Integrated Care Partnership

15.00 to 17.00, Monday 24 July 2023

Venue: 3rd Floor Coin Street Neighbourhood Centre

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

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

Agenda

No.	Item	Paper	Lead	Timing
	OPEN 15.00			
1.	**Welcome and introduction – opening business** *Receive apologies* **Minutes of the previous meeting and matters arising** *Minutes of the meeting on 25 April 2023 for acceptance as a record.*	**A**	RD / KW	15.00
2.	**Focus on Primary Care in the south east London health and care system** *An update on the developing role and scope of community pharmacy and the collaborations that are forming in SEL*	**B**	HE	15.10
3.	**Developing our Integrated Care Strategy** *Update on the proposed focus and ambitions for each of our five strategic priorities.*	**C**	TG/BC	15.35
4.	**Draft South East London Voluntary, Community and Social Enterprise (VCSE) Charter** *A proposal for a charter for working with the VCSE*	**D**	TR/BC	16:10
5.	**Questions from the public** *An opportunity for questions from members of the public.*	**-**	RD / KW	16:45
	CLOSE 17.00			

Presenters

AB	Andrew Bland	ICB Chief Executive Officer
HE	Holly Eden	ICB Director of Commissioning and Improvement
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

DRAFT

Integrated Care Partnership

Minutes of the meeting on 25 April 2023

Bromley Central Library

Present:

Name	Title and organisation
Cllr Kieron Williams [Chair]	Leader of the Council, London Borough of Southwark
Richard Douglas	Chair, NHS South East London ICB
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
Dr Gavin McColl	GP, Clinical Director Southwark PCN, Representative of SEL primary care services and networks
Michael Nutt	Chair, Bromley Healthcare CIC
Cllr Denise Scott-McDonald	Cabinet member for Health and Adult Social Care, Royal London Borough of Greenwich
David Quirke-Thornton	Lead Director of Adult Social Care
Charles Alexander	Chair, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust
Cllr Jim Dickson	Cabinet Member for Healthier Communities
Sir Norman Lamb	Chair of South London and Maudsley NHS Foundation Trust
Dr Toby Garrood	Joint Medical Director, NHS South East London ICB
Cllr Baroness Teresa O'Neill	Leader of the Council, London Borough of Bexley

In attendance

Name	Title and organisation
Ben Collins	Director of ICS System Development, NHS South East London ICB
Sarah Cottingham	Deputy Chief Executive and Executive Director of Planning, NHS South East London ICB
Mike Fox	Chief Financial Officer, NHS South East London ICB

1.	**Welcome**
1.01	Cllr Kieron Williams welcomed members to the meeting. Apologies were received from Jonty Heaversedge, Folake Segun, Catherine Mbema, and Andy Trotter
1.02	The minutes of the meeting on 25 January 2023 were approved as an accurate record subject to the following amendment: • Correct the attendance list to include Cllr Jim Dickson

2.	**Update on the south east London health and care system pressures**
2.01	Sarah Cottingham updated on the health and care system noting that pressure had continued since the previous meeting across all urgent and emergency care services driven by demand exceeding capacity and difficulties in maintaining flow, exacerbated by the effect of industrial action. Throughout the period of industrial action, the focus had been to maintain access to as many services as possible. During the recent action, significant planning efforts had been helped by the flexibility of staff in responding and a reduction of demand. However, the main impact was on elective care, with very significant numbers of out-patient and in-patient procedures cancelled.
2.02	The operational plan presented in the papers included key commitments in relation to urgent and emergency care including seeing 76% of A&E patients within 4 hours, improving hospital handover plans, reducing delayed discharges and shortening lengths of stay. Supporting actions included streaming in A&E, promotion of alternatives to A&E, work on admission avoidance services and expanding virtual wards and the same-day emergency care offer to allow patients to be treated without the need for admission. Significant effort had been devoted to improving the situation for those suffering mental health crisis, although after similar challenges in previous years the challenge was obtain results and sustain improvements over the longer term. A system summit on discharge held in March had systematically reviewed the approach and variation across boroughs and agreed common standards and delivery processes including transfer of care hubs.
2.03	There was also work underway to address systemic and long term issues such demand and capacity, the approach to mental health across the system and how to and how to improve productivity and efficiency.
2.04	Cllr Kieron Williams expressed thanks to staff across the boroughs and organisations in south east London for their efforts to keep services open.
2.03	Cllr Paul Bell reiterated thanks to the NHS, which was under unparalleled pressures, and noted the presentation raised a number of questions including the presentation of data on cancelled appointments, how the ICS was monitoring patients on waiting lists whose condition may have deteriorated or whose risk had increased, how life-threatening conditions developing in those waiting were being monitored and pain management assessed, and delays in relation to mental health assessments.
2.04	Dr Gavin McColl called for greater focus on primary, community and social care. Discharges had a knock-on effect on out of hospital services and it was helpful to view the system as a whole.
2.05	Charles Alexander emphasised the magnitude of the effect of industrial action which had been compared to the loss of a week of normal activity. The cancellation of thousands of appointments also put pressure on sometimes quite junior staff who had to deliver this difficult news to patients and their families.
2.06	David Quirke-Thornton welcomed the progress made in the discharge summit but pointed out that in most cases people were discharged not to care homes but to their families. It was important for the partnership to recognise the impact on carers and to work together with the voluntary sector to enhance the support provided to them.

