewisham LMC • SLaM • District nursing

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Strengthening Primary and Community Based Care

Programme/Delivery Board: Integrated Neighbourhood Network Alliance

Chair: Dr Taj Singharo Programme Lead: Fiona Kirkman

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Working Together in the Neighbourhoods: Enhancing ways of working across boundaries	❑ Use neighbourhood level data to identify priority needs and actions ❑ Identify key barriers and challenges faced to prevent effective collaboration across organisations ❑ Embed integrated ways of working ❑ Establish clear plan to address requirement from multiple stakeholders to develop a directory of service (DOS) ❑ Support implementation of HEE/Workforce tool and identify ability to utilise	➢ Identify next steps for DOS ➢ Determine how HEE tool can be utilised by clinicians **June 2023** ➢ Approve approach and identify one neighbourhood to test out ways of working ➢ Engage key stakeholders and gather baseline data to measure improvements **July 2023** ➢ Identify the main challenges and barriers to integrated working in pilot neighbourhood. ➢ Identify the priority needs of the local population in pilot neighbourhood **September 2023** ➢ Development of detailed plans and priorities to address challenges **October 2023**	• Development of data profiles for each neighbourhood. • Increase in job satisfaction and job retention	TBD by Alliance	Sarah Wainer, Director of System Transformation and Change	• Primary Care • Adult Social Care • Lewisham LMC • SLaM • District nursing • Lewisham Local • VCSE • Healthwatch • OHL • LGT • PCNs

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Strengthening Primary and Community Based Care

Programme/Delivery Board: Integrated Neighbourhood Network Alliance

Chair: Dr Taj Singharo Programme Lead: Fiona Kirkman

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Community Partnerships: Maximise opportunities by strengthening community partnerships	❑ Strengthening existing networks with local communities to support prevention and wellbeing. This includes overseeing the strategic development of social prescribing. ❑ Oversee social prescribing platform implementation, evaluation and procurement.	➢ Ensure all practices are signed up to Joy **May 2023** ➢ Convene community partnership group to support planning **July 2023** ➢ Support and encourage collaboration across social prescribing services across Lewisham to develop consistency in approach and shared learning **July 2023** ➢ Enhancement of and alignment to specific prevention and wellbeing initiatives in line with system priorities – e.g. hypertension case finding **August 2023** ➢ Evaluation of Joy Platform and plan for future procurement **April 2024**	• Development of data profiles for each neighbourhood. • Increase in job satisfaction and job retention	TBC	Fiona Kirkman, System Transformation Lead	• Primary Care • Adult Social Care • Lewisham LMC • SLaM • District nursing • Lewisham Local • VCSE • Healthwatch • OHL • LGT • PCNs • VCSEs

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Strengthening Primary and Community Based Care (Long Term Conditions)

Programme/Delivery Board : LTC and Planned Care Delivery Group

Chair: Dr Leo Emordi/Dr Ravi Sharma Programme Lead: Ian S. Ross

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Long Term Conditions	❑ To review the Lewisham datasets and pathways to maximise efficiencies and reduce duplication across system to release funding for investment ❑ Develop clear pathways from Primary, Community and Secondary Care ❑ Reduce the number of referrals for diagnostic procedures in secondary care as a result of activity being delivered in the community / early intervention.	➢ Initiate LTC & Planned Care Delivery Group – **April 2023** ➢ Identify specific areas of focus for both respiratory and CVD – **May 2023**	• Reduce the number of people living with unidentified LTCs. • Deliver services and management of care for people with long-term conditions that will be proactive, holistic, preventive and patient-centred. • Clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress. • Improve patient experience through early and accurate diagnosis of disease with effective treatment closer to home.	CVD and Respiratory milestones TBC although there are defined SEL objectives for CVD. For the Diabetes workstream we have established the following; • Delivery of the Primary Care Long Term Conditions Outcome Improvement Programme (OIP) • Make improvements to 8 CPs and 3TTs against 19/20 achievement and to reduce variation within the PCN to less than 20% between the highest and lowest performing practices • Continue promoting the injectables scheme (insulin / GLP1) in primary care for patients with diabetes • Housebound Annual Review Service for Patients with Long Term Conditions	Ian Ross/SEL LTC Team	• Primary Care • Adult Social Care • Lewisham LMC • SLaM • District nursing • VCSE • Healthwatch • OHL • LGT • PCNs

Delivery Plan 2023/24

Priority Area: Strengthening primary and community based care (Older People)

Programme/Delivery Board: Older People Transformation Board

Chair: Dr Emma Nixon / Kenneth Gregory Programme Lead: Tristan Brice

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Baseline data and predictive modelling of Older Adult health and social care activity	❑ Understand the circumstances of Older Adults with moderate care needs and their carers, the support they receive the consequences for their wellbeing of different support and the implications of different care arrangements for costs and value for money of the care system. ❑ Monitor impact of implementing the Lewisham proactive care model on the health and social care system	➢ Undertake baseline quantitative analysis of Older Adult activity of the health and social care system ➢ Interview staff, care providers, Older Adults with moderate needs and carers to understand the local system and support being provided. ➢ Develop predictive model for Older Adults	• Reduced unplanned A&E attendances for Older Adults • Reduced unplanned admissions for Older Adults • Report summarising what support is available for Older Adults with moderate needs and their experiences of accessing this support	Exact metrics to be agreed through Task and Finish group	Tristan Brice	• Primary Care • Adult Social Care • LGT • SLAM

Delivery Plan 2023/24

Priority Area: Strengthening primary and community based care (Older People)

Programme/Delivery Board: Older People Transformation Board

Chair: Dr Emma Nixon / Kenneth Gregory Programme Lead: Tristan Brice

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Proactive care model: Building on the learning from the frailty pilot and ensure spend is in line with SEL comparators .	❑ Identify and share the learning from the frailty pilot ❑ Operationalise the national proactive care model (including embedding the learning from the frailty pilot) to ensure meets the needs of Lewisham residents ❑ Socialise the Lewisham proactive care model amongst Lewisham residents	➢ Share learning from the frailty pilot ➢ Share national proactive model ➢ Identify Lewisham based Older Adults groups and agree how to keep them updated regarding the work of the programme ➢ Coproduce Lewisham proactive care model ➢ Embed the Lewisham proactive care model within the Lewisham system	• Reduced unplanned A&E attendances for Older Adults • Reduced unplanned admissions for Older Adults	Exact metrics to be agreed through Task and Finish group	Tristan Brice	• Primary Care • Adult Social Care • LGT • SLAM

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Providing families with integrated, high-quality, whole-family support services

Programme/Delivery Board: Family Hubs Integrated Leadership Alliance

Chair: Sara Rahman Programme Lead: Lorraine Harker

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Family Hub Transformation– establish Family Hub sites in each of the areas of Lewisham	❑ To establish five Family Hub Sites across Lewisham to provide accessible, physical and virtual points of contact for families, children and young people aged 0-19 (or up to 25 for young people with special educational needs) and to deliver integrated pathways.	➢ Create pilot Family Hub in Clyde Nursery, Deptford with a range of services including midwifery, health visiting, perinatal mental health and speech and language therapy. ➢ Evaluate pilot to establish lessons learnt for future Hubs ➢ Explore opportunities for paediatric outreach clinic based in Clyde. ➢ Establish Family Hub sites in: Area 4 in Bellingham C&FC, Area 3 in Downderry C&FC, Area 1 in Honor Oak Youth Centre ➢ Explore possibility of Family Hub site for area 2 being location in Kaleidoscope alongside Autism Hub	• Advice and guidance is available virtually and in Family Hubs across a wide range of topics. • Family Hubs are established s a priority for the local care network with a focus on priority health issues e.g. autism, asthma, diabetes, epilepsy, oral health and mental health • Outreach work focuses on hard to reach and vulnerable groups. • Staff receive training on debt, employment, housing, trauma informed practice, cultural competency and equalities	Milestones • Soft Launch of Clyde Pilot Hub 17th April 2023 • Evaluation of pilot June 2023 • Launch of Area 4 Bellingham Hub – September 2023 • Launch of Area 3 Downderry Hub – September 2023 • Launch of Area 2 Hub - December 2023 • Launch of Area 1 Honor Oak Hub March 2024 Metrics • Number of open Hubs • Feedback that families receive the support they need	Serita Kwofie, Head of Prevention and Early Help	• Children's Centres • Family Thrive • Midwifery • Health Visitors • SEND • Speech and Language Therapists • Drumbeat • Voluntary Sector • CAMHS

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Providing families with integrated, high-quality, whole-family support services

Programme/Delivery Board: Family Hubs Integrated Leadership Alliance

Chair: Sara Rahman Programme Lead: Lorraine Harker

	Aim To improve the communication, language and literacy skills of children aged 0-5 in Lewisham, through joined-up and evidenced-based approach that begins from the point of conception onwards					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Early Language and Home Learning Environment	❑ Improved speech, language and communication pathways and join-up across early years services to ensure support is available and tailored when needed for families ❑ Improved training provided to practitioners to support families with early language and communication development, focusing on improved child development outcomes in those who were babies and children at the height of the pandemic ❑ Increased access to support for families to ensure that they feel supported on how to provide an enriching home learning environment, and have more language-rich interactions with their children ❑ Better targeting of support to families that face challenges in supporting their children's communication development or face barriers to accessing services, including those on a low income	• Recruit Programme Co-ordinator to oversee the delivery plan • Establish single assessment process and package of interventions for staff across all Family Hub Services • Harness the expertise of Speech and Language Therapists to support delivery of early language interventions in universal services • Develop a Lewisham campaign to support early language development • Increase capacity and uptake of Making it REAL early language programme and embed in Family Hubs	• Increase in the number of parents accessing group community sessions supporting early language development • Families feel supported in how to provide an enriching HLE and have more language-rich interactions with their children • Increase in the number of Lewisham practitioners provided with training to support families with HLE	<u>Milestones</u> Delivery plan running from January 2023 - March 2025 <u>Metrics</u> • No. of children achieving or above the expected level in communication skills at 2-2.5 • Number of Lewisham practitioners provided with training to support families with HLE by March 2025 • Number of parents accessing group community sessions supporting early language development	Emily Newell	Speech and Language Therapy Children and Family Centres Libraries National Childrens Bureau Health Visiting Maternity Services

