South East London Integrated Care System

Integrated Care Partnership

13.00 to 15.00, Thursday 25 April 2023

Venue: Bromley Central Library High St, Bromley BR1 1EX

Co-Chairs:
Cllr Kieron Williams (KW) - Leader, Southwark Council

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

Agenda

No.	Item	Paper	Lead	Timing
	OPEN 13.00			
1.	**Welcome and introduction – opening business** *Receive apologies* **Minutes of the previous meeting and matters arising** *Minutes of the meeting on 25 January 2023 for acceptance as a record.*	**A**	RD / KW	13.00
2.	**Update on the south east London health and care system pressures** *An update on how the system is managing immediate operational pressures having an effect on south east London residents experience of health and care.*	**B**	SC	13.10
3.	**Implementing our integrated Care Strategy** *Progress on the workstreams set up for the implementation of the strategic priorities. .*	**C**	JH/BC	13.25
4.	**Voluntary Community and Social Enterprise (VCSE)** *Supporting a flourishing VCSE sector capable of delivering the contribution we need for our vision and our five strategic priorities.*	**D**	TR/ BC	13.45
5.	**The Mental Health Concordat** *Update and seeking support from Integrated Care Partnership members on the development of a London Mental Health Crisis Concordat.*	**E**	NL/BC	14:15

6.	**Questions from the public**	**-**	RD / KW	14.45
CLOSE 15.00				

Presenters

AB	Andrew Bland	ICB Chief Executive Officer
SC	Sarah Cottingham	ICB Director of Planning and Deputy Chief Executive
JH	Dr Jonty Heaversedge	ICB Joint Chief Medical Officer
TG	Dr Toby Garrood	ICB Joint Chief Medical Officer
TR	Tal Rosenzweig	Director of Voluntary Sector Engagement and Partnership
BC	Ben Collins	Director of ICS Development
NL	Sir Norman Lamb	Chair South London and Maudsley NHS FT

DRAFT

Integrated Care Partnership

Minutes of the meeting on 26 January 2023

Coin Street Neighbourhood Centre

Present:

Name	Title and organisation
Richard Douglas [Chair]	Chair, NHS South East London ICB
Cllr Kieron Williams	Leader of the Council, London Borough of Southwark
Cllr Paul Bell	Cabinet Member for Health and Adult Social Care, London Borough of Lewisham
Andrew Bland	Chief Executive Officer, NHS South East London ICB
Tal Rosenzweig	Director of Voluntary sector collaboration and partnerships.
Jill Lockett	Managing Director, King's Health Partners Academic Health Science Centre
Catherine Mbema	Lead Director of Public Health
Dr Gavin McColl	GP, Clinical Director Southwark PCN, Representative of SEL primary care services and networks
Michael Nutt	Chair, Bromley Healthcare CIC
Cllr Anthony Okereke	Leader of the Council, Royal London Borough of Greenwich
David Quirke-Thornton	Lead Director of Adult Social Care
Folake Segun	Director SEL Healthwatch, Healthwatch
Charles Alexander	Chair, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust
Sir Norman Lamb	Chair of South London and Maudsley NHS Foundation Trust
Mike Bell	Chair of Lewisham and Greenwich NHS Trust
Andy Trotter	Chair, Oxleas NHS Foundation Trust

In attendance:

Name	Title and organisation
Ben Collins	Director of ICS Development, NHS South East London ICB
Sarah Cottingham	Deputy Chief Executive and Executive Director of Planning, NHS South East London ICB
Sarah McClinton	Place Executive Lead and Director of Adult Social Services Greenwich
Tosca Fairchild	Chief of Staff, NHS South East London ICB
Mike Fox	Chief Financial Officer, NHS South East London ICB
Dr Toby Garrood	Joint Medical Director, NHS South East London ICB
Dr Jonty Heaversedge	Joint Medical Director, NHS South East London ICB

1.	**Welcome**
1.01	Richard Douglas welcomed members to the meeting.
1.02	The minutes of the meeting on 22 November 2022 were approved as an accurate record.
1.03	The revised ICP Terms of Reference were accepted by the Partnership.
1.04	Cllr Jim Dickson noted that the amendments to 4.10 were designed to ensure the ICP and ICB were working together and holding each other to account. The comment relayed in the minute of the last meeting showed the intention behind the change.
2.	**Response to winter and flow pressures**
2.01	Sarah Cottingham provided an update on pressures faced by the system, highlighting: • Particular pressure across the urgent and emergency care system regarding access to services and flow through hospitals, exacerbated by an increase in Covid-19, Flu and associated respiratory infections which was affecting waiting times. • There had been a surge in demand for paediatric services, driven by concern over Streptococcus A infections and complicated by antibiotic supply issues. South east London had worked to increase clinical and lab capacity and provide advice and guidance to staff, schools and the public. • Recent and future industrial action had required significant planning and management to ensure patient safety and there had been some cancellation of outpatient and inpatient procedures as a result. • Initiatives to mitigate these risks and pressures included implementation of a 'Bristol' flow model across sites in south east London to enhance flow and reduce ambulance handover delays, concerted effort to expedite discharges from hospital in a timely way making use of national funding, and work to increase primary care capacity, improve 111 resilience, and make better use of new models such as urgent community response and virtual wards.
2.02	Jill Lockett suggested arrangements in place during industrial action, such as GP support for the ambulance service, may offer lessons for care pathways more generally. Sarah Cottingham responded that insights on process and pathways had been gathered from the days of action and was being fed into pilots to take forward.
2.03	Folake Segun highlighted the importance of providing data on the performance of services for the public. Sarah Cottingham noted that detailed data was available publicly by hospital site and a summary of the information was provided at the Integrated Care Board public meetings.
2.04	Cllr Jim Dickson stated that long-term national funding increases would allow the system to invest in more permanent increases in capacity to alleviate pressures in future years, and were therefore preferable to the short-notice funding with short spending deadlines recently received in relation to discharge. Richard Douglas suggested that based on the pattern of previous years it may be possible to predict that tranches of support for pressures would be available later in the year,

	and to factor it earlier in as part of a risk-based approach to planning over the year.
2.03	Cllr Kieron Williams welcomed the update and thanked staff across health and care who were working under difficult circumstances described to deliver care for local people.
2.04	Sir Norman Lamb informed partners of a time-limited group set up across London to explore improvements for people in the UEC system experiencing mental health crisis. Around 600 people across London spent over 60 days in inpatient care which was not optimal for their health. A range of partners were involved including the Police and local government to discuss issues such as appropriate use of section 136 and improving discharge from mental health services. Consensus on these issues could significantly improve flow across the system and outcomes for patients. Charles Alexander welcomed a system focus on the issue, which had a negative impact on patients experiencing mental ill health as well as putting implications for patient safety and capacity in A&Es.
2.05	Tal Rosenzweig called for more creative thinking in response to the challenges to make use of innovative approaches in the voluntary and community sector to work with services as well as supporting people before they reached a crisis point with their mental health.
2.06	Mike Bell described some of the pressures at University Hospital Lewisham and Queen Elizabeth hospital, commenting that daily attendances of 1,200 people had been recorded compared to a normal average of 400-500. People medically fit for discharge often occupied the equivalent of four wards or a fifth of the bed base. There was a daily average of 12 ambulance handovers delayed over one hour, and 700 staff were off-work with sickness up from an average of 500. Efforts to respond were meeting with some success however, the implementation of a continuous flow model locally called the 'Woolwich way' was challenging for staff but was making a difference and there had been a ten-fold increase in the number of people who could be released home before 1pm with associated benefits for their recovery.
2.07	Richard Douglas concluded that the situation was difficult with multiple factors as well as opportunities for action. The ICP could help by focusing on what could be achieved by working together across the whole partnership. Andrew Bland suggested that the system support the work on mental health patients in emergency settings outlined by Sir Norman, and continue to analyse the causes of the pressures, and provide support to areas such as the care home market and promote a consistent core offer in community services across all six boroughs.
2.08	Cllr Kieron Williams suggested the pressures in social care and the voluntary sector be explored in future meetings as well as hospital, and that the partnership explore areas where it could make a tangible difference.
3.	**Integrated Care Strategy**
3.01	Dr Jonty Heaversedge introduced the strategic priorities and thanked the partnership and the public for their engaging with the process and contributing advice and direction. The strategy had been informed by population need, examination of existing strategies, and conversations with the public. A number of strategic priorities had been identified and tested against criteria to ensure they

represented the best opportunity to deliver the greatest benefit to the population, making use of resources and collaboration across the system. The vision for the system, and six attributes for the system had also been laid out in the paper. Next steps following approval and publication would be work in small groups to identify an approach to delivery, which would require resources and cross system working.

3.02 Jill Lockett welcomed the document but highlighted the importance of clear timelines for the delivery of aspects of the strategy would be important.

3.03 Norman Lamb commended the work but stressed the importance of addressing the social determinants of health, noting the impact of the cost-of-living crisis and consumer debt on mental health in communities.

3.04 Folake Segun commended the engagement with the public so far and advocated for continued public involvement in the reference groups to develop and deliver the priorities.

3.05 Cllr Kieron Williams asked the Partnership to seize the opportunity of using the full resources available across south east London, from the lived experience of residents, the insight of community groups, expertise from frontline workers and the voluntary sector, and contributions from universities. Initiatives such as Impact on Urban Health.

3.06 Cllr Jim Dickson welcomed the process which aligned well with the local strategy in Lambeth, and observed that the ICS should continue to help promote and enable work already existing locally across south east London.