2.07	Jill Lockett suggested there were innovations on waiting-list management focusing on the risk factors and wider determinants of health which could be used, and sector-wide work on diabetes which were opportunities to make improvements.
2.08	Tal Rosenzweig reflected that giving a greater voice to the VCSE sector in discussions could help drive more innovative ways of thinking and addressing the issues.
2.09	Cllr Denise Scott-McDonald expressed a concern about how health inequalities would be addressed. Whilst some young people and their families could afford private treatment this was out of reach for those on low incomes.
2.10	Michael Nutt noted that waiting times were often discussed as a proxy for efficiency and suggested that numbers of people treated and staff working in the system would provide more illumination on the challenges.
2.11	Andrew Bland suggested that following the discharge summit there had been a step forward in consistency, but large trusts still needed to deal with multiple processes when discharging to the boroughs they served. Although localism was important to reflect the variation across the system there would be benefit in a core offer, sponsored by the Partnership, and consistently applied across south east London.
3.	**Implementing our integrated Care Strategy**
3.01	Ben Collins updated on progress with the strategy which had set out a vision and five priorities around prevention, early years, mental health and primary care and long-term conditions. The ambition was now to assess the evidence, and look innovatively and creatively at these five priorities to set out a clear overall approach, high-level delivery plans and measurable goals in each area.
3.02	Clinical and managerial co-leads identified for each area were working with small groups to test thinking with local delivery boards, and would bring the results to the strategy steering group and the integrated care partnership. Currently the approach was at the stage of diagnosis of the fundamental programmes, and would need to move quickly to setting a strategic approach, in order to identify by the autumn clear metrics and an implementation plan at system, borough and neighbourhood level.
3.03	Work on prevention had focused on how core medical prevention such as screenings and vaccinations could be delivered well, and had identified some issues of trust and a potential role for the VCSE to help reach certain groups. For early years the focus was on targeting support for the first 1001 days of life, identifying variation in quality of support, team-working and working out how to maintain relationships and continuity of care with young families. In relation to the ambitions for Mental health the focus was on early intervention with a focus of strong partnership working and better deployment of VCSE services and potential partnerships with schools. Primary care and Long term Conditions was a broader strand of work with the most complexity and most remaining to do to decide where this work can have most value and improve access for those excluded from the system.
3.04	