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Providing families with integrated, high-quality, whole-family support services

Programme/Delivery Board: Family Hubs Integrated Leadership Alliance

Chair: Sara Rahman Programme Lead: Lorraine Harker

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Infant Feeding	❑ Ensure all parents and carers have the information, practical advice and support they need to support breastfeeding initiation and continuation, expressing breastmilk, and/or formula feeding where that is more appropriate ❑ Ensure those least likely to access services are engaged as early as possible to help them understand the benefits of breastfeeding and responsive skin-to-skin feeding, and how to access the support available to them, helping to reduce inequalities. ❑ Ensure parents have opportunities to meet other mothers and access peer-to-peer support ❑ Ensure all Family Hubs staff receive appropriate, accredited training to ensure infant feeding advice is accurate, helpful and consistent, and staff know how to work together across agencies and settings to provide seamless support ❑ Ensure that timely, high-quality, one-to-one infant-feeding support is available in the critical post-birth period	➢ Develop a system-wide Infant Feeding pathway for parents and professionals including for babies with tongue-tie ➢ Ensure that all Family Hubs sites are breastfeeding friendly in line with BFI guidance ➢ Deliver Unicef Breastfeeding and Relationship Building Training including Champions programme ➢ Establish midwifery-led tongue-tie clinic ➢ Establish Infant Feeding Peer Support Scheme ➢ Scale up antenatal education sessions focused on infant feeding ➢ Establish Infant Feeding and Formula Pathways ➢ Increase the capacity of Health Visiting Infant Feeding Hubs across the borough	• Maintain high level of breastfeeding at 6-8 weeks infancy • Reduce in the waiting times for tongue-tie procedures • Increase in the number of trained peer supporters working in Lewisham • Increase in the number of women from target groups accessing infant feeding support services, including health visitor drop-ins and peer support • 100% of Family Hub buildings identified as breastfeeding friendly in line with BFI guidelines	<u>Milestones</u> From April 2023 to March 2025 <u>Metrics</u> • Increase in the no. of staff receiving accredited training in infant feeding • Decrease in average waiting time for frenotomy procedure for tongue-tie • Increase in the number of women from target groups (i.e. low socio-economic background, aged 25 and under and minority ethnic backgrounds) accessing infant feeding support services	Emily Newell	Maternity Services Health Visiting Peer Support Scheme Children and Family Centres

South East London Integrated Care System

Delivery Plan 2023/24

NHS South East London

Priority Area: Providing families with integrated, high-quality, whole-family support services

Programme/Delivery Board: Family Hubs Integrated Leadership Alliance

Chair: Sara Rahman Programme Lead: Lorraine Harker

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Parenting Support	❑ Parents are able to understand their child's development, build relationships with them and deal with challenging behaviour ❑ Fathers and male care givers have increased access to support in the perinatal period ❑ Increase parents access to peer support in the perinatal period	➢ Increase capacity of the LBL Parent Champions Programme ➢ Establish the Empowering Parents Empowering Communities (EPEC) programme ➢ Establish a targeted 1-1 support offer for fathers of children aged 0-2 ➢ Establish the Triple P Baby parenting programme	• Increase in the number of parents with children aged 0-2 accessing parenting support programmes • Increase in access to parenting support programmes for parents from high deprivation areas • Increase in the number of parents, particularly fathers, receiving peer support from a structured programme e.g. EPEC • Increase in number of local parents trained to be volunteer peer champions through Parent Champion Programme	• Number of parents accessing parenting programmes • Number of parents accessing parenting programmes from high deprivation areas • Number of parents receiving peer support from a structure programme e.g. EPEC • Number of volunteer peer champions	Harsha Ganatra	Children and Family Centres Future Men Family Thrive Health Visiting Maternity

Delivery Plan 2023/24

Priority Area: Providing families with integrated, high-quality, whole-family support services

Programme/Delivery Board: Family Hubs Integrated Leadership Alliance

Chair: Sara Rahman Programme Lead: Lorraine Harker

Aims
- Increase support to parents and carers that promotes positive perinatal emotional wellbeing and addresses mild perinatal mental health difficulties
- Increase support to parents and carers that encourages healthy parent-infant relationships and address any low-level difficulties
- Ensure that all services interacting with parents in the perinatal period have the skills, resources and capacity to support parents in these two areas

Workstream	Objectives	Action (what and by when)	Outcome	Milestones and Metrics	Led by	Key partners
Parent-Infant Relationships and Perinatal Mental Health	❑ Develop and improve care and referral pathways to ensure support is provided when needed for babies and their families, in a co-ordinated way across maternity and early years services. ❑ To ensure that practitioners with Lewisham maternity and early years services have a good awareness of the importance of parent–infant relationships and perinatal mental health, and have the resources and support needed to have sensitive, inclusive conversations with parents and carers about wellbeing and challenges they might be experiencing, as early as possible. ❑ Develop a package of interventions for parents that encourage healthy parent-infant relationships and address any low-level difficulties, delivered by multi-agency staff. ❑ Develop a package of interventions for parents to support positive perinatal mental health and address any low-level emotional wellbeing needs	➢ Reviewing processes for universal assessment of PMH and PIR difficulties undertaken during the perinatal period ➢ Developing system-wide Parent and Infant Mental Health pathway for 0-5 year olds ➢ Developing a framework for supervision, coaching and consultation for multi-agency Family Hubs staff working with Perinatal MH and Parent-Infant Relationships ➢ Expanding training for Family Hub workforce on Perinatal MH and Parent-Infant Relationships ➢ Establishing comprehensive Parent-Infant Relationship offer including package of targeted interventions delivered by a 'virtual team' of multi-disciplinary staff ➢ Expanding Perinatal Mental Health Peer Support Programmes for new and expectant parents	• Increase in the number of parents receiving structured support with parent-infant relationships and accessing support for perinatal mental health • Increase in the number of professionals attending training in parent-infant mental health • Increase in the number of Family Hub Practitioners attending training in parent-infant relationships • Increase in the number of parents receiving peer support for perinatal mental health by March 2024.	• Improved emotional wellbeing following structured support • Improved parent-infant bonding and attachment following structured support • Number of parents receiving support with parent-infant relationships and mental health • Number of professionals attending training • Number of parents receiving peer support for perinatal mental health	Emily Newell	• Health Visitors • Midwifery • Children and Family Centres • Family Thrive • Future Men • Children' Social Care • CAMHS • Mind

Delivery Plan 2023/24

South East London Integrated Care System

NHS South East London

Priority Area: Addressing Health Inequalities

Programme/Delivery Board: Health Inequalities and Health Equity Working group Chair: Catherine Mbema Programme Lead: Tim Hughes

Area	Aim					
	Objective	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Workstream 1: Equitable preventative, community and acute physical and mental health services	❑ To design, test and scale up new models of service provision that achieve equitable access, experience and outcomes for all. This includes a number of South East London ICS funded projects and the work of the Lewisham Cancer Alliance.	➢ Reducing inequalities in elective surgery waiting lists (LGT) ➢ Improving recording of special category data project (LGT) ➢ Specialist Smoke Free Pregnancy midwife in post (LGT ➢ Developing a community based prevention outreach programme (LBL) ➢ Lewisham Cancer Awareness Network initiative (LBL) ➢ Population Health Fellows in post (LGT)	• A reduction of inequalities in access, experience and outcomes from surgery. • Ability to analyse data to identify any inequalities in access and outcomes of care, providing the opportunity to immediately act on this data to improve care for people who are face significant health inequalities. • Reduction in the Smoking at Time of Delivery (SATOD) rate. • Reduction in inequalities in uptake of cancer screening and vaccination uptake. • Implementation of frameworks such as Core20Plus5.	To be developed.	Matthew Hopkins/Emily Newell/Tim Hughes	Lewisham & Greenwich NHS Trust, SEL ICS, Lewisham Council
Workstream 2: Health Equity Teams	❑ To develop place-based teams to provide leadership for system change and community-led action	➢ Recruitment of 6 Health Equity Fellows across each Lewisham Primary Care Network (PCN) – action completed by Dr Aaminah Verity by May 2023. ➢ Fellows to work with appointed VCS groups to co-develop and deliver projects per PCN to be delivered across 2023-24.	• Co-produced local work to achieve health equity delivered by 2024.	To be developed	Dr Aaminah Verity/Tim Hughes	Lewisham PCNs/VCS group/Lewisham Council
Workstream 3: Community Development	❑ Infrastructure development to empower communities and deliver community-led service design and delivery	➢ Commissioning VCS groups to form Health Equity teams with Health Equity Fellows – action in progress. ➢ Delivery of co-produced projects.	• Co-produced local work to achieve health equity delivered by 2024.	To be developed	Jason Browne/Lisa Fannon/ Tim Hughes	Lewisham Councill/Lewisha PCNs
Workstream 5: Workforce Toolbox	❑ To increase awareness and capacity for health equity within practice	➢ Development of toolkit and pilot by leaders and key service areas by September 2023.	• Lewisham-wide toolkit accessible to all frontline staff to improve awareness of health equity and impact of racism, trauma and other factors on the Lewisham population.	To be developed	Tim Hughes	Lewisham Council/LGT/Lewisham Health and Wellbeing Board.