Implementing the priorities – work on CYP mental health

3.07 Martin Wilkinson introduced work on children and young people's mental health and emotional wellbeing across south east London. A transformation plan for the coming years had been drafted working in partnership with places and providers, and would be brought to the mental health transformation board. The plan focussed on key interventions across ten priority areas identified as part of work on children and young people's health inequalities. Interventions listed in the paper included schemes to reduce waiting times for Children and Adolescent Mental Health Services, preventative work led by Places and local authorities in south east London, as well as prevention and early intervention work in collaboration with south west London ICS as part of South London Listens. Work was also being carried out to support parental mental health and to provide support in primary care. The publication of the strategy was an opportunity to work with the partnership to scale up approaches being carried out locally under the direction of health and wellbeing boards.

3.08 Sir Norman Lamb welcomed the work and the recognition of the need for investment but expressed a preference for fundamental system redesign of a CAMHS service that failed many families rather than small improvements to the current model. South east London could learn from more advanced health systems elsewhere. Implementing a model for ages 12-25 was preferable to employing people to support a transition to adult services at 18. The importance of digital solutions and early years intervention involving parents should also be recognised.

3.09	Richard Douglas noted that there although it may be necessary create something new, it would be necessary to keep improving existing services until the new arrangements were in place.
3.10	Mike Bell pointed out the links between the strategic priority on early years to many of the services provided by the trusts as well as this work. Access to perinatal mental health services, promoting community partnership models on areas such as support for breastfeeding, school nursing and health visiting were all vital – Lambeth Southwark and Lewisham had high numbers of adverse child experiences and all services needed to be trauma-informed and able to identify children needing support.
3.11	Tal Rosenzweig observed that people were sometimes more likely to engage non-statutory services and encouraged the ICS to support services developed by communities, for communities. There was a significant number of marginalised people across the six boroughs, and holistic, trauma informed care tailored to their needs was vital.
3.12	Cllr Kieron Williams agreed on the need for ambition over the long term and more immediate improvement to existing services. Nationally many of the young people needing mental health support did not receive it and Black and ethnic minority young people were significantly underrepresented in services. Evidence based solutions needed to be put in place, for example a Southwark commitment to provide mental health in every school could be extended across the system with the addition of providing support to every parent.
3.13	Martin Wilkinson welcomed the comments, noting work already in place to work on how support could be provided in every school and to role out Empowering Parents Empowering Communities (EPEC) hubs in every borough. The Integrated Care strategy would continue to drive the work, but there could be more work with partners in the system on the long-term model of provision in line with comments about extension of young peoples services rather than support to transition to adult services.
4.	**Medium Term Financial strategy**
4.01	Mike Fox outlined the ongoing process to develop of the Medium-Term financial strategy. The operational and financial environment for was extremely challenged, but the intention of the strategy was to achieve a shift in the deployment of resources in order to better address health inequalities within communities, whilst maintaining other commitments such as the mental health investment standard and achieving financial balance. To make this possible it would be important to obtain best value for all investment made across the ICS, especially as the requirements for efficiency savings would be particularly challenging.
4.02	Richard Douglas stated that the partnership should be sighted on the significant financial resources represented across the partnership and the need to put them to best effect. The strategy also committed to a separate amount of money aimed at reducing health inequalities rising to £175m by the end of the five year period. Although it may seem small relative to the total spend it should be sufficient to achieve a lot and the Integrated Care Board had committed to preserving this as an investment.

4.03	Andrew Bland reiterated that with no new funding available to south east London, the delivery this commitment would require action by all providers to improve efficiency in all areas of spend.
4.04	Charles Alexander noted that it was important to be realistic about the level of efficiency that was possible for providers in to deliver addition to that required by NHS England.
4.05	Folake Segun noted that the partnership would be aware of the need for a different approach to tackle some of the systems across south east London which patients had described as broken, as well as the wider financial challenges. To ensure that funding was used effectively to createchange there would need to be robust equality impact assessments, quality impact assessments and carer's impact assessments of proposed work.
4.06	Mike Bell noted that while the challenges on providers were clear, the principle of a long term shift of spend from acute services to community and preventative and anticipatory care models was vital. Earlier intervention could avoid many of those in wards needing to attend hospital. It would be important to ensure that all activity, not just that funded by funds reserved for prevention, was framed in a way that supported the reduction of health inequality.
4.07	Kieron Williams supported the principle of moving resource into reducing health inequalities as well as from acute services to those more preventative and in the community. The two most important that many people in community ending up in severe ill health and mental and physical health. It was crucial to turn this around, although this would be difficult because of the immediate concerns of residents about access A&E or the elective treatments that they needed.
4.08	Charles Alexander noted that the strategy focused on revenue funding, but reminded the partnership capital funding was also severely limited for all providers nationally, such that trusts struggled even to complete remedial work. Rather than defer to work co-ordinated by the ICB, all acute providers should be participate in this redistribution by working directly with colleagues in primary care and local communities.
4.09	Catherine Mbema welcomed investment in prevention and confirmed that public health across south east London could help colleagues ensure the work was able to demonstrate impact for residents.
4.10	Dr Gavin McColl commented that community mental health transformation programmes had been successful partly because by funding partly through Additional Roles Reimbursement Scheme (ARRS) and partly through community mental health trusts meant both parties were participating in discussions on an equal footing promoting a joint commitment and better joined up working. It may be more useful to measure the joined up working that the ICP would like to see rather than relying on existing measures.
4.11	Richard Douglas commented that the identifying outcome measures and ways to measure the success of joint working could benefit from further discussion within the partnership.

5	**Local Authority Adult Social Care - Current Position and Challenges and Forward Look**
5.01	Sarah McClinton noted the broad range of responsibilities for local government across mental health, older people, children and people with learning disabilities, which meant that the ICS was a good opportunity to work together in local care partnerships to improve health and wellbeing. • In the context of pressures on the system it was important to point out that only half of those waiting to be discharged from hospital needed social care placements and other needs included NHS support, therapies or continuing care, and therefore a joined up approach was necessary. • The difficulties with short notice funding arrangements were laid out in the paper, as well as the settlement for the future. A focus on discharge had meant that spending home care provision had increased be 16-35%. This affected social care budgets which often accounted for over 60% of the overall spend for local authorities who were legally required to break even. • DASS duties under the care act were to be examined by the CQC from April 2023. Across London around 8000 people were waiting for social care of some kind; all would be at risk of deteriorating health and early intervention was important to prevent the need for further interventions including hospital. • Pressures in the NHS were having a knock-on effect and a tendency to focus only on acute care was potentially exacerbating health equalities elsewhere. • Only around 3% of people needing social care support when leaving hospital needed a care home. and the challenge with care home capacity related to the complexity and acuity of the patients rather than bed numbers, and it was important to wrap support around care homes particularly for mental health and dementia. • There was a healthy home care market in south east London, with established as well as emerging providers, and the challenge was to build up the skills of staff to ensure that the needs were adequately cared for in the community and to address issues on pay. Without giving people support with reablement and recovery there was a risk that people deteriorate and began to need more urgent an emergency services. • The care workforce was a key challenge, and needed to be continued as part of the workforce strategy, and there was capacity in the community.
5.02	In response to a question Sarah McClinton clarified that most social care related to support provided in peoples homes and the home first principle was important. Of those not meeting the criteria to reside in hospitals, only half were waiting social care package for discharge.
5.03	Cllr Kieron Williams noted that while the social care settlement funding to address inflation dealt with the short term issue it was not clear how improvement to social care would be funded. Given the issues with workforce, he asked how career paths across both NHS and social care could be developed.
5.04	Sir Norman Lamb agreed with the three recommendations in the paper, in particular the optimisation of care models, emphasising the potential for improvement that could come from NHS mental health and local authority services working closely together.

5.05	Jill Lockett suggested that Kings Health partners could help with the development of improving data and service models and workforce. Kings College London also had focused on social care workforce as part of its public policy and social policy work and could help with this area. She suggested the introduction of housing to the data, drawing on the high impact changes for housing identified by the local government association.
5.06	Dr Gavin McColl commented that the 8000 waiting across London would have an effect on primary care and asked how long they were typically waiting. He suggested that the social care workforce to be brought in so that they felt part of primary and community care team.
5.07	Jim Dickson asked that in the optimising service models and workforce needed to include the London living wage as a key component as pay was a key issue.
5.08	The partnership accepted the recommendations.
6.	**Questions from the public**
6.01	Questions received in advance from the public were mentioned on the Website
6.02	*A question was raised about a underlying theme of housing – national guidance indicated that housing providers should have a bigger presence in the ICP than currently exists, and suggested housing associations could assist work, and would help with funding conversations.*
6.03	Richard Douglas recognised the importance of housing in the conversation although limited. Cllr Keiron Williams noted that housing was important for the effect it could have on people's health and wellbeing, as well as the importance of houses for discharge, and homes for nurses and care workers. Local councils represented on the partnership were themselves significant landlords.
	CLOSE

Integrated Care Partnership

Item 2
Enclosure B

Title:	**System Pressures Update**
Meeting Date	25th April 2023
Authors:	Sarah Cottingham Director of Planning and Deputy CEO
Executive Lead:	Andrew Bland, Chief Executive Officer

Purpose of paper:	To update on system pressures across south east London	Update / Information	X
		Discussion	X
		Decision	
Summary of main points:	This paper provides a high level overview of the recent and current system pressures across south east London, focussing particularly on urgent and emergency care, and alongside that NHS industrial action. It also provides a brief forward look to 2023/24. detail on the implementation phase and plans for the five strategic priorities.		
Potential Conflicts of Interest	None		
Relevant to the following Boroughs	**Bexley**	X	**Bromley** X
	Greenwich	X	**Lambeth** X
	Lewisham	X	**Southwark** X
	Equality Impact	n/a	
	Financial Impact	n/a	
Other Engagement	Public Engagement	n/a	
	Other Committee Discussion/ Engagement	n/a	
Recommendation:	To note the update		

SOUTH EAST LONDON INTEGRATED CARE PARTNERSHIP

SYSTEM PRESSURES UPDATE

April 2023

1 Introduction

1.1 This paper provides a high level overview of the recent and current system pressures across south east London, focussing particularly on urgent and emergency care, and alongside that NHS industrial action. It also provides a brief forward look to 2023/24.