	Michael Nutt stressed the importance ensuring primary care and long term conditions continued to include long term conditions. The issues in relation to this priority would affect low-income families, groups from ethnic minorities, and the elderly; three groups which don't necessarily have advocacy through the system. It was therefore concerning that this was an area of less progress.
3.05	Cllr Paul Bell advised that simple messaging would be needed on what changes would be created as a result of the strategy, including what worked well currently and what needed to be improved in the future.
3.06	Cllr Jim Dickson welcomed the work so far but reiterated the importance of seeing some visible change, reaching underserved communities, and addressing their inability to access services.
3.07	David Quirke-Thornton asked for more ambition on adult mental health which should not aim just to prevent worsening of the situation. There were also key opportunities in relation to the creation of family hubs for health and local authority teams to work together to provide support for families.
3.08	Sir Norman Lamb noted the whole purpose of the ICS was to bring together health and care, and that it was important to demonstrate that resource would be reallocated upstream. It was vital to remain ambitious in relation to children and young people at the same time as recognising the challenges of the system which was failing families too often. Incremental improvement was unlikely address the need of people and transformational change was required.
3.09	Jill Lockett noted the need to move at pace on metrics, and suggested the opportunity to link this strategy to the research and innovation strategy all ICBs were required to publish.
3.10	Andrew Bland suggested that the representatives on the partnerships would need to lead on some of the strategic priorities. And to sponsor conversations across the system which may require organisations to accept slightly less funding, to allow more funding for upstream work.
3.11	Cllr Kieron Williams noted that there was need to identify the real practical changes that would be required for the strategy, could we get to a common shared ambition that all partners could sign up to, and suggested that a powerful story illustrating what integration meant in practice so that everyone was clear.
3.12	Cllr Denise Scott-McDonald commented that there were stories from residents who had been in the health system for some years as children, young people and then as adults. The strategy should help to ensure that the care that people received was the same across these services, which was not always residents' experience.
3.13	Dr Gavin McColl suggested that funding may need to be shared rather than reduced. It may be useful to set out what was expected as part of integrated working, and to think of ways that Local Care Partnerships could be empowered to make the most of opportunities to work in an integrated way to deliver the strategy.
3.14	

3.15	Dr Toby Garrood noted that problem definition was important and done well would help to identify real changes to pathways, better utilising services already in place as well as identifying need.
3.16	Richard Douglas suggested that a short meeting with the chairs may be useful to provide direction for the work, with the aim of involving partnership members more in the ownership of the work and being able to bring some of the difficult decisions to the partnership for resolution. The Partnership supported the areas of focus, and for proposals for an approach to be brought back to the partnership.
4.	**Voluntary Community and Social Enterprise (VCSE)**
4.01	Tal Rosenzweig suggested her aim for a vibrant diverse voluntary, community and social enterprise sector to be a strategic leader in the system, as well as address some of the challenges faced by the sector. In south east London, the VCSE was composed of over 6000 organisations with trusted relationships with local communities and providing holistic support. The sector often acted as a bridge between the community and statutory services, and had seen a huge increase in demand for its services and support for a range of intersecting needs from health to housing and children's issues which was impacting capacity.
4.02	It was difficult for the sector to fund its work sustainably with the increase in demand, and it was necessary to use most of the available funding to provide services, rather than for investment in the infrastructure necessary for longer term sustainability. Tendering processes required organisations to compete against each other and consumed time and resources, favouring larger organisations. Smaller organisations were often sub-contracted by successful larger bidders with a risk that their independent voice would be lost.
4.03	The VCSE had the potential to produce more ideas and services which were more appropriate for communities if it was an equitable partner in the system and had power in decision-making spaces. Although there was some progress in some areas there was more to be done.
4.04	Dr Gavin McColl suggested that by working closer with those delivering statutory services, VCSE organisations could take advantage of those who had expertise in contract management who worked for larger organisations. Joint funding models with primary care teams could help the VCSE sector as well as helping primary care teams avoid a tendency for medicalising peoples problems.
4.05	Jill Lockett proposed that for each of the aims of the strategy there ought to be exploration of innovative use of the voluntary sector, and encouraged the partnership to see the wide landscape represented by the voluntary sector rather than focusing on its ability to help with narrowly defined individual issues.
4.06	Cllr Jim Dickson emphasised the importance of facilitating long-term relationships built on trust through procurement and management processes which avoided excessive monitoring and focused on a small number of outcomes to assess performance. Lambeth the voluntary sector was a partner jointly responsible with other health and care organisation for delivering the goals of the whole partnership.