Delivery Plan 2023/24

Priority Area: Maximising our roles as anchor organisations, being compassionate employers and building a happier, healthier workforce

Programme/Delivery Board: Workforce Steering group

Chair: Meera Nair/Charles Malcolm-Smith Programme Lead: Charles Malcolm-Smith

	Aim					
Workstream	**Objectives**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Workforce Programme	❑ Establish a partnership workforce steering group to provide oversight, monitor progress, ensure co-ordination and identify new and emerging workforce needs ❑ Develop the plans for delivering the workforce ambition, key deliverables and success measures of the LCP Plan	➢ Convene group for initial meeting **June 2023** ➢ Development of agreed overarching workforce plan **July-September 2023** ➢ LCP strategic board sign-off **October 2023**	Agreed Workforce Programme	tbc	Charles Malcolm-Smith, People & Provider Development Lead	• Primary Care • LGT • SLaM • LBL, including adult social care, CYP services and public health • VCSE organisations

Delivery Plan 2023/24

Priority Area: Maximising our roles as anchor organisations, being compassionate employers and building a happier, healthier workforce

Programme/Delivery Board: Workforce Steering group

Chair: Meera Nair/Charles Malcolm-Smith Programme Lead: Charles Malcolm-Smith

	Aim					
Workstream	**Objective**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Career Insight Programme	❑ Support widening participation in health careers	➢ Confirm alignment and scheduling with Lewisham Challenge programme **June 2023** ➢ Establish steering group with partners **August 2023** ➢ Schedule programme events **August 2023** ➢ 6 week programme **October-November 2023**	• provide year 12 school students in Lewisham with wider understanding of the range of careers within the health and care sector	Pilot programme completed autumn 2023 Minimum 20 participants supported to progress to further study or education in health and care careers	Charles Malcolm-Smith, People & Provider Development Lead	• Primary Care • LGT • SLaM • LBL, including adult social care, CYP services and public health, Lewisham Challenge programme

Delivery Plan 2023/24

Priority Area: Maximising our roles as anchor organisations, being compassionate employers and building a happier, healthier workforce

Programme/Delivery Board: Workforce Steering group

Chair: Meera Nair/Charles Malcolm-Smith Programme Lead: Charles Malcolm-Smith

	Aim					
Workstream	**Objectives**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Integrated Workforce Planning	❑ Support the development and of an integrated approach to the planning and provision of care in the community with a specific focus on integrated neighbourhood and place based teams	➢ Define optimum service to be delivered by the integrated neighbourhood team for that population **June 2023** ➢ Identify skills/competencies needed to deliver that service **July 2023** ➢ Workforce plan for integrated working in neighbourhoods (include skills and competencies and roles required) **July 2023**	Approach established for developing future operating models	tbc	Fiona Kirkman, system Transformation Lead & Charles Malcolm-Smith, People & Provider Development Lead	SEL ICB Health Education England

Delivery Plan 2023/24

Priority Area: Maximising our roles as anchor organisations, being compassionate employers and building a happier, healthier workforce

Programme/Delivery Board: Workforce Steering group

Chair: Meera Nair/Charles Malcolm-Smith Programme Lead: Charles Malcolm-Smith

	Aim					
Workstream	**Objectives**	**Action (what and by when)**	**Outcome**	**Milestones and Metrics**	**Led by**	**Key partners**
Apprenticeships	❑ Establish new roles, eg in AHP or therapy support.	➢ Initial scoping with partners to identify areas of focus and opportunities **tbc**	• support the widening participation of local workforce • new joint roles or rotations or placements between services	tbc	Charles Malcolm-Smith, People & Provider Development Lead	• Primary Care • LGT • SLaM • LBL, including adult social care, CYP services and public health

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 9
Enclosure 7

Title:	**Lewisham Primary Care Group – Chairs' Report**
Meeting Date:	18 May 2023
Author:	Chima Olugh, Primary Care Commissioning Manager (Lewisham).
Primary Care Group Chair	Anne Hooper.
Executive Lead:	Ceri Jacob, Lewisham Place Executive Lead.

Purpose of paper:	The purpose of the Primary Care Group is to provide leadership, challenge and oversight for the delivery of primary care services in Lewisham, focused on, and working with, the local population and providers. The Group also provides guidance to the Lewisham Local Care Partnership on key primary care priorities.	Update / Information	**X**
		Discussion	
		Decision	

Summary of main points:	This report contains key topic areas from the Group's meetings held in March and April 2023 and covers the following areas. 1. Vaccination Programmes 2. Primary Development Plan 3. PCN Enhanced Access 4. A Review of the Primary Care Group Terms of Reference 5. Downham Family Medical Practice CQC Update 6. Changes to the 2023/24 GP Contract 7. Lewisham Structured GP Practice Visit Summary Report.
Potential Conflicts of Interest	**Not Applicable**

Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	**X**	**Southwark**	

	Equality Impact	No direct impact identified.
	Financial Impact	None
Other Engagement	Public Engagement	None
	Other Committee Discussion/ Engagement	Some of the areas covered have been discussed with SEL Lewisham LMC, Healthwatch Lewisham and Lewisham Primary Care Leadership Form.
Recommendation:	**The Lewisham Local Care Partnership is asked to note the updates from the Chairs Report.**	

Lewisham Primary Care Group Chairs' Report

1. Covid-19 Vaccination Programme

The Covid-19 spring booster programme targets a small cohort of people, mainly those aged 75 years and over, those in care homes, and those aged 5 years and over with a weakened immune system.

The programme will run from April till June and will be mainly led through practice/PCN call/recall. Most PCNs are running clinics once a week, with community pharmacy also offering support.

The Downham Health & Leisure site has been stood up for Sevenfields PCN, while the Goldsmiths Community Centre will be available soon.

The updated Covid-19 vaccines boost protection and gives slightly higher levels of antibody against the more recent strains of COVID-19 (Omicron) than the previous vaccines.

2. Primary Development Plan (Five Year Forward View)

The five year forward view for Primary Care in Lewisham articulates the direction of travel and outlines the priority areas of focus over the next 1 – 5 years. The plan highlights the main areas where primary care is an enabler to wider system change and delivery of improved outcomes.

The latest version of plan was shared with the Group as part of the ongoing engagement and feedback with key stakeholders.

Summary engagement timetable

Stakeholders	Engagement dates
GP Practices	May 2023
Primary Care Networks	April and May
Primary Care Leadership forum	April and May
GP Federation	April and May
Lewisham Local Care Partnership Strategic Board	April & May 2023
Local Medical Committee	March and May 2023
Lewisham Primary Care Group	Monthly
Lewisham Clinical and Care Professional Lead	31/03/2023
Lewisham Place Executive Group	13/04/2023
Lewisham SMT	Bi-monthly
Lewisham Training Hub	TBA
Peoples Partnership/Voice and Influence	April and June 2023
Healthwatch Lewisham	24/03/2023
Local Dental Committee	05/05/2023
SELDOC (GP Out of Hours)	TBA
Lewisham citizens	TBA
Medicines Management	March and April
Public Health	March and May

The Group will have oversight of the plan and monitor progress against agreed outcomes.

3. PCN Enhanced Access

PCN Enhanced Access commenced on 1st October 2022. In the lead up to the launch date commissioners supported PCNs to ensure services were ready on time.

Following the first 6 months of the service the ICB will conduct a retrospective piece of work with PCNs to understand what has worked and were support might be needed.

Key areas of focus will include:

- Collate any operational issues and complaints.
- Start assurance work going forward.
- Capture user feedback.

4. Review of the Primary Care Group Terms of Reference

The Primary Care Group was established in July 2022 and the Terms of Reference (ToR) was subsequently approved by the Lewisham Local Care Partners Strategic Board.

The Group carried out a review of its ToR in order to ascertain whether it was carrying out the delegated responsibilities effectively.

During the 9 months of its existence the Group has received positive feedback on its functions, and it has agreed to continue to work through the best approach to carry out its functions.

The Group agreed the following:

- It would keep abreast of the recently delegated responsibilities, community pharmacy, dentistry and optometry and review the ToR within the year to accommodate the new areas.
- It would establish stronger links with the Lewisham Primary Care Leadership Forum.
- It needs to understand whether it was fulfilling the needs and expectations of the Lewisham Place Executive Lead.

The Group would carry out regularly self-assessments to ensure it continued to meet the success criteria outlined in the ToR.

5. Downham Family Medical Practice CQC Update

The Care Quality Commission (CQC) carried out an announced comprehensive inspection of the Downham Family Medical Practice on 30 June 2022. The report was published on 24 November 2022 and was rated as ‘Requires Improvement’ in the ‘Safe’, Effective’ and ‘Well-led’ domains.

ICB officers met with the practice on 1 March 2023 to discuss the concerns highlighted in the CQC report. At that meeting it was agreed that there would be ongoing support provided to the practice by the Medicines Optimisation team, the Quality team and the Primary Care team as and when requested by the practice.