1.2 Since the Integrated Care Partnership last met our system has faced ongoing flow pressures across urgent and emergency care, exacerbated by usual seasonal pressures, alongside planning for and managing the impact of industrial action. This has resulted in challenges in our hospital sector but also the NHS and social care more widely, including impacting on the level of elective care that we have been able to provide during periods of industrial action.

1.3 As well as seeking to manage these challenges, whilst safeguarding quality and safety for local residents, we have been proactively communicating with key stakeholders and the public through social media, Trust websites and through direct patient and carer contact to ensure advice can be readily accessed, to provide information on services available and on any that have been impacted, including alternative arrangements as appropriate.

2 Urgent and emergency care and winter pressures

2.1 The urgent and emergency care system has been under pressure throughout 2022/23, with pressures felt across all areas of service provision, including 111 and 999 services, primary care, mental health and acute care emergency departments. The overlay of seasonal pressures plus industrial action on a system already under strain in terms of demand, physical and staffing capacity, in and out of hospital, have resulted in challenges in securing flow and meeting access targets across the urgent and emergency care pathway. We have experienced delays in the time taken to see, treat and discharge patients from our Emergency Departments, with both 4 and 12 hour waits exceeded, delays in handing over patients from ambulances to our Emergency Departments, delays in moving patients out of Emergency Departments in to inpatient beds across physical and mental health and delays in discharging patients from hospital at the point at which they are medically fit. These flow challenges are not unique to us, and are being felt regionally and nationally, with south east London's urgent and emergency care performance broadly in line with regional averages. However we are not in the position we would want to be and improving urgent and emergency care represents a key current and onward priority for our system.

2.2 We have worked continuously over 2022/23 to seek to increase resilience in our urgent and emergency care pathway, with many in year initiatives having focussed on improving flow. In addition systems received significant additional funding over 2022/23 focussed on providing additional support for managing winter pressures, targeted around additional in hospital and community based capacity, the implementation of continuous flow models and discharge support. Our urgent and emergency care performance has however remained challenged, albeit we have broadly sustained our position rather than seeing continued deterioration.

2.3 As we look forward to 2023/24, a year for which we have made a number of commitments related to improved performance, we will need to challenge ourselves to ensure that we are targeting our actions to avoid spreading ourselves too thin with multiple initiatives, that we are systematically testing and evaluating what does and does not work and that we have put in to place the enabling support required to maximise demonstrable and sustainable improvement. As well as focussing on tactical care pathway opportunities and changes we also need to tackle some of the underlying and more systemic factors that are driving our urgent and emergency care challenges – tackling population health and unequal representation in our urgent and emergency care services, improving our workforce recruitment, retention and morale, understanding and addressing demand and capacity imbalances and improving our productivity and efficiency.

3 Industrial strike action

3.1 The NHS has experienced a period of unprecedented strike action over quarter four 2022/23 and April with Royal College of Nursing (RCN) and GMB, UNISON and Unite strikes in January 2023, plus British Medical Association (BMA) junior doctors strikes in March and April.

3.2 As a system we have retained the system planning and management arrangements put in to place for previous industrial action. This included a coordinated system approach, giving an ability to feed in and respond to national and regional planning and strike management processes as well as ensuring the adoption of consistent planning approaches and policies, upfront planning and real time system management during the strikes themselves. We have had an active clinical cell that has met to provide clinical leadership and advice. Wider system support was also put in to place with additional out of hospital capacity provided where possible and with a real push on expediting discharge and supporting flow.

3.3 Our approach to all industrial action has been to minimise disruption to patient care and to support emergency services to operate as needed, with patient safety of paramount consideration. Looking at emergency care there is evidence of reduced demand during the periods of industrial action for 111 services and in our Emergency Departments but the number of London Ambulance Service conveyances for hospital held up as did the number of emergency admissions, so it would appear that those needing emergency care and treatment did receive it.

3.4 However ensuring a continued ability to operate a safe and effective in hospital emergency care pathway, alongside safeguarding provision in maternity, anaesthetics and for urgent cancer care, has resulted in wider service impacts. Consultants stepped down and, in some instances, worked in areas outside their specialities to cover rota gaps due during the junior doctor industrial action and this, alongside the wider safeguarding of emergency and very urgent care, has required the cancellation of elective work. The number of cancellations across outpatient and day case/inpatient care will have been significant and adds to the challenge of reducing our waiting list backlogs and increasing our elective activity to do so, as we will need to try to make up the activity lost to industrial action in an already pressured and constrained elective system.

4 A forward look

4.1 For 2023/24 the NHS in south east London has committed to improve the key urgent and emergency care related standard for Emergency Department waiting times, with a plan that incrementally improves performance over the year to secure the national A&E standard of 76% of patients attending A&E being seen, treated and discharged within four hours. Within that we will need to improve our hospital handover waiting times, our flow through the hospital and wider urgent and emergency care system and improve the timeliness of the transfer of care out of hospital post admission. Meeting our performance improvement commitments will therefore require action from across the system as well as within hospitals.

4.2 A number of actions are planned, focussed on the effective management of the Emergency Department front door, including triaging, signposting and redirection on to alternative care pathways where appropriate. We are also working to improve the utilisation of our admission avoidance services, including virtual wards. We continue to develop and expand our same day emergency care offer in hospital, including the scope and conditions we can manage on a same day basis and increasing, where needed, the opening hours of our same day emergency care units. We have undertaken audits to demonstrate the opportunities that exist around redirection, use of admission avoidance service and same day emergency care. We continue to work to improve the support to patients attending emergency departments in mental health crisis through improving our assessment processes and through enhancing our crisis alternatives, alongside the development of our community services. Our hospitals will also continue to iterate and improve the continuous flow models they have been testing over winter of 2022/23, recognising that we did not see the positive impact expected from implementing these models, so need to continue to refine them for use locally. In doing so we are seeking to be clear about the action we will take, the support required to secure them and understanding expected and actual impact, to ensure rigour and an evidence based approach to urgent and emergency care improvement.

4.3 A key area of whole system focus will be on discharge, and this has been subject to significant focus since the last Integrated Care Partnership meeting. In March 2023, the ICB held a system discharge summit, sponsored by the ICB Chief Executive and the Chief Executive of the Royal London Borough of Greenwich. The summit brought senior leaders from across our system together to discuss discharge, or the transfer of care process, focussed on understanding the challenges and opportunities around discharge and the setting of clear commitments and objectives to secure improvement in both process and outcomes for the forthcoming year.

4.4 The summit was extremely well attended and there was a real energy around our coming together as a system to take stock, understand our current position and to affirm a clear forward commitment to working collaboratively over 2023/24 to secure timely and high quality transfers of care and improvements to our discharge processes and outcomes.

4.5 At the end of the summit SEL leaders were challenged to coalesce around an ambitious set of common standards delivered locally, underpinned by a system wide discharge improvement plan. The ICB's Discharge Solutions Improvement Group, which has representation from across health and care, is now developing the detail of this improvement plan which will be shared with senior leads from across our system for endorsement. This will include a set of recommendations that have been developed as a result of a March 2023 review of our SEL Transfer of Care hubs, which coordinate the transfer of care for more complex patients who require ongoing support post discharge. Post agreement of the improvement plan we will regularly track progress as well as ensuring we are working collaboratively to ensure the support required is available and in place to enable the delivery for our improvement commitments. Our expectation is this plan will drive evidenced improvement whilst also standardising approaches, our offer and outcomes across our system to the benefit of our residents.

4.6 Finally and as highlighted in section 2 of this paper we will also be acting in year to start addressing some of the underlying factors driving our urgent and emergency care system challenges, including:

- Demand and capacity - ensuring a systematically assessed understanding of imbalances across our system, to understand drivers and solutions to the variation in flow, demand and capacity pressure we currently see across our system. We have already commenced work to review demand and capacity for our mental health services focussed particularly on crisis demand and associated bed requirements and will further expand our work to look at acute services.
- Productivity and efficiency - building from the work undertaken in 2022/23 we will seek to understand the productivity and efficiency opportunity around urgent and emergency care pathways, with a particular focus on understanding the reasons for the increase in length of stay we have seen over 2022/23 and opportunities for addressing this through flow and care pathway changes.
- Population health and inequalities - as part of our integrated care strategy development, linked to the development of Integrated Neighbourhood Networks, providing community based care including approaches to same day urgent care and long term conditions management and in the context of broader urgent and emergency care recovery. We will be developing our offer or specification with a consideration of targeted population approaches reflecting over representation in our urgent and emergency care system linked to deprivation and inequalities. We will further link this to our developing approaches to targeted prevention, seeking to understand, identify early and provide support around the management of key population risk factors.

4.7 It is recognised these more systemic issues will take time to address and improve, but that we need to combine an approach that looks at short term tactical care pathway solutions alongside longer term population and infrastructure solutions.