4.07	Cllr Paul Bell asked that the recommendations avoid duplication, noting the significant work already undertaken in Lewisham. Expressing some concern about the lack of limitations on social enterprises in some areas such as chief executive pay, he advised that the purpose and form of these enterprises needed to be clear.
4.08	Michael Nutt noted that while Bromley Healthcare was a larger organisation providing 35 commissioned services, it faced similar challenges to those described, a particular difficult was the distinction between capital and operating funds which affected the ability to delivery long term services, and so the allocation of money was as important as the tendering process.
4.09	Cllr Denise Scott-McDonald raised concern about the voice of service users in determining the outcomes and success measures applied to VCSE organisations. For support aimed at service users who experienced inequality such as Black men it was important to promote organisations composed of people with lived experience of the issues being addressed.
4.10	Richard Douglas noted that in bringing the paper to the group the reflection of the chairs had been that the system was risk-averse in relation to the VCSE sector and did not make it easy for organisations to contribute. A concordat articulating ways of working with the VCSE across the system may be a way forward.
4.11	The Partnership welcomed the presentation and agreed for a concordat to be presented to them at a future meeting.
5	**The Mental Health Concordat**
5.01	Sir Norman Lamb noted that the work on a Mental Health Concordat had started in recognition that people in mental health crisis were experiencing repeated failures of care across London. People remained in A&E departments for hours or sometimes days in crisis, often being looked after by police officers instead of the appropriate mental health staff, and inpatient beds were full across the system, with frequent occasions of people being placed in beds out of the area in which they lived. In addition, many people could have avoided a reaching a mental health crisis if better support had been provided to them beforehand.
5.02	All partners involved, from police and NHS to service users themselves, had been involved in the development of the Concordat's four principles, which incl There were four principles: to support people to avoid falling into mental health crisis, to provide care closer to home and avoid conveying people to A&E, to provide support in a timely way to those in A&E, and to improve flow through the mental health system with purposeful admissions with a discharge planned on admission. These principles were supported by a range of actions, for example a commitment to a substantial reduction in the use of Section 136 of the mental health act, a coercive action which disproportionately affected black people in our community.
5.03	Dr Gavin McColl noted that involving the voluntary and community sector presented a real opportunity. Although the focus on mental health crisis was right, there was also opportunities for improvements in lower-level mental health where there was limited provision but a large volume of need. He noted that many patients had a various complex needs, and interventions or services limited to mental health may be confusing for patients.

5.04	Dr Toby Garrood asked if more could be done to identify and support people who were at risk of falling into mental health crisis.
5.05	Cllr Paul Bell supported the work but suggested the term 'Concordat' chosen seemed unusual. The wider context to issues was a lack of funding and a realistic workforce strategy for health and local government. He asked that care should be consistent with all the current standards and best practice, and that ways of managing behavioural disturbance needed to be aligned with the aim to reduce use of section 136.
5.06	Cllr Denise Scott-McDonald described the document as timely given the impact that the Covid-19 pandemic was having on accelerating mental health issues, particularly for young people.
5.07	Jill Lockett praised the principles and south east London's response, pointing out that it would also be important to consider the physical health of those with mental health conditions.
5.08	David Quirke-Thornton strongly supported the Concordat, and actions including reduction of use of section 136, which would create require every part of the system to work together to deliver.
5.09	Sarah Cottingham commented that south east London's responses had been listed, however the key challenge would be ensuring that the actions made an impact and the comments in the session had been useful.
5.10	Cllr Jim Dickson added that there was variation in approach across the six boroughs living well agenda, and lot to learn from each other.
5.11	The partnership supported the Mental Health Concordat work.
6.	**Questions from the public**
6.01	***A member of the public shared an example of a resident whose internet and phone service had been cut off for three months due to a fault with the provider. The resident, who was a carer and suffered from mental health issues, was not allowed to book a GP appointment at the GP practice reception and had to change practices to get access to an appointment. In another example, a patient needing a letter to travel abroad with a controlled substance was told to use e-consult, the letter was not provided in time for the trip and the patient was charged £30. The questioner suggested GPs were not being flexible enough given that technology sometimes did not work for people.***
6.02	Dr Gavin welcomed the comment which demonstrated that there was a significant pace of change to introduce digital tools which often were helpful but not for everyone and all the time, there was also variation in the ability of individual providers to keep up with this change.
6.03	***A member of the public commented on the difficulties some faced in obtaining support for mental health, and that a service called Horizon House provided by Oxleas NHS FT had been 'better than any pill' for people with***

	mental health issues in providing peer to peer support and help with simple life skills, but funding had been reduced.
6.04	Sir Norman Lamb strongly endorsed the suggestion to collaborate much more closely with voluntary sector organisations, who could make real difference to local people for example helping those experiencing loneliness and isolation to find companionship and build relationships.
6.05	***A member of the public commented on fantastic work being done by a local social prescribing link worker but observing there seemed more work than one person could handle – she wished the partnership well in their work to provide more support in this area.***
6.06	Cllr Kieron Williams welcomed the contribution which would remind the partnership of the need to continue working towards achieving the goals set out to improve health and care for local people.
6.07	***A member of the public asked if the strategic priorities and other work being led by the partnership was being developed through genuine co-production with the public and those using the services.***
6.08	Cllr Kieron Williams noted that the strategic priorities had been developed working with local people to get their views and the partnership was committed to working with residents in boroughs he thanked the questioner for the reminder to make the contribution of residents and service users clearer in papers and presentations.
	CLOSE