Officers’ Decision

The borough Team and relevant subject matter experts considered the report and met with the practice to determine what actions had already been taken by the practice. The practice gave assurances that efforts had been made to address all areas in the report and robust systems were already in place to ensure patient care is both safe and effective.

The borough team decided that no formal contractual action will be taken in this case and the practice will be asked to develop a timed action plan which will be monitored.

The Group will receive regular update reports from the borough team in relation to the progress being made by the practice to develop their action plan and implement any changes.

6. Changes to the 2023/24 GP Contract

One of the big changes in the PCN DES this year is the introduction of the unconditional **national Capacity and Access Support payment** which previously had to be earned through the achievement of the Investment and Impact Fund (IIF) targets.

The IIF for 2023/24 has been redesigned to focus on a small number of key national clinical priorities, while at the same time providing general practice and Primary Care Networks (PCNs) with the time, funding, and flexibility to ensure patients can access good and timely care.

The Capacity and Access Support payment is £2.765 (adjusted population) and will be paid monthly and equates to 70% of IIF allocation.

The **Local Capacity and Access Improvement payment** is a maximum of £1.185 (adjusted population) and equates to 30% IIF allocation.

The Local Capacity and Access Improvement payment will be made in respect of improvements made in the following three key areas:

- Patient experience of contact
- Ease of access and demand management
- Accuracy of recording in appointment books.

The detail on the ambitions to improve primary care access will be detailed in the soon to be published Delivery Plan for Recovering Access to Primary Care.

7. Lewisham Structured GP Practice Visit Summary Report

The Group received a summary update on the recently concluded GP practice visits carried out by the primary care team.

The main purpose of the practice visits was;

- To meet in person with practice teams and get a better feel for how things are on the ‘ground’.
- To improve engagement with practices and understand the critical challenges facing General Practice.
- To understand the current resilience, stability and quality position of practices.
- To support quality improvement and ensure a systematic process to manage variation across a range of key clinical and non-clinical areas.
- Support practices to develop and improve ways of working and highlight areas of good practice.

A detailed copy of the report can be found in Appendix A - Lewisham Structured GP Practice Visit Summary Report.

South East London
Integrated Care System

Lewisham Structured GP Practice Visit Summary Report

April 2023

South East London Integrated Care System

Report Objectives

NHS South East London

The purpose of this report is to provide a summary update on the recently concluded GP practice visits carried out by the primary care team.

The report sets out the primary care team approach to quality improvement and how we intend to help identify vulnerable GP Practices and support resilience.

The Primary Care Group is asked to note the report.

The Process

All practices were contacted and asked to choose a suitable date for the visit.

Practices were requested to have as a minimum one GP and the Practice Manager present at meetings.

It was acknowledged that some practices might benefit from the visit being held across a group of practices - in such cases particular arrangements were agreed.

All 27 practices were visited between 17 October 2022 and 21 March 2023.

Purpose of the visits

a) An opportunity to meet f2f with practice teams and get a better feel for how things are on the 'ground'.

b) To improve engagement with practices and understand the important issues facing General Practice.

c) To understand the current resilience, stability and quality position of individual practices.

d) To support quality improvement and ensure a systematic process to manage variation across a range of key clinical and non-clinical areas.

e) Support practices to develop and improve ways of working and highlight areas of good practice.

Key Areas of Focus

To ensure some consistency, officers focused on key areas for discussion:

- **Practice Workforce**
- **Practice Estates**
- **How the practice is functioning within the PCN**
- **Patient Access**
- **Enhanced Access**
- **Digital Offers - AskFirst, eConsult, Patient Access etc.**
- **ICT - Laptops, Apex Edenbridge, DXS**
- **Call and recall processes for vaccinations, SMI PHCs, LDHCs etc.**
- **Transformation work/projects the practice is working on**
- **Miscellaneous.**

Workforce

South East London Integrated Care System

A mixed response from practices:

- Overall, it is very difficult to recruit staff into any position.
- Need a robust ICS workforce plan around recruitment and retention.
- Practices losing GP sessions and struggling to meet patient need.
- There is some benefit in the Additional Roles Recruitment Scheme.
- The ARRS needs a wrap-around support package as not as straightforward as people assume and staff feel isolated.
- Need focused patient facing communications and engagement to educate them on ARRS, using social media, patient information system in the waiting rooms, websites etc.

Workforce - What Practices Said!

One practices has enough GPs, including trainees and Ukrainian GPs who are working towards their PLAB. Enough nursing capacity.

Practice is struggling with GPs and has lost 17 GP sessions.

Practice is down 4 GPs equivalent to 15 sessions per week in the last 3 months.

Full capacity of practice staff but raises the issue of adequate space.

Workforce is well balanced.

South East London Integrated Care System

Estates

NHS South East London

- A majority of practices are struggling with space - clinical and non-clinical.
- Space needed for the ARRS and back office functions.
- Practices constantly looking for sources of funding to apply for in order to create additional space.
- The ongoing patient record digitisation will help create some additional space for some practices.
- Practices have different landlords (NHSPS, LGT, LBL, partner owned), and the situation with leases can affect what alterations can be made to properties.
- Major estates developments across the borough (Sydenham Green Health Centre, Marvels Lane, The Jenner Health Centre, The Waldron Health Centre etc.)

PCN Development Working

- This is working relatively well for most practices.
- The pace of development of PCNs varies across the borough and relationships are being developed gradually.
- The various practices and PCN relationships are developing at varying rates/pace.
- Practices are building on the great work during the pandemic where they very quickly set up the successful PCN covid-19 vaccination sites.
- Enhanced Access is the next big thing for PCNs – this is working relatively well in some PCNs. Main issue is ICT and practice to practice system interoperability.
- There is variation across PCNs in the efficient use of the ARRS.

South East London Integrated Care System

Access

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- All practices are experiencing very high demand.
- There is no “one size fits all” approach to access.
- Practices delivering a mixture of face to face and virtual appointments, with a high proportion of face to face appointments (reception areas were busy).
- Practices employing a range of online consultation tools to improve access.
- Most practices using Cloud Based Telephony to improve access.
- Nearly all practices have highly usable and accessible websites (level 3).
- Practices have used the access QOF Quality Improvement module to develop plans around how to improve access.

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Access

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Variety in tools:

Surgery Connect, WhatsApp BOT, AskFirst, AccuRx, eConsult,

1x practice utilising QOF QI to work on DNAs with nurse support.

All children and elderly seen on the day f2f. Then a pool of others

Practices are pushing to see vulnerable/mental health patients especially if they have not been seen in a while.

Have a call board system to monitor incoming calls. All children and elderly seen on the day f2f. Then a pool of others.

ICT

- Majority of practices expressed concern over IT. Computers are very slow to start up (this takes up valuable time) and adds more pressure to the system, also impacts on service quality and provision.
- Issues with HSCN connection and WiFi in some buildings.
- Practices advised to report issues through the appropriate channels.
- Practices using a range of IT tools to enhance patient care e.g. Apex Edenbridge, AccuRx, DXS and iPlato.
- There is an ongoing SEL GPIT Refresh Programme which should help resolve some of the issues.

Call & Recall Processes

- All practices have good call & recall systems in place
- Practices with difficult to engage populations struggle with high DNA rates.
- Some practices plan home visits for childhood immunisation to increase uptake.
- Planned care teams used for call/recall.
- Some practices making good use of care coordinators for call/recall.
- Low uptake of childhood immunisations and other vaccines has been an issue across a majority of practices.

Innovation

- One practice is using overseas PLAB doctors to support working practice including document management.
- Use of planned care team to carry out call/recall for LD and SMI PHCs.
- Practice developed the Doctaly Assist Reception flow with Doctaly (WhatsApp BOT).
- Surgery Connect
- The Lewisham Home Visiting service was appreciated by all practices
- One practice is running virtual group consultation sessions for back pain/paediatricians/mens health).

Emerging Themes (1)

The themes emerging from the visits were the same for most practices:

- Transfer of secondary care workload: There were concerns around the inappropriate workload transfer and/or unjustified passing back of referrals from secondary care to primary care which was adding unnecessary strain on practice workforce.
- There was a need to improve the interface and communication between primary and secondary care
- Increasing numbers of practice staff abused by patients.
- Training opportunities were identified – some of these will be looked into by the local Training hub.
- Radiology issues.
- Pathology issues.

South East London Integrated Care System

Emerging Themes (2)

NHS South East London

- Restrictive physical space of some buildings.
- Issues with recruitment & retention of staff.
- The visits identified that practices remain under continued pressure, have increased patient demand and not enough capacity to match.
- Issues with ADHD services and referrals locally. The lack of support is a national issue with no immediate solution.
- Need for a gender dysphoria clinic (possibly with a GPWSI involved). One practice has over 80 patients and is struggling to cope.