Integrated Care Partnership

Item 3
Enclosure C

Title:	Implementing our Integrated Care Strategy
Meeting Date	25th April 2023
Authors:	Ben Collins, Director of System Development
Executive Lead:	Andrew Bland, Chief Executive Officer

Purpose of paper:	To update the Integrated Care Partnership on progress against our published strategic priorities for South East London and inform the Partnership of the timeline for implementation.	Update / Information	X
		Discussion	X
		Decision	
Summary of main points:	Following extensive engagement with our partners and the public in 2022, and discussion with our Integrated Care Partnership in November and January, we published our Integrated Care Strategic Priorities in February 2023. We have now set out the governance and leadership arrangements for the delivery of these strategic priorities, drawing on expertise from across the system both in the coordinators of the priorities and by explicitly including existing cross-system forums within the process. Whilst the implementation processes will differ across the five priorities, we have set a shared approach based on ensuring engagement with stakeholders across our system. That process has begun with a 'discovery' phase; in all five priorities, engagement work is underway to create an in-depth and shared understanding of the problem and context, including recognition of relevant existing improvement and transformation work. The process will continue with the development of a clear evidence base and set of strategic options for change. These options will need to be refined into an actionable delivery plan with measurable metrics and targets. A second strategy publication is due by the end of September 2023, which will provide additional detail on the implementation phase and plans for the five strategic priorities.		
Potential Conflicts of Interest	None		

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

	Lewisham	X	**Southwark**	X
	Equality Impact	The strategy establishes a focus on health inequalities. We selected strategic priorities based in part on the opportunity to address health inequalities. There is now a commitment to address health inequalities as we turn our five strategic priorities into action.		
	Financial Impact	The strategy sets out priorities that are likely to require investment; the overall approach is as set in the medium-term financial strategy. We will assess value for money in relation to specific investments or projects as we develop implementation plans for delivering our strategic priorities.		
Other Engagement	Public Engagement	Extensive public engagement on the strategic priorities occurred from July to December 2022 including open meetings, surveys and opportunities to input online. The upcoming engagement on the Joint Forward View, which references the five strategic priorities, provides a further near-term opportunity for engagement.		
	Other Committee Discussion/ Engagement	Extensive engagement with our Integrated Care Partnership, our Local Authorities and Local Care Partnerships and a Strategy Steering Group with representatives from our providers.		
Recommendation:	The Partnership are asked to note progress made against the five strategic priorities and to provide any reflections or guidance on our approach to their continued implementation.			

South East London Integrated Care System

Implementing South East London's Integrated Care Strategy

Integrated Care Partnership – 25 April 2023

1. Introduction

1.1. In February 2023, we published our integrated care strategic priorities for South East London for the next five years. The strategy was the result of extensive discussions involving leaders, staff and partners from across our system, community organisations and our residents. We set out to develop a tightly focused strategy, which homes in on a small number of areas where collective action across South East London will help us improve care.

1.2. Our strategy publication, summarised in Figure 1, sets out a vision for future health and care in South East London, focusing on the shift to preventative action, ensuring convenient, joined-up, whole-person care, addressing health inequalities, working in partnership, and securing our sustainability. It also sets out five immediate priorities for joint working across our system covering core medical prevention activities, support for children and families in very early years, early intervention for children and adults facing mental health challenges, addressing access to our primary care system and improving care for people with long term health conditions. This paper updates the Partnership on progress since February in implementing these five strategic priorities.

Figure 1: Summary of our mission, vision and priorities

2. Governance and delivery arrangements for our priorities

2.1. As the leadership group with overall responsibility for our integrated care strategy, we envisage that our Integrated Care Partnership will provide overall oversight and endorse the overall approach proposed for each of our five priorities. As during the strategy development phase, we also envisage continuing to update our Integrated Care Board regularly so that it can input on proposals for the five areas.

2.2. We have identified two coordinators or co-leads for each of the five priorities, in general including a manager and clinician from our integrated care system. These coordinators are responsible for bringing together partners and developing proposals for each priority for testing with the Partnership and the Board. Our co-leads are also working closely with our SEL VCSE Director and our SEL Healthwatch Director, who will help to ensure that we bring VCSE and service user perspectives effectively into the work.

2.3. There are already established transformation boards or oversight groups which bring together leaders from across our system, including our local care partnerships and our Trusts, whose role is to oversee cross-system activity in the five priority areas. Our co-leads will be responsible for testing proposals with these groups before they are presented to the IC Partnership and IC Board (see Figure 2). They will also test their proposals with our strategy steering group, which brings together the executive directors of our local care partnerships and strategy directors from our Trusts.

Figure 2: Coordinators and oversight groups for our five priorities

Prevention	Early Years	Children and Young People's Mental Health	Adults' Mental Health	Primary care and long term conditions
Coordinators: • Director of Prevention and Partnerships, SEL ICB • Lead Director of Public Health, SEL ICS	Coordinators: • Chief Nursing Officer, SEL ICB • Director for Mental Health, Children and Young People and Health Inequalities, SEL ICB	Coordinators: • Chief Operating Officer, Partnership Southwark • Director for Mental Health, Children and Young People and Health Inequalities, SEL ICB	Coordinators: • Chief Operating Officer, Partnership Southwark • Director for Mental Health, Children and Young People and Health Inequalities, SEL ICB	Coordinators: • Director of Prevention and Partnerships, SEL ICB • Primary Care Member, SEL ICP • Director of Commissioning and Improvement, SEL ICB
Main oversight groups: • SEL Population Health and Equity Advisory Group • Vital 5 Delivery Group • Directors of Public Health	Main oversight groups: • Children and Young People Transformation Board • Local Maternity System	Main oversight groups: • Children and Young People Transformation Board • Mental Health Programme Board	Main oversight group: • Mental Health Transformation Board	Main oversight group: • Primary Care Network

3. Approach and structure to this phase of work

3.1. In our strategy publication, we committed to continuing to work closely with partners and local people as we develop work programmes and implementation plans for our five strategic priorities. In particular, we committed to thoroughly assessing the evidence, being ambitious and innovative in our thinking and developing practical and focused plans that lead to tangible improvement.

3.2. In its meeting of 26 January, IC Partnership members also highlighted need to be ambitious in our thinking, to review evidence from other systems, to consider non-medical approaches, to work closely with VCSE and service users, to consider broad

redesign as well as incremental improvements to existing models, and to strike the right balance between cross system and local action in the five areas.

3.3. While each of our priorities is at a different stage, our co-leads are using a loose 'double diamond' method to help bring together the many stakeholders, explore the problem and allow for innovative solutions. For each strategic priority, the process has begun with a discovery phase to establish the evidence base around the priority and engage with stakeholders. The large amount of information gathered will then be sifted through to create a shared definition of the problem. Time will then be taken to design our solution(s), considering different options and opportunities, again through engagement with stakeholders from across the system; we will also draw on examples of best practice from both within and external to south east London. The final stage will be to narrow down those options and set a delivery plan.

3.4. While each of the priorities is different, we envisage that each version of this process will follow a comparable structure (see Figure 3), including a diagnosis of the problem to address or opportunity to exploit, a review of the existing evidence base, an assessment of different strategic options, and proposals for an overall approach. We also envisage that each will put forward a set of metrics and targets for direct improvement in care over the next five years. Once we have identified an overall approach, we will need in a second phase to outline the process for implementing the proposals. We envisage coordinated action and sharing of learning across our system, and there may also be a need for action at SEL level. However, we envisage that much of the implementation for these priorities will take place at the level of our local care partnerships, involving multiple partners at Borough level.

Figure 3: Structure for implementation phase for our five priorities

Diagnosis	An assessment of the most important challenges and opportunities in the area, drawing on evidence. E.g. do the underlying issues relate to lack of services, variation, poor coordination, the wrong models, ineffective approaches for specific groups? What bright spots are there? What groups or areas are most affected?
Evidence base	What does the existing research and evidence tell us about effective approaches to addressing the issue? Are there proven approaches or models of care or promising examples of innovation to address the problems we have identified? Are there common characteristics of successful approaches?
Strategic options	What are the main strategic options we should consider to address the problems identified in our diagnosis, e.g. expand current services, supplement existing services with alternative forms of support, new services, create a different approach for disadvantaged groups, deliver the service
Proposed overall approach	An overall strategic approach to addressing the problem that is simple and coherent, has a clear rationale, addresses the underlying diagnosis of what's going wrong, harnesses the strengths of our system, is realistic and actionable given resource and other constraints (e.g. sufficiently targeted) and consistent with the overall direction for our system set out in our vision statement (see proposed tests for assessing the approach below).
Metrics and targets	Benchmarking and measurable short to medium targets for improvement, including potentially some proxy measures to track progress in the short term and outcome measures to track longer term improvement.
Implement-ation plan	A plan setting out what will need to happen to what timescales to deliver the overall approach, including what should happen at different levels in our system, what should be done universally across South East London, what should be left to local delivery, what minimum consistency of approach is required, and assessment of the resource implications for consideration by the ICB and relevant partner organisations.

4. Progress so far on the five priorities

4.1. Whilst we are at an early stage of developing our five strategic priorities and remain within the discovery phase as set out in our approach, progress has been made in all areas.

4.2. These priorities are also reflected in the Joint Forward View; the engagement on the Joint Forward View, which the ICB Board intends to begin from the 19th April, provides a further opportunity for broad engagement which will be fed into the discovery phase output.

Prevention

4.3. A high-level plan for the Prevention priority programme has been produced; further development is underway to refine the priority and develop detailed plans and actions.