Integrated Care Partnership

Item 2
Enclosure B

Title:	**Focus on Primary Care in the south east London health and care system**
Date:	24th July 2023
Authors:	Holly Eden and Clare Fernee
Executive Lead:	Sarah Cottingham, Executive Director of Planning

Purpose of paper:	Providing the ICP with an overview of the recently published primary care access recovery plan and our response including an update on the role and scope of community pharmacy in SEL.	Update / Information	x
		Discussion	x
		Decision	

Summary of main points:	• Primary care services provide the **first point of contact** in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services, but also includes wider first contact clinicians and professionals.
	• During the past 10 years a number of plans, strategies and frameworks have been produced including the Fuller Review in 2022 and recently the recovery access plan for primary care.
	• NHS England published the 'Delivery Plan for recovering access to primary care' in May 2023, which has 2 main objectives:
	  ○ To tackle the 8am rush and reduce the number of people struggling to contact their practice.
	  ○ For patients to know on the day they contact their practice how their request will be managed
	• The Delivery Plan for Recovering Access to Primary Care is one of three recent NHS strategic recovery plans addressing priority areas alongside elective recovery plan and urgent and emergency care recovery plan
	• One of the headlines of the plan is to build capacity which includes working with community pharmacy to develop their capacity and scope.		

Recommendation:	The Integrated Care Partnership is asked to note the contents of the report		

South East London Integrated Care System

Primary Care Focus

Including an update on the developing role and scope of community pharmacy and the collaborations that are forming in South East London

24 July 2023

Primary Care in South East London

Six Local Care Partnerships (LCP) with Six borough ICB primary care teams embedded into LCPs

198 practices -
255 (including branch) surgeries
Circa 5,000 staff members

216 Dental and orthodontic contracts

Primary care services provide the **first point of contact** in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services, but also includes wider first contact clinicians and professionals. It can also include NHS111 and some same day urgent care services.

Clinical Effectiveness South East London

One clinical effectiveness programme

35 Primary Care Networks with 58 Primary Care Network Clinical Directors

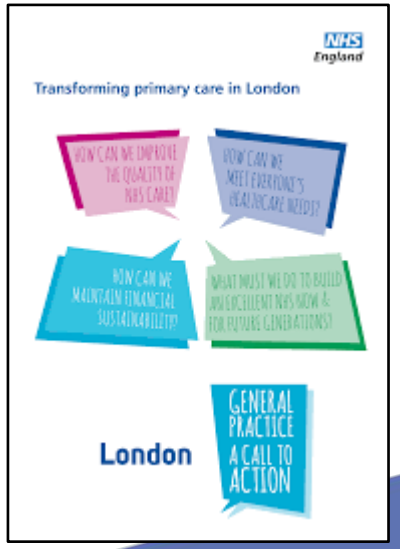
324 Community pharmacies
One pharmacy Alliance