South East London Integrated Care System

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Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 10
Enclosure 8

Title:	**Risk Register**
Meeting Date:	Thursday 18th May 2023
Author:	Cordelia Hughes
Executive Lead:	Ceri Jacob

Purpose of paper:	The purpose of the paper is to provide an update to the Lewisham Health & Care Partners Strategic Board regarding the Lewisham Risk Register.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

1.Current Status and Direction of Risk

Risk (header only)	Direction of Risk
448. Savings Target - Identification & delivery of savings	⟷
449. Absorption of cost pressures	⟷
334. Inability to deliver revised Mental Health Long Term Plan trajectories.	⟷
335. Financial and staff resource risk in 2023/24 of high-cost packages through transition. This is a recurring annual risk.	⟷
338. New and expanding primary care workforce supported through the PCN DES ARRS funding is not optimised.	**CLOSED**
347. Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.	⟷
377. All Initial accommodation centres including Pentland House and Clear Springs Hotel have high levels of vulnerable Adults & Children and Young People asylum seekers residents.	⟷
359. Failure to deliver on statutory timescales for completion of EHCP health assessments	⟷
360. Failure to deliver on statutory timescales for completion of ASD health assessments.	⟷

Key - Direction of Risk

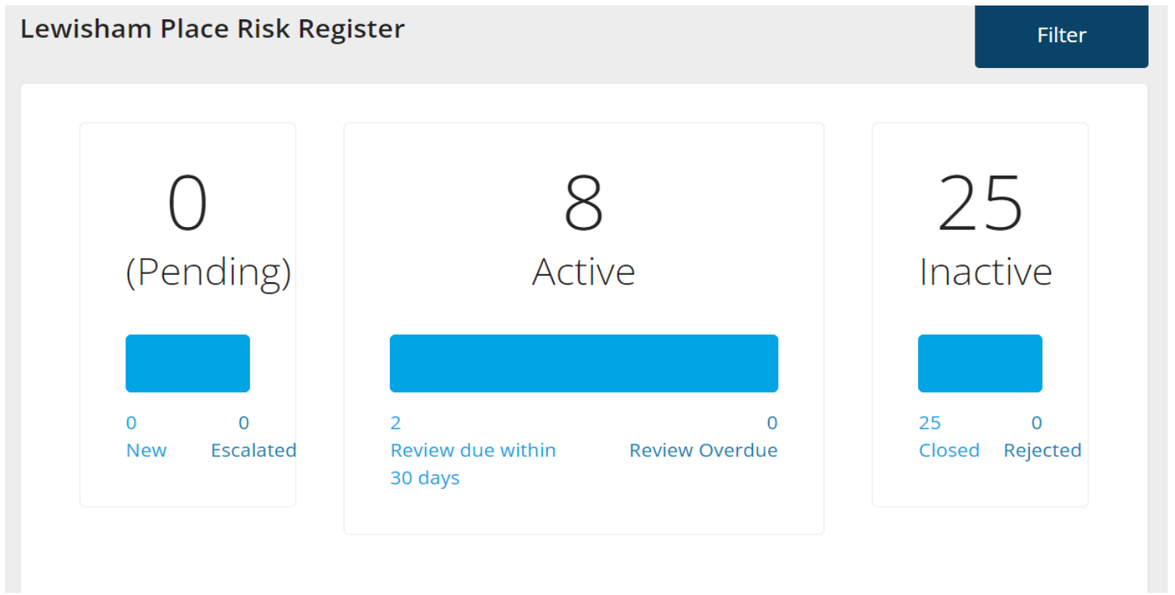
↓ Risk has become worse.

⟷ Risk has stayed the same.

↑ Risk is improving.

	2.Process The Assurance Team requested that all risk owners' re-word their risks for the Board meeting on 17th May providing further detail into the impact and implications for which the Board need to consider. **3.New Risks** No new risks to report on. **4.Key Themes:** The key themes from the risk register relate to finance/budgetary impact and quality of care around successful delivery of services.			
Potential Conflicts of Interest	**N/a**			
Relevant to the following Boroughs	**Bexley**		**Bromley**	
	Greenwich		**Lambeth**	
	Lewisham	✓	**Southwark**	
	Equality Impact	Yes		
	Financial Impact	Yes		
Other Engagement	Public Engagement	Yes		
	Other Committee Discussion/ Engagement	The Risk Register is discussed at the monthly Place Executive Group (PEG) meeting and bimonthly at Lewisham SMT/Extended SMT. The Risk Forum has been formalised and will operate with representatives from all ICB directorates and LCPs, and the ICB's risk specialists such as the Assurance Team. It will be chaired by the Chief of Staff with the aim of ensuring a consistent approach to the identification and management of risk across the ICB. It will also support the smooth escalation of risks from LCP to SEL levels and vice-versa. In addition, changes have been implemented to the risk management framework which summarises the key changes proposed to the ICB's risk management framework for 2023/24. The Board will sign off the risk appetite statement at May's meeting.		
Recommendation:	The Lewisham Health & Care Partners Strategic Board are asked to note the upcoming changes to the risk process across SEL. The ICB Board will be taking more of an interest in the risk process as mentioned above for corporate and borough risks going forward and have asked for all high-level red risks to be reviewed at the Planning and Finance Committee along with the BAF.			

Risk Register Summary (in accordance with Datix)



Likelihood	Consequence				
	Negligible	Minor	Moderate	Major	Catastrophic
Almost Certain	0	0	0	0	0
Likely	0	0	1	0	0
Possible	0	2	3	1	0
Unlikely	0	0	1	0	0
Rare	0	0	0	0	0