4.4. The programme is in an early stage of engagement with various groups and key stakeholders from across the ICS. This builds on the engagement undertaken through the strategy development process, during which a shift in focus towards prevention emerged as both a standalone priority and cross-cutting theme. The next phase of targeted engagement specific to the Prevention priority seeks to both move the plan into a greater level of specificity and identify areas of alignment with other programmes and strategic priorities.

4.5. Thus far, three themes have emerged through this focused engagement:

4.5.1. There is a need to develop trust and confidence in the prevention services we offer.

4.5.2. Providing equal access to preventative and wellbeing services to all should be a key priority, considering especially those who are not currently accessing support.

4.5.3. Success will require us to work with a range of partners who can not only provide services but who are able to build relationships with local people and communities.

4.6. The first draft of a discussion document to be used for further engagement with a wider set of partners is in development. This will focus on establishing where an Integrated Care Partnership approach can add value above and beyond existing local and other activities within the prevention agenda.

4.7. This discussion document is a critical part of the current discovery phase, through which we are engaging stakeholders from across the system to gather information on the problem. This includes recognising work ongoing in the prevention agenda; as just one example, our Vital 5 approach will continue to deliver in the near-term as we use this priority to set the medium-long term strategic direction.

Early years

4.8. Early years spans across many different services including maternity care and children services and falls under the commissioning responsibility of both local authorities and health.

4.9. Provision of services for early years varies across our six boroughs. There are several national published guidance documents for best care for early years, primarily aimed at integration of services and there is significant work already underway across our Local Care Partnerships aimed at improving outcomes for children in the early years.

4.10. Given the potential breadth of the early years priority and the work already underway through Local Care Partnerships, there will be a workshop on 27th April 2023 with a wide range of health and care professionals and system stakeholders to further scope and define this priority area.

4.11. The workshop has been well received by system partners and stakeholders and currently there over 80 attendees due to attend indicating the high interest in this strategic priority area. Attendees include individuals from the Local Maternity System, Maternity Voice Partners, the Neonatal Network, the ICS Children and Young People Programme Board, public health, maternity clinical and care professional leads from Place, health and care commissioners and health visiting.

4.12. The workshop aims to:

- Recognise the work already underway through Local Care Partnerships on maternity care and early years, linked to national policy guidance, the ICB's Joint Forward View Plan and Local Care Partnership Delivery Plans.
- Identify one to two areas within the early years space where partnership working through the strategy would result in additional benefit to the work already underway. This could involve working at a greater pace on things already in train or it could be focusing our attention on a new area of work where work has perhaps been limited across the six boroughs.

4.13. This workshop forms a key part of the discovery phase of priority development, as set out in our approach and structure for the work. This process will set the medium-long term strategic direction for the priority; however, we recognise that there is a substantial volume of work ongoing to improve early years health and care services in the near-term. For example, four of our six boroughs have been designated family hub boroughs as part of the National pilot.

Children and young people's mental health

4.14. There is a strong understanding of the challenges affecting children and young people's mental health across the ICS, both through the engagement undertaken as part of the strategy development process and through previous work undertaken on health inequalities in children and young people's mental health across system partners (i.e., a strong understanding of the diagnosis and the evidence base). As a result, the initial focus has been on identifying where the strategy work adds the most value or can accelerate work at a faster pace through stronger partnership working.

4.15. Initial engagement has begun to take place via the Mental Health Programme Board, with specific input from the Mental Health Voluntary and Community Sector Steering Group (a dedicated mental health group which brings together VCSE partners from each of our six boroughs to provide both the collective view of the local borough and also their organisation across both adults and children and young people's mental health). Discussions from these fora focused specifically on working closer with schools to provide early intervention for children and young people's mental health and developing capacity across the VCSE sector to provide services wider than traditional mental health services.

4.16. A discussion paper has been drafted summarising the feedback to date and given the need to drive this work through Local Care Partnerships, the paper has initially been shared with ICB Place Executive Leads for review and comment. Work is now underway to revise the paper jointly with the ICB Place Executive Leads, with a view to then sharing more widely with system partners.

4.17. As set out in the approach, the current focus is on the discovery phase, working with our stakeholders to gather information on the problem. This includes recognising the myriad of improvement work underway in this area, for example within the Children and Young People Transformation Plan, which will continue to deliver change in the near term as we set a strategic direction for the medium-long term.

Adults' mental health

4.18. Like children and young people's mental health, there is a good understanding of the issues affecting adults' mental health and initial engagement has again been through the Mental Health Programme Board and the Mental Health Voluntary and Community Sector Steering Group.

4.19. Our Integrated Care Strategic Priorities for 2023-28 state that for adult mental health we want to ensure people "receive early and effective support for common mental health challenges", focusing in particular on partnership working across public services and the voluntary sector, and this remains the scope of the priority area.

4.20. Given the overlaps with children and young people's mental health and adults' mental health, feedback from initial discussions has been included within the same discussion paper and the discussion paper is in the process of being further developed jointly with ICB Place Executive Leads.

4.21. As for all priorities, this priority is currently in the discovery phase, through which we are working with our stakeholders. In seeking to establish the context for the priority we are also considering the work ongoing in this area; for example, we are entering the third year of our community mental health transformation programme, which has invested 40% of its funds into VCSE providers.

Primary care and long-term conditions

4.22. This strategic priority as set out in the strategic priorities document is the broadest and least refined of the five. As such, the initial focus has been on developing a shared understanding of the challenges faced and the strategic options available to the system, including by establishing an evidence base. A document setting out the diagnosis and strategic options for consideration is under development.

4.23. Early engagement focused on this priority has been undertaken, and a further programme of wider engagement is planned. This will include meetings with each of the Local Care Partnership leadership teams within the next 6 weeks. Initial discussions have also been held at the Primary Care Leadership Group and the Long-Term Conditions Steering Group meetings.

4.24. The first draft of a discussion paper, drawn from these initial conversations, is in development. This broadly categorises the challenges into two areas which, whilst interconnected, require different delivery approaches:

4.24.1. Providing convenient access to high quality primary care, including a focus on addressing health inequalities.

4.24.2. Developing a more proactive and joined up approach to care for people with long term conditions.

4.25. This discussion paper forms a key output from the initial discovery phase of the priority development process, as set out in our approach. During this phase we are also keen to recognise the myriad of work ongoing which is relevant to this priority, including at place level. For example, each of our boroughs are working with practices and PCNs to develop access improvement plans; these will focus on a set of actions to enable practices to provide improved access to patients and reduce the pressure on general practice staff.

5. Timescales

5.1. We have committed to completing the next phase of work on our five priorities by the Autumn, including developing our overall approach to each area, and implementation plans (see Figure 4). We have also committed to key milestones (see Figure 5) leading to a second strategy publication, due by the end of September 2023, which will provide additional detail on the implementation phase and plans for the five strategic priorities.

Figure 4: High-level timescales for 2023

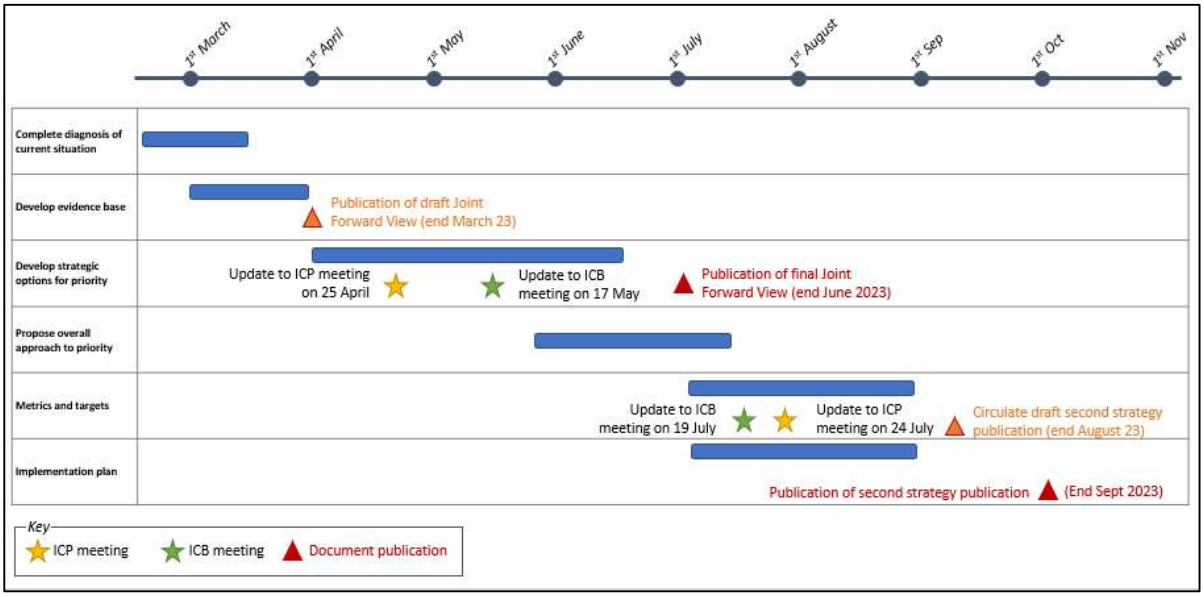

Figure 5: Key milestones for 2023

Milestone	Date	Work to be completed
Publication of Joint Forward Plan	End June 2023	Provide a summary of our work so far, (which should by this stage have covered diagnosis, research evidence, options and options appraisal, an possibly outline of the proposed approach)
IC Board Meeting	19 July	Set out options appraisal and overall proposed approach to each priority. Share initial thinking on metrics and implementation.
IC Partnership Meeting	24 July 2023	As above, set out options appraisal and overall proposed approach to each priority for guidance / endorsement. Share initial thinking on metrics and implementation.
Draft second strategy publication	End August 2023	Draft to include overall approach, metrics and targets, high level implementation plan including who will do what in our system to what timescales.
Second strategy publication	End September 2023	To share with ICB and ICP by correspondence in time for publication end September (noting ICB meets 20 September and ICP on 26 October)?