Ref	Risk Title	Risk	Inherent Risk (L x I)	Residual Risk (L x I)	Target Risk (L x I)	Direction of Risk	Risk sponsor	Risk owner	Ongoing controls	Assurances	Impact of ongoing controls	Control gaps
									Finance			
448	**Savings Target - Identification & delivery of savings**	The ICB - Lewisham has a minimum start savings target of 4% for 2023/24 currently estimated at c. £3.6m. Savings schemes to deliver this target have not yet been fully identified. There is a risk the delegated borough budget will be exceeded if sufficient savings cannot be identified and delivered in the financial year 2023/24.	3x2=6	3x2=6	2x2=4	↔	Ceri Jacob	Michael Cunningham	1) A careful and detailed budget setting process has been conducted to identify target savings. 2) Sound budgetary control will continue to be applied to ensure expenditure trends are monitored, and any deviations from budget are identified at an early stage. 3) The ICB's Planning and Finance Committee receives monthly reports showing the status of savings schemes against target. 4) The Lewisham borough SMT review and discuss savings identification and delivery on a regular basis.	• Monthly budget meetings. • Monthly financial closedown process. • Monthly financial reports for ICS and external reporting. • Review financial position at CHC Executive meeting. • Lewisham Senior Management Team Review.	The impacts of controls will be assessed in the new financial year however risk will remain the same but will be reviewed in new financial year.	1. There are no currently identified control gaps.
449	**Absorption of cost pressures**	The ICB Lewisham is facing material cost pressures in 2023/24 associated with the potentially continuing impact of CATM/NCSO drug pricing on prescribing budgets, and the impact of significant increases in Any Qualified Provider (AQP) rates on continuing healthcare budgets. There is a risk the delegated borough budget will be exceeded if these cost pressures cannot be fully mitigated.	3x2=6	3x2=6	2x2=4	↔	Ceri Jacob	Michael Cunningham	1) A careful and detailed budget setting process has been conducted to identify cost pressures. 2) Sound budgetary control will continue to be applied to ensure expenditure trends are monitored, and any deviations from budget are identified at an early stage. 3) The ICB's Planning and Finance Committee receives monthly reports showing the financial position of the borough including commentary on cost pressures. 4) The Lewisham borough SMT review and discuss cost pressures and mitigations on a regular basis.	• Monthly budget meetings. • Monthly financial closedown process. • Monthly financial reports for ICS and external reporting. • Implement efficiency plans to maximise part year effect on expenditure run rates in 2022/23. • Review of prescribing position at Planning and Delivery Group. • Review of individual budget lines continues to be undertaken by Medicine Mgt team and finance and remedial action taken where possible.	The impacts of controls will be assessed in light of budgetary positions in 2023/24.	1. There are no currently identified control gaps.
									Commissioning			
334	**Inability to deliver revised Mental Health Long Term Plan trajectories**	There is a risk that mental health Long Term Plan trajectories cannot be met. This is caused by limited access, increased demand, insufficient workforce and insufficient digital solutions to meet a proportion of local demand. This will impact on the ICB's ability to meet statutory requirements and health inequalities.	3x3=9	2x3=6	3x2=6	↔	Kenny Gregory	Natalie Sutherland	1.Outcomes framework measure for Community Mental Health Transformation (CMHS) being produced across SEL ICB., 2.Place based assurance framework being updated to reflect new interventions and monitored through all-age MH Alliance Leadership Board from April 2023., 3.Understand the need of people not being admitted after attending A&E to understand what interventions could be accessed instead of A&E, and what the gaps in the system are. 4.Continue to implement the CMHS transformation plan and local at priorities for year 3 (2023/24).	Alliance data/performance review process to be established to provide local oversight and improvement actions.	Improvement against KPIs and better collaboration and integration across services (in line with provider alliance ambition).	1.Mitigation plans formulated for Red rated measures i.e. Physical Health Checks for SMI., 2.Increased scrutiny on recruitment process for CMHS workforce expansion at both place and SEL, 3. Re/establish alliance sub-groups for improved oversight and ownership i.e. Crisis Collaborative, assurance and outcomes forum to review system dashboard and other key system assurance processes
335	**Financial and staff resource risk in 2023/24 of high cost packages through transition. This is a recurring annual risk.**	Financial and staff resource risk in 2023/24 of high cost packages through transition. This is a recurring annual risk. Financial risk in 2023/24 of new high cost LD packages through transition i.e. young people with significant health needs requiring double handed and overnight waking care or with behaviour which is significant challenging in children's services. Also, the impact of 22/23 eligible patients leaving day schools in 23/24 which will represent (a) additional day time care costs previously met by education, or (b) 'hotel and support' costs additional to the costs of education if the person is placed in a residential college or (c) costs relating to full time residential care. This risk is SEL wide. These risks are reflected both in financial terms with cost of care potentially being in the hundreds of thousands of pounds a year. The complexity of health need also represents an increase in nurse time on complex case management.	4x4=16	4x3=12	4x3=12	↔	Kenny Gregory	Heather Hughes	Head of CHC is attending quarterly Transition panels from a CHC perspective but will also flag early warning signs for joint funding requests. Regular comms from (1) from the CYP DSR meeting to the adult DSR meeting and (2) from the CYP CHC lead re children already joint funded and where likely demand for joint funding in adulthood is predictable. Quarterly flagging of transition you people not alerted through either process and a RCA of why those young people were not flagged to the adult CHC Team. Quarterly review of ongoing requirement for joint funding funding of packages previously agreed.	Compliance with the Joint Funding Protocol. Monthly reporting at the Joint Commissioning Finance Group.	Mitigation of financial risk to Lewisham ICS/ ICB. Strengthened projection of future financial risk. Improved robustness and visibility of transitioning plans.	1. Quarterly projection of when younger SEN adults will leave day education and the potential impact on CHC budget to CHC Exec. (High cost) Joint Funded packages to be included as a standing agenda item at monthly Integrated Commission Budget Monitoring.
									Primary Care			
347	**Initial Health Assessments not completed for Children Looked After (CLA) within the 20 working days.**	There is a risk that Initial Health Assessments (IHAs) are not completed for Children Looked After (CLA) within the 20 working days. This is caused by a delay in timely notifications by Children's Social Care. This results in a delay in identifying the health needs for CLA and can impact the ICB's ability to meet statutory requirements and can lead to health risks for Children if not seen in a timely manner.	4x3=12	3x3=9	3x1 =3	↔	Ceri Jacob	Christiane Nitsch	1.KPIs and data set in place., 2.The Designated Doctor and medical colleagues undertake all the IHAs, 3.No named nurse for CLA,role is being covered once a week on interim by Specialist Nurse for Care Leavers. Recruitment ongoing. 4.Currently quarterly Steering Group has been set up (first meeting in Jan 23) - monthly meeting previously in place to where discussion took place around Social Workers completing forms for IHAs, 5. Team have developed SOP for process and discussion for training package, 6.Designated Professionals are part of the Partnership CLA Steering Group for service improvement, 7.Director of Quality and designated professionals together with Commissioners will review service specification and requirements in 6 weekly meetings, 8.Benchmarking tool completed and shared with Commissioners and Directors (Quality and Place DRs), 9. The Steering Group set up by local authority and health will also look at initial health assessments and out of Borough placed children	Statutory guidance in place. IHA reviews are being completed but assessments are delayed as forms are not being completed in a timely manner. Currently D Dr and adoption medical officer as well as other medics are completing IHAs in the interim. Also, on the workplace for CLA steering group.	IHA reviews are being completed but assessments are delayed as forms are not being completed in a timely manner. Currently D Dr and adoption medical officer as well as other medics are completing IHAs in the interim. Also, on the workplace for CLA steering group.	1. Gap in service provision. Escalated to Lewisham Place Executive Director.
377	**All Initial accommodation centres including Pentland House and Clear Springs Hotel have high levels of vulnerable Adults & Children and Young People asylum seekers residents.**	Initial Accommodation Centres:- Pentland House and Clear Springs have high levels of vulnerable adults, children and young people (asylum seekers) and to date no safeguarding Adult referrals into MASH, ATHENA or PREVENT. Impact: data implies that referral pathways are not being followed and not concordance with Lewisham local safeguarding referral pathway for adults. Risk is; large volume of adults, children young people deemed to be at risk..	3x3=9	3x3=9	1x1=1	↔	Ceri Jacob	Fiona Mitchell	1.Escalated to Helen Edwards (Head Safeguarding), 2.Susie Barker (Director of Quality), 3.Fergus Downie (Housing and Refugee Resettlement Manager) and LSAB. 4.Meetings arranged with Fergus Downie and Idris Gobir (Clear Springs Ready Homes Ltd) monthly to discuss embedding referral pathways into organisations. 5. The Home Office commissions Clear Springs Ready Homes Ltd to support this provision who commission Stay Belvedere Hotels Ltd to support initial accommodation centres in Lewisham. 5. All pathway information and safeguarding resources for training has been forwarded to Clear Springs Ready Homes Ltd,however no engagement. UPDATE:- 13/04 - Pentland House has engaged with some safeguarding training provision. Meetings held with Director of Asylum Home Office and others in an attempt to reach a solution. Joint letter forwarded to Home Office from Lewisham Safeguarding Adults Board (LSAB) and Lewisham Safeguarding Children's Partnership (LCSP), outlining concerns. Another meeting is scheduled in April 2023 with Home Office, Clear Springs Ready Homes Ltd, Lewisham ICB and Adults and Child MASH.	As outlined in controls.	Embedding safeguarding into Pentland House (capability, knowledge and referral).	1. Initial accommodation centres not commissioned by ICB but Home Office. ICH has no contractual service agreement. However, primary care resources to centre supported by Lewisham ICB.
									Children and Young People			
359	**Failure to deliver on statutory timescales for completion of EHCP health assessments**	Failure to deliver on statutory timescales for completion of Education Health Care Plan health assessments (EHCP). This is being driven by challenges in recruitment and capacity of community paediatricians and therapists. Significant increase in families requesting Special Educational Needs Assessment (SENA) Lewisham has one of the highest numbers for requests for Special Educational Needs Assessment. This will impact on the ICB's ability to meet statutory timescales for completion of EHCP assessments as it does not have the capacity to carry them out within the 22 weeks deadline.	4x4=16	3x4=12	2x3=6	↔	Sara Rahman	Paul Creech	1.GPs are being rotated from Primary Care into community paediatrics to support some activity and free time for statutory CMPS work., 2. Paediatric Nurse in place to support medical work which does not require a Paediatrician., 3. Trust are using American recruitment agent to recruit internationally. So far response has been limited but LGT are revieing the applications., 4.Therapists continue to work weekends to clear the back-log of reviews., 5. Monthly Recovery meetings held with Head of Integrated SEN & LGT Manager to review EHCNA numbers. Detailed performance data identifies delays for assessments by teams to help determine areas to improve., 6.The DCO reviewing the joint working arrangements between health and SEND to streamline the process. EHCNA requests are triaged to reduce the number of new assessments necessary	Monitoring ongoing to gauge impacts of controls. New Head of Integrated SEND is now in place and attending monitoring meetings.	Increase in EHCPs health assessments being completed on time.	1. Families not attending appointments., 2. Appointments changed., 3. Delayed paperwork (service user end)., 4. Brexit has led to loss of staffing (therapists)., 5. COVID has also had an impact on staffing levels., 6. Increase in EHCP requests
360	**Failure to deliver on statutory timescales for completion of ASD health assessments.**	Failure to deliver on statutory timescales for completion of Autism Spectrum Disorder health assessments. There is an 18 month waiting list. This is being driven by challenges in recruitment of community paediatricians. Impact on ICB - referral to treatment timescale, reputational risk, financial risk - ICB to pay for private assessments.	4x3=12	3x3=9	2x3=6	↔	Sara Rahman	Paul Creech	1.Quarterly review of ASD assessments with LCG, 2.SEND and the DCO., 3. GPs are being rotated from Primary Care into community paediatrics to free up capacity for ADOS assessments. Paediatric Nurse in place to support medical work, 4. International recruitment ongoing (x2 Paediatricians recruited). New adverts in place to attract more applications. being carefully considered to inspire applicants	Monitoring ongoing to gauge impacts of controls via Quarterly monitoring meetings.	Reduction in waiting times for assessments.	1. Availability of partners to undertake joint ASD assessments. COVID has increased childhood anxiety in some kids.

Key - Direction of Risk

↓ Risk has become worse.

↔ Risk has stayed the same

↑ Risk is improving

South East London Integrated Care System

NHS South East London

Lewisham Local Care Partners Strategic Board
Cover Sheet

Item 11
Enclosure 9

Title:	**Month 12 Finance Report**
Meeting Date:	**18th May 2023**
Author:	Michael Cunningham
Executive Lead:	Ceri Jacob

Purpose of paper:	The purpose of the paper is to update the Lewisham Health & Care Partners Strategic Board on the financial position of the ICB at Month 12.	Update / Information	✓
		Discussion	✓
		Decision	

Summary of main points:

As per the national NHS year-end timetable, the ICB was required to submit its draft annual accounts and supporting documentation by 9am on 27 April. This high-level report summarises the overall ICB financial position for the 9 months ending 31 March 2023.

The final ICB financial allocation for the Month 4 to 12 period was **£3,121,225k.** As at Month 12, the ICB delivered a **£16k surplus** against its total allocation.

As previously reported, the key financial pressure within the ICB financial position related to the **prescribing** budget, which was **£12,687k** overspent. Prescribing data is received two months in arrears, so the latest information we have relates to January 2023. An estimate for prescribing expenditure for February and March has been accrued into the ICB financial position. The overspend is driven by both activity and price pressures. Activity (based upon the number of items prescribed) for the first 10 months of 2022/23 compared to the same period for last year, **has increased by circa 3.4%.** The ICB has also been impacted by increases in price driven by issues outside of its direct control – including the short supply of specific drugs and the price of Category M drugs which are nationally set. All ICBs have been similarly impacted.

In reporting this Month 12 position, we are pleased to report that the ICB has **delivered all of its financial duties**:

- Surplus positions against its overall Resource Limit **(£16k)** and Running Cost Allowance **(£748k);**
- Delivering all targets under the **Better Practice Payments code**;
- Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
- Delivered the **month-end cash position**, well within the target cash balance.

	The draft ICB accounts are now subject to the usual external audit process. Deadline for submitting the audited accounts is 30 June. The ICB in Lewisham reported an overspend of £474k (less than 0.4% of budget) on a budget for the month 4 to 12 period of £119,675k. This deviated from the month 11 forecast outturn for the year by £548k due to the late presentation of some unexpected costs. Without these a normalised reporting position would have shown an underspend of £35k. Details are provided in this report.				
Potential Conflicts of Interest	**Not Applicable**				
Relevant to the following Boroughs	**Bexley**		**Bromley**		
	Greenwich		**Lambeth**		
	Lewisham	✓	**Southwark**		
	Equality Impact	Not applicable			
	Financial Impact	The paper sets out the ICB financial position as at Month 12			
Other Engagement	Public Engagement	Not applicable			
	Other Committee Discussion/ Engagement	The ICB Finance Report Appendix A is a standing item at the ICB Planning and Finance Committee.			
Recommendation:	The Lewisham Health & Care Partners Strategic Board is asked to **note** the ICB financial position as at Month 12.				

NHS
South East London

Lewisham Local Care Partners

Strategic Board - Finance Report

Month 12 2022/23

Overall Lewisham Position

	Outturn Budget 2022/23	Outturn Actual 2022/23	Outturn Variance 2022/23	Forecast Outturn Variance 2022/23 - As At Month 11	Normalised Outturn 2022/23	Normalised Outturn Variance 2022/23
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Acute Services	1,469	1,593	(124)	(16)	1,477	(8)
Community Health Services	21,756	21,338	418	968	21,222	535
Mental Health Services	4,751	4,642	109	-	4,642	109
Continuing Care Services	15,373	15,590	(217)	(647)	15,590	(217)
Prescribing	28,812	29,930	(1,118)	(835)	29,654	(841)
Other Primary Care Services	1,357	1,372	(16)	76	1,372	(16)
Other Programme Services	248	143	105	134	143	105
Programme wide projects	-	-	-	-		-
Delegated Primary Care Services	42,640	42,640	-	-	42,640	-
Corporate Budgets	3,268	2,900	368	393	2,900	368
Total FOT	**119,675**	**120,149**	**(474)**	**74**	**119,640**	**35**

- At month 12, the borough is overall reporting an overspend of £474k (0.4% of budget) for the full year 2022/23. This reflects an adverse movement of £548k from the month 11 forecast outturn.
- This adverse movement includes three main elements; 1) further worsening of the prescribing over spend compared to month 11 forecast £277k, 2) increased activity through urgent care centres £116k and 3) non recurrent community health service charges associated with the prior year £116k presenting in month 12.
- The presentation of these costs late in month 12 meant it was not possible to mitigate in year without risk of reporting a significant underspend, although in circumstances where these costs had been identified earlier, these would have been mitigated from other budgets within the delegated budget.
- The normalised position had these three cost elements not presented at month 12 is a £35k underspend.
- The borough achieved its savings target for the year of £2.6m, with the exception of prescribing showing a small under achievement of £29k.

NHS
South East London

Appendix A

SEL ICB Finance Report

Month 12 2022/23

Contents

NHS
South East London

1. Executive Summary

NHS South East London

- As per the national NHS year-end timetable, the ICB was required to submit its draft annual accounts and supporting documentation by 9am on 27 April. This high-level report summarises the overall ICB financial position for the 9 months ending 31 March 2023. The financial position of the Places will be reported through their local governance.

- The final ICB financial allocation for the Month 4 to 12 period was **£3,121,225k.** As at Month 12, the ICB delivered a **£16k surplus** against its total allocation.

- As previously reported, the key financial pressure within the ICB financial position related to the **prescribing** budget, which was **£12,687k** overspent. Prescribing data is received two months in arrears, so the latest information we have relates to January 2023. An estimate for prescribing expenditure for February and March has been accrued into the ICB financial position. The overspend is driven by both activity and price pressures. Activity (based upon the number of items prescribed) for the first 10 months of 2022/23 compared to the same period for last year, **has increased by circa 3.4%.** The ICB has also been impacted by increases in price driven by issues outside of its direct control – including the short supply of specific drugs and the price of Category M drugs which are nationally set. All ICBs have been similarly impacted.

- In reporting this Month 12 position, we are pleased to report that the ICB has **delivered all of its financial duties**:
  - Surplus positions against its overall Resource Limit **(£16k)** and Running Cost Allowance **(£748k);**
  - Delivering all targets under the **Better Practice Payments code**;
  - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
  - Delivered the **month-end cash position**, well within the target cash balance.

- The draft ICB accounts are now subject to the usual external audit process. Deadline for submitting the audited accounts is 30 June.

2. Key Financial Performance Indicators

NHS South East London

	Month 12			Rating
	Target	Actual	Under/(Over) Spend	
	£'000s	£'000s	£'000	
Expenditure not to exceed income	3,157,551	3,157,535	16	
Operating Under Resource Revenue Limit	3,121,225	3,121,209	16	
Not to exceed Running Cost Allowance	30,569	29,821	748	
Month End Cash Position	4,338	281		
Operating under Capital Resource Limit	0	0		
95% of NHS creditor payments within 30 days	95.00%	99.97%		
95% of non-NHS creditor payments within 30 days	95.00%	98.10%		
Mental Health Investment Standard (Annual)	404,710	405,460		

- The above table sets out the ICB's performance against its key financial duties as at Month 12. We are pleased to confirm that all financial duties have been delivered for the 9 month period to 31 March 2023.
- The ICB delivered a **£16k** surplus against its total Revenue Resource Limit (£3,121.2m) and a **£748k** surplus against its Running Cost Allowance (£30.5m).
- As reported in previous finance reports, the key area of financial pressure related to the prescribing budget. Year-end prescribing expenditure was £179.2m, generating an overspend of £12.7m. This overspend was mitigated by underspends in other ICB service areas – including acute, community, mental health and corporate budgets.
- The ICB has delivered its financial duties with respect to its cash limit (final cash balance was **£281k**, well within the target), paying invoices in a timely manner (both for NHS and Non-NHS creditors, the actual performance exceeded the **95%** target) and expenditure against the Mental Health Investment Standard (MHIS) exceeded the target by **£750k –** as set out in Appendix 1.

3. Debtors and Creditors Position

NHS South East London

- At the end of the financial year, the ICB had total debtors of £9.457m, 96.3% of which were less than three months old. The ICB has continued to increase its focus on debtors and as consequence the value of invoices outstanding continues to decrease month on month. As at 31 March 2023, the largest balances outstanding are with NHS England (£3.5m) and £4.1m across five London Boroughs. There are no disputes in relation to these outstanding invoices.
- As at year-end, total aged creditors were £49.276m. The overall level of creditors increased by 13% in-month as a result of a rise in billing by local organisations. Largest balances of invoices outstanding included £22.0m with Local Authorities (Lewisham £9.7m, Lambeth £5.5m, Greenwich £3.0m, Bromley £2.0m, Southwark £1.5m and Bexley £0.8m); £5.2m with Bromley Healthcare CIC, £1.8m with GSTT, £1.2m with SLAM and £1.0m with NEL ICB. Invoices are being validated and some of these have already been paid in April.

Aged debtors

Customer Group	Aged 0-30 days £000	Aged 1-30 days £000	Aged 31-60 days £000	Aged 61-90 days £000	Aged 91-120 days £000	Aged 121+ days £000	Total £000
NHS	1,167	871	2,203	4	91	92	4,428
Non-NHS	3,393	836	361	273	34	132	5,029
Total	**4,560**	**1,707**	**2,564**	**277**	**125**	**224**	**9,457**

Aged creditors

Customer Group	Aged 0-30 days	Aged 31-60 days	Aged 61-90 days	Aged 91-120 days	Aged 121-180 days	Aged 181+ days	Total £000
NHS	3,840	996	93	1,213	525	70	6,737
Non-NHS	32,075	8,345	752	521	566	280	42,539
Total	**35,915**	**9,341**	**845**	**1,734**	**1,091**	**350**	**49,276**

4. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at Month 12, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing expenditure) was **£3,854.9m**.

- As at month 12, the ICB had drawn down 99.6% of the available cash for the year. In March, there was a £62,140k supplementary draw down that the ICB utilised. The cash key performance indicator (KPI) was achieved in all months for this year, showing continued successful management of the cash position by the ICB's Finance team to achieve the target cash balance. The final cash balance at the end of Month 12 was **£281k**, well within the target set by NHSE.