Integrated Care Partnership

Item 4
Enclosure D

Title:	**A resilient and vibrant VCSE sector in South East London**
Date:	25 April 2023
Authors:	Tal Rosenzweig (Director of VCSE Collaboration and Partnership and ICP member), Ben Collins (Director of System Development).
Executive Lead:	Jonty Heaversedge (Joint Medical Director)

Purpose of paper:	The purpose of this paper is to: i) instigate an initial discussion with Partnership members on how we might support the resilience and success of the voluntary, community and social enterprise sector (VCSE) in SEL, given the challenges the sector currently faces; and ii) seek Partnership members support for a future Partnership discussion on more concrete options for how we might work together to strengthen the VCSE sector in SEL.	Update / Information	X
		Discussion	X
		Decision	
Summary of main points:	There is an increasing demand for VCSE support, particularly since the pandemic. However, the sector faces real financial pressures and increasing running costs. Whilst we have access to national data on the state of the sector, we do not have much granular SEL level data, although our VCSE partners say the national picture is reflected in SEL and our SEL VCSE Strategic Alliance has flagged some of the particular challenges the sector is experiencing in SEL. As a system, we are increasingly reliant on the VCSE sector to work with us as key partners to deliver our priorities and improve the health, care and wellbeing of people in SEL. Key areas we might explore as a system to support the resilience and vitality of the sector include looking at how we might fund the sector more sustainably, how we tender for services, how we contract and performance manage the sector and how we work in partnership with the sector. The paper invites Partnership members to share their perspectives on these areas outlined, discuss how we might work together as a system to strengthen the VCSE sector in SEL, and proposes that we return to a future ICP with more concrete options for how we might work together to do so.		
Recommendation:	Partnership members are asked to discuss: • The role the VCSE sector should play in our system; • The challenges currently faced by the sector; • The opportunities we might pursue as a system to address these issues, and the approaches we might take to tackle some of these challenges; and • How we might support greater overall financial stability, sustainability and capacity of the VCSE sector.		

	The Partnership are also asked to support the proposal to carry out further work to deepen our understanding of the sector in SEL, so that we can return to the Partnership later this year with more concrete options for how we might work together to strengthen the sector.

South East London Integrated Care System

A resilient and vibrant VCSE sector in South East London

Integrated Care Partnership – 25 April 2023

1. Introduction and purpose of this paper

1.1. South East London (SEL) benefits from an incredibly diverse voluntary, community and social enterprise (VCSE) sector. We have small, grassroots organisations supporting specific local communities, settlement houses from the late nineteenth century, national charities, major grant giving charities and research bodies.

1.2. We cannot underestimate the importance of the sector: as a leader and driver for equity and social change, as an advocate for service users, as a provider of statutory health and care services, and as an alternative form of support alongside public services. Our reliance on the sector was brought home during the pandemic, when we depended on the VCSE's insights into local communities, its relationships with local people, its agility, and its ability to mobilise volunteers to help shield and support the vulnerable and deliver vaccination programmes.

1.3. We envisage the VCSE playing an increasingly important leadership role in our system in future. We will depend on the VCSE's holistic approach and unique insight to help us shape and deliver our vision for health and care. We will also depend on the VCSE to help us address health inequalities and operate as effective anchor institutions.

1.4. However, at present the sector faces significant challenges which may prevent it from delivering its full potential in our system. Over the last two decades, public funding for the VCSE across the UK has significantly reduced[1]. Short-term COVID-19 related emergency funding, which supported many VCSEs to stay afloat, has also ended. Many VCSE organisations are struggling to cope with rising costs, and some have already become insolvent. This predominantly impacts smaller, specialist 'By and For'[2] organisations and community initiatives[3].

1.5. This paper provides an initial summary of key issues that VCSE organisations have raised within our SEL VCSE Strategic Alliance and in other forums. While there is work happening across our system, our VCSE partners see potential for coordinated action across our partnership to support the sector. The paper discusses how we might enable the growth of a dynamic VCSE ecosystem, create the conditions for the VCSE to be a leader of innovation, and ensure the sector's sustainability.

1.6. Our objective at this stage is to gain initial reactions from our Integrated Care Partnership and guidance on areas for further exploration. We propose to return to the

[1] https://www.civilsociety.co.uk/news/government-funding-for-charities-at-15-year-low.html#sthash.Bs3Zbsjy.dpuf

[2] 'By and For' organisations are VCSE organisations run by the community, for the community.

[3] The Ubele Initiative (2021). Booska Paper: Exposing structural racism in the third sector

Partnership and Integrated Care Board with options on how we might work together to better support the VCSE sector later in 2023.

2. The increasing need for VCSE support

2.1. The VCSE sector across the UK has seen an unprecedented increase in demand for support due to the impact of the pandemic, the housing crisis, increasing cost-of-living and poverty. VCSE organisations also report increased demand for their services given pressures on statutory services. Research by Nottingham Business School and Pro Bono Economics[4] shows an increase in demand for a wide range of VCSE services, including helping people to avoid or cope with poverty, helping children catch-up on missed education, providing mental health and wellbeing support, and supporting people with housing needs and homelessness, with disabilities, and with long term health conditions. VCSE infrastructure organisations, which support the development of the local VCSE sector, have also seen an increase in demand since the pandemic.

2.2. This general analysis is mirrored in more detailed reports on specific VCSE services and population groups. For example, Women's Sector organisations have highlighted a significant increase in demand for services from women suffering domestic violence[5]. VCSE mental health organisations have reported a 175% increase in demand for support following the pandemic[6]. And two thirds of VCSE organisations providing youth services have reported an increase in the demand for services[7].

2.3. All the main SEL VCSE providers who work in the health and care and wellbeing sector, as well as SEL VCSE infrastructure organisations, have reported an increase in demand. Bromley Well, One Bexley, Mum's Aid, all of the SEL based Mind organisations, Bexley Deaf Centre, Re-Instate, The Nest, The Motherhood Group, Social Inclusion Recovery Group, Mabadiliko, Intercultural Therapy, Rock I and Bromley Y are some examples of SEL organisations who have reported a major increase in demand. These organisations also report people are presenting with multiple, intersecting needs, requiring complex, holistic, wrap-around support.

2.4. Whilst we currently lack granular SEL data, the insight and evidence suggests an increase in demand for VCSE services in our communities. Our strategy process highlighted the importance of strengthening VCSE support and embedding the VCSE offer alongside statutory health and care services across all our priority areas. The process also highlighted variation in support currently available, for example, support for young mothers and early support for common mental health challenges.

3. Funding and sustainability

3.1. Despite increasing demand for the sector's support, VCSE organisations across England have experienced a significant reduction in public funding over the last fifteen years. The National Council for Voluntary Organisations (NCVO), the representative organisation for charities, voluntary organisations and community groups in England, reports declining central and local government expenditure on the VCSE, from £17.9 billion in 2007/8 to £15.4 billion in 2019/20. Across England, the majority of funding also tends to be project-based, and often does not cover the VCSE's core running

[4] Nottingham Business School and Probono Economics (2022). Breaching the Dam.
[5] Women's Aid (2021). The Domestic Abuse Report 2021: The Annual Audit.
[6] Rethink Mental Illness (2021): Demand for mental health advice soars in year after first lockdown.
[7] UK Youth (2021): The impact of Covid-19 on England's youth organisations.

costs. This is having detrimental impact on the sector's sustainability and longevity[8].

3.2. Alongside reductions in public funding, VCSE organisations are also experiencing substantial cost increases. The NCVO reports a 3% increase in VCSEs' costs of doing business from 2018/19 to 2019/20. Whilst we do not yet have aggregate data, it is inevitable that VCSE organisations will have seen a greater cost increase for 2021/22, reflecting rising inflation in wages, energy and other overheads. In September 2022, more than a third of London's Violence Against Women and Girls (VAWG) Grassroots Fund organisations, supported by the Mayor's Office for Policing and Crime (MOPAC), reported increasing costs as their primary concern for their sustainability[9].

3.3. We know that the smallest VCSE organisations are more likely to be severely impacted by reductions in funding and increasing costs. Research by the University of Birmingham on the impact of COVID on charities' finances found that, whilst charities experienced a 15% reduction in income on average, smaller charities in the 25th percentile experienced a reduction of 40%. These smaller, grass-roots organisations often play particularly important roles in local communities and for disadvantaged or seldom listened to groups who experience some of the greatest health inequalities. For example, the BLACHIR report[10] highlights that, to address structural health inequalities and disadvantages, we need to invest in and support the growth of a sustainable, specialist, Black and minority-led VCSE organisations.

3.4. Again, we do not have detailed information on the levels of public investment in the VCSE in SEL. However, our VCSE partners believe that the pattern of expenditure in our system reflects these national trends. Partners have argued that there has been a 'hollowing out' of the sector over the period. (During our engagement on our strategy in 2022, we heard examples of VCSE services in SEL which had been decommissioned or scaled back.)

3.5. These financial difficulties are making it harder for the VCSE sector to recruit staff, particularly as the sector is unable to compete with public and private sector salaries. Nottingham Trent University's 2022 VCSE Barometer[11] found that 83% of charity employers were struggling to fill vacancies.

3.6. Members of our SEL VCSE Strategic Alliance point to the annual funding cycles that provide very little financial stability, making it harder for VCSE organisations to recruit and retain staff, and make investments in services. The short-term nature of funding cycles and short notice confirmation of the renewal of funding creates job-insecurity within the sector, with the risk that staff leave for better resourced sectors.

3.7. Our SEL VCSE Strategic Alliance also point to the lack of resourcing for VCSE organisations to participate in the wider leadership and development of our health and care system. VCSE representatives are often the only members of boards, steering groups or participants in workshops not remunerated for their time and expertise.

Given the importance of the VCSE for our future system, **we would welcome Partnership members' perspectives on how we might support greater overall financial stability, sustainability and capacity of the sector**.

[8] https://www.ncvo.org.uk/news-and-insights/news-index/five-insights-voluntary-sector-civil-society-almanac-2022/#/

[9] The London Community Foundation (2022). The women and girls paying the price for the cost of living.

[10] Lewisham Council & Birmingham City Council (2022): BLACHIR report.

[11] Nottingham Trent University (2022). VCSE Barometer.

4. Tendering processes

4.1. Over recent decades, NHS and Local Authority commissioners have relied on competitive tendering processes to award contracts to the VCSE and other service providers. Whilst there are some potential advantages, there is an increasing awareness of the potential disadvantages including:

- Prioritisation of cost-effectiveness, which leads to poor resourcing and result in reduce quality and effectiveness of provision;
- Hindering of collaboration and the building of stable and trusted long-term relationships between groups that need to work flexibly together;
- Loss of specialist provision within the sector (smaller specialist VCSEs not able to compete for funding and being 'absorbed' by larger ones as a result);
- Loss of service flexibility and agility as organisations having to adapt service design to fit funders requirements instead of people's needs to secure funding.
- Creation of a 'sub-contracting' culture within the sector which leads to smaller organisations losing their autonomy and voice[12][13].

4.2. VCSE organisations specifically argue that competitive tendering promotes rivalry between VCSE organisations, who are pitched against each other to secure small pots of funding, to the detriment of relationships and the ability of the sector to collaborate on shared challenges. The uncertainty created by tendering also undermines the ability of core groups of VCSE staff to build stable relationships with key partners in statutory services, so that they can work flexibly together. Some members argue that tendering imposes substantial costs on the VCSE sector and favour large organisations, for example national organisations with dedicated tendering teams, at the expense of small organisations with close links to local communities.

4.3. As we know, the overall model for ICSs in England moves us away from competitive tendering and instead fosters partnership working between organisations to improve health and care, aligned to a common purpose. This is reflected in the operating model for our integrated care system in SEL, which is based on building trusting relationships, collaboration and pooling resources to address major challenges.

4.4. We see merit in further exploring the current approaches and the range of options available for allocating contracts to VCSE partners. For example, this could include making greater use of procurement based on social value or recalibrating our approach as a system to deciding when to competitively tender versus allocating resources through grants. We can also explore new and emerging alternative approaches to traditional commissioning, or even develop our own approach which will help us overcome some of the challenges described above. There are of course several practical and technical issues we would need to consider. However, we would not be the first ICS to look at this, and so there is learning we can take from other systems.

We would welcome the Partnership's reflections and guidance on how we might gain a better picture of funding for the VCSE in SEL, the different approaches we might consider for allocating resources to the sector, and potential issues or challenges we would need to address.

[12] NCVO (2020). Charities' 'competitive behaviours' in contracting negatively impacting sector | NCVO
[13] Newbigging K, Rees J, Ince R, et al. (2020). Moving forward: the development and sustainability of the voluntary sector.

5. Contract and performance management

5.1. In addition to tendering, our VCSE partners have raised concerns about the contract and performance management requirements for publicly funded services. These concerns particularly relate to detailed service specifications for how services should be provided, and the rigidity of the range and type of indicators used to monitor performance that commissioning organisations use.

5.2. One resulting issue relates to how current contracting and performance management hinders the ability of VCSE organisations to develop innovative services that offer an effective alternative to or complement to traditional statutory services. When fulfilling its full potential, the VCSE sector develops genuinely innovative services that are distinctly different to traditional public services, for example more responsive approaches that respond directly to the needs and priorities of individual service users, asset-based approaches that harness the skills and capabilities of people and communities to improve their care and wellbeing, and non-medical approaches which address the underlying needs of people with health challenges.

5.3. VCSE partners have told us that highly prescriptive approaches to specifying services and monitoring performance prevents VCSE organisations from providing these alternative approaches and hinders learning. Instead, these make it necessary for VCSE organisations to deliver services in the same way, with the same focus, as traditional public services. This prevents VCSE organisations from adapting their approach to reflect new ways of serving local people or in response to changing circumstances. They also impose significant bureaucracy and cost, with particular impact for smaller, specialist 'By and For' VCSE organisations.

Does the Partnership agree that we should look in more detail at current practice and potential options and alternative approaches to contracting and performance management for VCSE organisations?

6. Partnership working

6.1. Learning from the last decade, and from the pandemic in particular, highlights the importance of equitable cross-sector collaboration to support local communities[14]. This learning highlights the role of the VCSE sector not just as a service provider, but as a key partner in the strategic leadership and design of services, contributing expertise and resources to transformational change[15].

6.2. Although we have good relationships with the VCSE sector across our system and places, the VCSE and statutory public services often operate in distinct silos. There is a risk of that this results in loss of learning and insight across the system and reduces opportunities to make best use of each sector's particular skills and approaches.

6.3. We are at a unique point in time where both national policy and the design of our integrated system seek to promote and enable ongoing and true cross-sectors collaboration, with a true focus on embedding VCSE sector within the system. There is scope to investigate how we might build more equitable and effective partnerships with

[14] House of Lords Public Services Committee (2021). Children in crisis: the role of public services in overcoming child vulnerability.
[15] Research in Practice (2019). Strategic partnerships with the voluntary sector: Messages from research and practice.

the VCSE across our system, from the strategic leadership of the system to more effective collaboration between staff delivering services.

We would welcome the Partnership's reflections on the approaches we might take to breaking down barriers and supporting closer collaboration between the VCSE and statutory services.

7. Discussion and next steps

We welcome the Partnership's thoughts, steers and questions on the challenges outlined above, in particular:

- The role the VCSE sector should play in our system;
- The challenges currently faced by the sector;
- The opportunities we might pursue as a system to address these issues, and the approaches we might take to tackle some of these challenges; and
- How we might support greater overall financial stability, sustainability and capacity of the VCSE sector.

We propose to come back to the Partnership and the Board with more concrete options on how we might work together to strengthen the VCSE sector in SEL later in 2023.

Integrated Care Partnership

Item 5
Enclosure E

Title:	**The London Mental Health Crisis Concordat 2023**
Date:	25 April 2023
Authors:	Jessica Levoir (Head of Partnerships) Rupi Dev (Director, Mental Health, Children and Young People & Health Inequalities)
Executive Lead:	Sarah Cottingham (Executive Director of Planning)

Purpose of paper:	The purpose of this paper is to update Integrated Care Partnership members on the development of a London Mental Health Crisis Concordat, with a view to: • Seeking Partnership support for the pan-London Mental Health Crisis Concordat, and agreement to sign-up to the principles, commitments and actions set out (see section 2.2 of paper). • Discussing what we would need to do as a system to implement the Concordat in South East London (SEL), above and beyond actions already in train (see section 3 of paper). • Discussing how we might need to work together to implement these.	Update / Information	
		Discussion	X
		Decision	X
Summary of main points:	A pan-London Mental Health Crisis Concordat is in development, for London system partners to sign up to in order to: 1) Prevent mental health crises 2) Provide people in mental health crisis with access to the care and support they require. The Concordat is being developed by a Task and Finish Group established by the London Urgent Emergency Care Mental Health Recovery Board, in response to the fact that people in crisis tend to present to Urgent and Emergency Care (UEC) departments. Given current UEC pressures, the UEC environment is not necessarily the best place for a person in crisis to be. The draft Concordat covers four principles, and within each principle is a set of commitments and actions that partners will sign up to working together to achieve. The draft is currently being tested with ICSs in London before being finalised.		

Recommendation:	Partnership members are asked to: • Review the draft concordat and support the Concordat in principle. • Provide any reflections or guidance on the draft Concordat and our approach to delivering the Concordat, as per the discussion points in section 5 of the paper.

The London Mental Health Crisis Concordat 2023

Integrated Care Partnership – 25 April 2023

1. Context

1.1. The support and care we provide to people experiencing a mental health crisis in South East London (SEL) requires improvement. In 2021/22, SEL had the third highest rate of detentions under the Mental Health Act of any area in England. This is also an area of significant inequality; more Black men are detained under the Mental Health Act than their White counterparts[1], and this inequality is growing.

1.2. Many people in crisis present at Emergency Departments (ED), and often when people in crisis are detained the police take them to an Emergency Department. As discussed at the ICP in January, pressures in Urgent and Emergency Care (UEC) services have been high in SEL for some time, and so we recognise the ED setting is not a suitable environment for most people in mental health crisis. To address these issues and improve the experience of people in crisis we must work together as system, with NHS Trusts, Local Authorities, the police, and voluntary, community and social enterprise organisations.

1.3. These issues are not unique to SEL so it has been recommended collective action is taken across London. The London UEC Mental Health Recovery Board has been established to understand how the London health and care system can address these issues. This Board has agreed a concordat should be developed for all London ICSs and other stakeholders to sign up to, with the aim of reducing the number of people who fall in to crisis and improving the experience and the treatment of people who do. By taking effective action together we should be able to reduce the number of adults attending ED in crisis and reduce the number of adults detained under the Mental Health Act (with a specific focus on the use of Section 136). A Task and Finish group, on which SEL is represented, is leading development of the Concordat. The draft Concordat is now being tested with ICSs in London and is summarised in section 3 below.