Annual Cash Drawdown Requirement for 2022/23	2022/23 AP12 - MAR 23	2022/23 AP11 - FEB 23	2022/23 Month on month movement
	£000s	£000s	£000s
ICB ACDR (M4-12)	3,120,178	3,071,213	48,965
CCG ACDR (M1-3)	964,003	964,003	0
Capital allocation			
Less:			
Prescription Pricing Authority	(225,909)	(206,713)	(19,196)
Other Central / BSA payments-HOT	(2,504)	(2,268)	(236)
Pension uplift 6.3%	(2,038)	(2,038)	0
PCSE POD charges adjustments	1,246	1,041	205
Remaining Cash limit	**3,854,976**	**3,825,237**	**29,739**

Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of CCG cash requirement %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
CCG							
Apr-22	290,000	27,000	317,000	34.93%	3,625	2,830	0.98%
May-22	292,000	0	609,000	67.10%	3,650	1,254	0.43%
Jun-22	287,000	0	896,000	98.72%	3,588	856	0.30%
ICB							
Jul-22	295,000	15,000	310,000	10.48%	3,688	253	0.09%
Aug-22	310,000	0	620,000	20.95%	3,875	197	0.06%
Sep-22	335,000	0	955,000	32.27%	4,188	690	0.21%
Oct-22	305,000	12,000	1,272,000	44.10%	3,813	1,918	0.63%
Nov-22	317,000	0	1,589,000	99.62%	3,963	919	0.29%
Dec-22	302,000	0	1,891,000	65.70%	3,775	185	0.06%
Jan-23	320,000	0	2,211,000	76.50%	4,000	509	0.16%
Feb-23	327,000	0	2,538,000	87.30%	4,088	1,761	0.54%
Mar-23	347,000	62,140	2,947,140	99.60%	4,338	281	0.08%
	3,727,000	**116,140**					

South East London Integrated Care System

Mental Health Investment Standard (MHIS) – Month 12 update

28 April 2023

MENTAL HEALTH INVESTMENT STANDARD (MHIS)

South East London Integrated Care System

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 21/22 outturn by a **minimum of the growth uplift of 5.52%**. This spend is subject to annual independent review.
- MHIS excludes:
  - Spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - Out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
  - Spend on SDF and other non recurrent allocations
- The MHIS target is measured for the financial year 2022/23 and therefore brings together the Q1 CCG 22/23 and the SEL ICB Q2-Q4 22/23 reported position
- Slide 3 summarises the SEL ICB reported month 12 position for the delivery of the Mental Health Investment Standard (MHIS). The ICB is reporting that it will deliver the target value of **£404,710k** with a forecast of **£405,460k (£750k over delivery).** Within this position, mental health prescribing is overspent by £1,609k (17.2%) with Cat M and No Cheaper Stock Obtainable (NCSO) drugs continuing to have a significant impact.
- Slide 4 sets out the position by ICB budgetary area.

Ongoing risks to delivery

- We continue to see an increase in spend in some boroughs on mental health, for example on S117 placements and LD placements which are not included in the MHIS definition.
- For ADHD, although it is outside the MHIS definition and is therefore excluded from this reported position, we are seeing a significant cost pressure resulting from increasing demand of approximately £1.6m. This cost is managed within the overall mental health budgets. Work is underway to understand and manage the drivers for this demand.
- Prescribing spend is volatile within and across years – in 21/22 we saw a reduction in spend on Sertraline of approximately £2m on a total plan of approximately £11.7m (17%). In 22/23, spend is increasing as described above.

SUMMARY MHIS POSITION M12

South East London Integrated Care System

Mental Health Spend By Category	Category Reference Number	Total Mental Health (per recategorisation exercise) Plan 31/03/2023 Year Ending £'000	Planned Spend - NHS Plan 31/03/2023 Year Ending £'000	Planned Spend Non-NHS Plan 31/03/2023 Year Ending £'000	Outturn Spend - NHS Actual 31/03/2023 YTD £'000	Outturn Spend - Non-NHS Actual 31/03/2023 YTD £'000	Outturn Spend - NHS Forecast 31/03/2023 Year Ending £'000	Outturn Spend - Total Forecast 31/03/2023 Year Ending £'000	Total Mental Health Variance 31/03/2023 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	*38,119*	34,851	3,465	38,316	35,004	3,398	38,402	(283)
Children & Young People's Eating Disorders	2	*2,773*	2,773	0	2,773	2,784	0	2,784	(11)
Perinatal Mental Health (Community)	3	*8,790*	8,790	0	8,790	8,814	0	8,814	(24)
Improved access to psychological therapies (adult and older adult)	4	*31,824*	25,345	5,921	31,266	25,432	6,268	31,700	124
A and E and Ward Liaison mental health services (adult and older adult)	5	*15,786*	15,786	0	15,786	16,084	0	16,084	(298)
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	*12,035*	12,035	0	12,035	12,072	0	12,072	(37)
Adult community-based mental health crisis care (adult and older adult)	7	*30,014*	29,553	361	29,914	29,620	328	29,948	66
Ambulance response services	8	*942*	942	0	942	943	0	943	(1)
Community A – community services that are not bed-based / not placements	9a	*108,044*	95,904	10,848	106,752	96,208	11,483	107,691	353
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	*21,850*	10,724	8,004	18,728	12,083	9,012	21,095	755
Mental Health Placements in Hospitals	20	*6,331*	5,820	602	6,422	5,830	688	6,518	(187)
Mental Health Act	10	*6,341*	0	5,643	5,643	0	5,826	5,826	515
SMI Physical health checks	11	*743*	522	39	561	798	26	824	(81)
Suicide Prevention	12	*0*	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	*107,601*	107,601	0	107,601	107,860	0	107,860	(259)
Adult and older adult acute mental health out of area placements	14	*3,631*	2,828	491	3,319	2,828	653	3,481	150
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		***394,824***	**353,474**	**35,374**	**388,848**	**356,360**	**37,682**	**394,042**	**782**
Mental health prescribing	16	*9,345*	0	10,954	10,954	0	10,954	10,954	(1,609)
Mental health in continuing care (CHC)	17	*541*	0	288	288	0	464	464	77
Sub-total - MHIS (inc CHC, Prescribing)		***404,710***	**353,474**	**46,616**	**400,090**	**356,360**	**49,100**	**405,460**	**(750)**
Learning Disabilities	18a	*0*	0	0	0	0	0	0	0
Autism	18b	*0*	0	0	0	0	0	0	0
Learning Disability & Autism - not separately identified	18c	*27,701*	11,432	15,059	26,491	11,466	16,540	28,006	(305)
Dementia	19	*13,852*	12,015	1,468	13,483	12,083	1,555	13,638	214
Sub-total - LD&A & Dementia (not included in MHIS)		***41,553***	**23,447**	**16,527**	**39,974**	**23,549**	**18,095**	**41,644**	**(91)**
Total - Mental Health Services		***446,263***	**376,921**	**63,143**	**440,064**	**379,909**	**67,195**	**447,104**	**(841)**

SUMMARY MHIS POSITION M12 – position by budgetary area

South East London Integrated Care System

Mental Health Investment Standard (MHIS) position by budgetary area

Mental Health Investment Standard Categories:	Category number	Month 12 Outturn position for the financial year ended 31 March 2023					
		Annual Plan	SEL Wide Spend	Borough Spend	All Other	Total	Variance (over)/under
		£000s	£000s	£000s	£000s	£000s	£000s
Children & Young People's Mental Health (excluding LD)	1	£38,119	£34,830	£3,572	£0	£38,402	-£283
Children & Young People's Eating Disorders	2	£2,773	£2,784	£0	£0	£2,784	-£11
Perinatal Mental Health (Community)	3	£8,790	£8,814	£0	£0	£8,814	-£24
Improved access to psychological therapies (adult and older adult)	4	£31,824	£25,438	£6,262	£0	£31,700	£124
A and E and Ward Liaison mental health services (adult and older adult)	5	£15,786	£16,084	£0	£0	£16,084	-£298
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	£12,035	£12,072	£0	£0	£12,072	-£37
Adult community-based mental health crisis care (adult and older adult)	7	£30,014	£29,620	£328	£0	£29,948	£66
Ambulance response services	8	£942	£943	£0	£0	£943	-£1
Community A – community services that are not bed-based / not placements	9a	£108,044	£96,228	£11,463	£0	£107,691	£353
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	£21,850	£12,069	£8,820	£205	£21,095	£755
Mental Health Placements in Hospitals	20	£6,331	£5,830	£688	£0	£6,518	-£187
Mental Health Act	10	£6,341	-£235	£6,062	£0	£5,826	£515
SMI Physical health checks	11	£743	£798	£26	£0	£824	-£81
Suicide Prevention	12	£0	£0	£0	£0	£0	£0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	£107,601	£107,860	£0	£0	£107,860	-£259
Adult and older adult acute mental health out of area placements	14	£3,631	£2,828	£653	£0	£3,481	£150
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**£394,824**	**£355,963**	**£37,874**	**£205**	**£394,042**	**£782**
Other Mental Health Services:							
Mental health prescribing	16	£9,345	£0	£0	£10,954	£10,954	-£1,609
Mental health continuing health care (CHC)	17	£541	£0	£0	£464	£464	£77
Sub-total - MHIS (inc. CHC and prescribing)		**£404,710**	**£355,963**	**£37,874**	**£11,623**	**£405,460**	**-£750**
Learning Disability	18a	£0	£0	£0	£0	£0	£0
Autism	18b	£0	£0	£0	£0	£0	£0
Learning Disability & Autism - not separately identified	18c	£27,701	£11,335	£13,395	£3,277	£28,006	-£305
Learning Disability & Autism (LD&A) (not included in MHIS) - total	**i**	**£27,701**	**£11,335**	**£13,395**	**£3,277**	**£28,006**	**-£305**
Dementia	19	£13,852	£12,080	£1,119	£439	£13,638	£215
Sub-total - LD&A & Dementia (not included in MHIS)		**£41,554**	**£23,415**	**£14,513**	**£3,716**	**£41,644**	**-£90**
Total Mental Health Spend - excludes ADHD		**£446,264**	**£379,377**	**£52,388**	**£15,339**	**£447,104**	**-£840**

- Approximately 85% of MHIS spend is delivered through SEL wide contracts, the majority of which is with Oxleas and SLaM
- Borough based budgets include voluntary sector contracts and cost per case placements spend
- Other spend includes mental health prescribing and a smaller element of continuing health care