2. Draft Concordat summary

Vision

2.1. The Concordat represents a commitment of health and care system partners to work together, with voluntary community and social enterprise (VCSE) partners, community groups and police, so that:

[1] Detentions under the Mental Health Act - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

- When a person is in mental health crisis we support them to access the care and support they require, regardless of where they first seek help.
- The right prevention and early intervention support is in place to prevent mental health crises.

2.2. The Concordat puts an emphasis on providing services and support that are: 1) seamless, timely, and equitable; 2) co-produced, and tailored to meet the needs of London's diverse population; 3) anti-racist and culturally competent.

Concordat principles and commitments

2.3. To achieve this vision, the Concordat **outlines four key principles, and commitments and actions aligned to each, to adhere to and deliver on as a system and as individual partners**. These are summarised in the table below.

2.4. The concordat also sets out that partners will **regularly review their progress against agreed key metrics for each principle, and that as a collective we will continuously learn and share best practice**.

Concordat principle	Related commitments and actions
Principle 1: We prevent crisis by supporting people to live well in their communities, and work to tackle inequity in access and outcomes to community mental health services, with a particular focus on Black men. Delivered through:	More accessible, high-quality care, closer to home will reduce the risk of people reaching crisis point. This will be delivered through the community mental health transformation programme, and through this we commit to i) increasing access to core community mental health services, ii) reducing unwarranted variation in waiting times for access to new and integrated models, and iii) improving outcomes for people with severe mental health problems.
	Embed lived experience and culturally appropriate support in community mental health service delivery, committing to i) increasing 'mobilisation' and access to culturally appropriate community based mental health support services (through new models), ii) maintaining a directory of culturally appropriate mental health services, and iii) participating in a London-wide Black and Minority Ethnic mental health advisory group to inform co-design and transformation.
	Committing to ensuring advance care plans are routinely in place, so people with a longer-term mental health diagnosis receive appropriate, ongoing care. This is aligned to Government plans to put care and treatment plans on a statutory footing.
Principle 2: People experiencing crisis can access care closer to home, reducing the need for avoidable Emergency Department (ED) attendances, and front-line	Delivery of '111 First for Mental Health' Programme, which will result in increased access to mental health services for patients experiencing crisis via NHS 111. NHS 111 will become the single point of access for people experiencing mental health crisis. Expectation that all ICBs will be operational by the end of Q4 23/24.

staff can access advice to support the most appropriate pathway for patients potentially subject to a S136.	ICSs will have culturally appropriate and easily accessible front door alternatives to ED such as community crisis cafes and other services with self-referral capacity. These alternative services will be added to a London-wide online directory, so they are easily accessible to partners across London.
	Establish centralised S136 hubs (one North London, one South London) to provide the Metropolitan Police Service with a single point of access to mental health teams for timely advice. As part of the wider 111 First for Mental Health programme, this service will launch in 23/24, and the South hub will be hosted by a South London MH Trust.
	All ICBs have committed to Mental Health Joint Response Cars (MHJRCs) becoming a business-as-usual operating model in their areas. As a London collective, we will commit to continuing to fund the MHJRCs to ensure operation seven days a week.
Principle 3: If people attend ED in a mental health crisis they are seen in a timely way and provided with proportionate and effective support, including alternatives to admission.	The sector will continue to commit to i) delivering the operational aspects of the London Mental Health Compact, ii) adhering to the core principles set out in the Compact, and iii) work collaboratively across our partners to provide high quality care. Drawing on existing regulations and policies governing mental health services in England, as well as existing good practice, the London Mental Health Compact outlines the roles and responsibilities of individual organisations along all children and young people and adult patient pathways to admission.
	Adherence to the 'Core 24' service standard in all EDs, and that all EDs will be compliant with the ‘Core 24’ standards for liaison psychiatry. Core 24 is a liaison mental health service model provided 24 hours a day, 7 days a week.
Principle 4: When an individual requires an inpatient bed, admission is purposeful, close to home with a clear plan for discharge on admission.	Commit to ensuring inpatient stays are therapeutic, patient centred, and recovery focussed, acknowledging this requires effective partnership working within ICSs and with VCSE partners.
	Similarly, commit to embedding the key principles of effective inpatient care, set out as: 1) admissions will be purposeful, admitted only if a person requires assessment, intervention or treatment that can be provided in a hospital setting; 2) inpatient care will deliver therapeutic benefit; 3) discharge is proactively planned and effective.
	Commit to ensuring appropriate partnership arrangements are in place across ICSs (including VCSE) to ensure that no

	individual is in an inpatient setting for longer than necessary.
	Commitment to 'eliminating' inappropriate Out of Area Placements (OAPs) for acute inpatient care. Where an inpatient admission is required, this must adhere to national guidance on OAPs.
	Commitment to working collectively to deliver future recommendations from the inpatient mental health quality transformation programme, which will seek to transform the quality of inpatient care.

3. Delivering the four Concordat principles in SEL

3.1. A significant amount of work is already underway in SEL which will deliver the four principles in the concordat and meets some of the commitments set out, detailed in **Appendix A**.

3.2. However, we recognise these are mainly health-based interventions, and to fully meet the Concordat principles and commitments we must develop and deliver solutions that are cross-system. **We would welcome Partnership members' views on what these might be, or how we might go about delivering these**.

4. Next steps

4.1. Initially, the aim was for the Concordat to be agreed and signed in April. However, there is a recognition that stakeholder testing and input is important given the level of commitment being sort and the number of actions proposed. The draft Concordat is now in the process of being tested with ICSs in London.

4.2. The next UEC Mental Health Recovery Board will be meeting on Thursday 27th April 2023 where we expect to hear more about the next steps for the Concordat.

5. Areas for Partnership discussion

- Is the Partnership supportive of the principles and commitments set out in the Concordat? And would the Partnership supportive of us signing up to the Concordat as a SEL system?
- Are there any areas in the Concordat that you think are particularly important for us to deliver? Or should be reviewed as part of the drafting process?
- What do we need to do as a system to implement the Concordat in SEL, above and beyond actions already in train in SEL?
- How we might we best work together to implement the Concordat in SEL?

Appendix A – Work currently ongoing in South East London

Concordat principle	SEL progress
Principle 1: We prevent crisis by supporting people to live well in their communities, and work to tackle inequity in access and outcomes to community mental health services, with a particular focus on Black men. Delivered through:	• Community transformation programme underway across SEL. New core in place for newly established integrated teams with final year of the programme (from April 2023) focusing on embedding the core offer and specialist pathways. • Active case management through Home Treatment Teams and Community Mental Health Teams to identify patients most at risk of crisis and admission. • Over the last few years, there has been a shift in presentations to EDs for people known versus unknown to services (40:60 split for some sites). Further work underway to understand the journeys and pathways for these patients. • South London Listens developing local tailored solutions including upskilling community leaders and volunteers, and Well Being Hubs forming part of the ICS' prevention and early intervention focus. • The ICB has commissioned an independent review of mental health ED and crisis care demand.
Principle 2: People experiencing crisis can access care closer to home, reducing the need for avoidable Emergency Department (ED) attendances, and front-line staff can access advice to support the most appropriate pathway for patients potentially subject to a S136.	• Previous investment into crisis lines (all ages, 24/7 in SEL) and MHJRCs. Mental Health Joint Response Cars) • Crisis alternatives in development including the Lambeth Hospital Mental Health Crisis Assessment Suite (MHCAS). • Expansion of S136 Health Based Places of Safety in SEL (currently at 5, with final space due to open in Q1 23/24). • Development of the mental health hub to take calls directly from 111 and building S136 advice and guidance (hub due to go live in Q3 2023/24). • Procurement of private bed capacity within London to prevent people having to travel far from home for inpatient care and block bed capacity being managed as part of our provider bed base.
Principle 3: If people attend ED in a mental health crisis they are seen in a timely way and provided with proportionate and effective support, including alternatives to admission.	• Compliance with standards for ED liaison including 85-90% of patients referred to the liaison teams being seen within an hour. • Mental health screening in place at the ED front door for all sites, providing alternatives and signposting where appropriate to do so.

	• Clinical Assessment Units in place at three of five ED sites to provide an alternative, safe space for people who present in ED in crisis. Work underway to ensure the models maximise capacity and deliver value for money both in terms of patient experience and unit efficiency. • Development of the crisis house model (one adult crisis house open, second crisis house for adults to open in May 2023, and CYP crisis house to open in 2023/24).
Principle 4: When an individual requires an inpatient bed, admission is purposeful, close to home with a clear plan for discharge on admission.	• SEL-wide discharge framework to support delivery of best practice across the ICS, and significant flow improvement programmes in place across each mental health trust. Both providers continue to perform against national length of stay benchmarking, however, the numbers of people clinically ready for discharge remain a challenge. • Additional private bed capacity to support timely admission and reopening of beds at Oxleas. Private bed capacity is within London to prevent people having to travel far from home for inpatient care and block bed capacity being managed as part of our provider bed base. • Step down capacity through The Orchards already in place for SLaM (36 beds in place in total supporting the four boroughs served by SLaM). • Recognising the number of out of area attendances and placements within SLaM, dedicated role for mental health now in place within the ICB's Surge Hub to support repatriation of patients (ensuring care is close to home) and support overall flow through the South East London bed base.