7 GP federations
1 Lead training hub and 5 further locality hubs

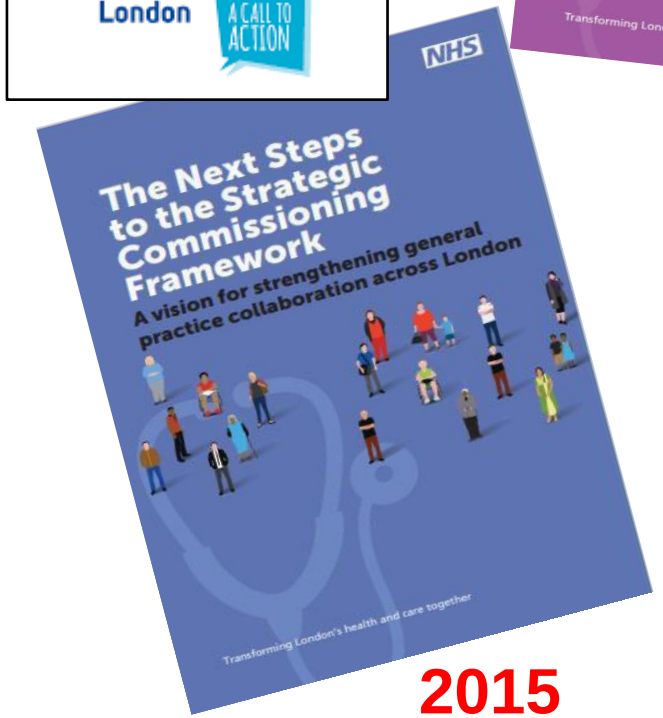
Strategic Context

South East London Integrated Care System

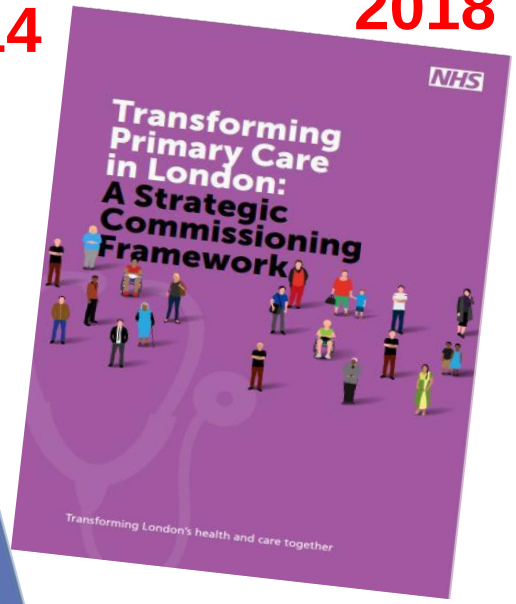
2014



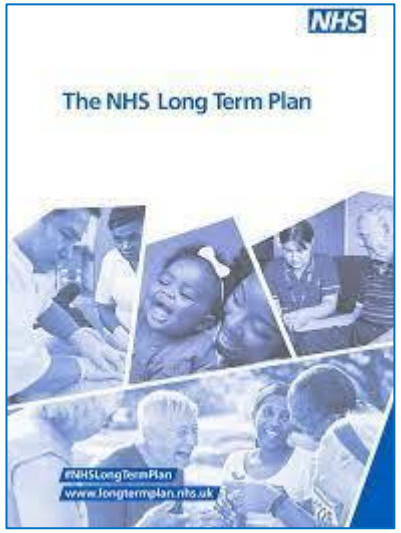
2015

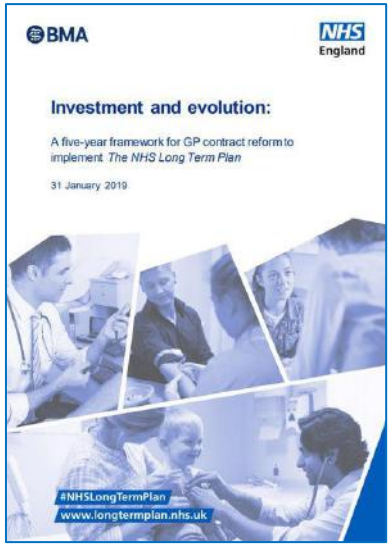


2018

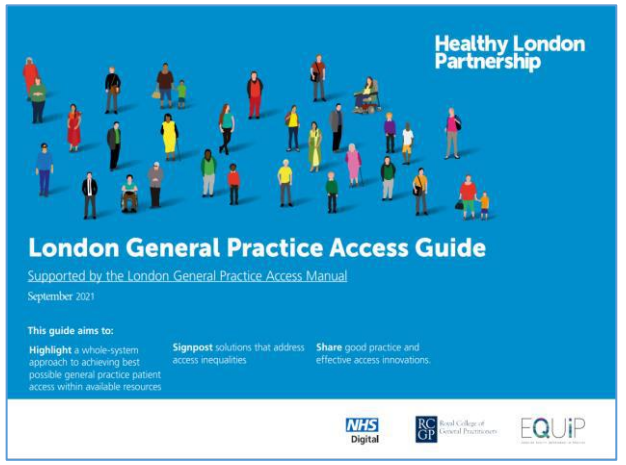


2019





2021



2022

2023

Strategic Context

In the last 10 years there have been multiple national and regional documents/ plans/ approaches to tacking the issues in general practice particularly.

The latest is the delivery plan for recovering access to primary care - which is only part of the challenge. We also need to grow capacity to meet the needs of the population.

Some of that will be by providing those who feel confident with a self management plan, it may be that for some needs they can be better met by someone outside of general practice, there is also the opportunity to access and utilise PCN arrangements through additional roles and to support general practice to recruit and retain staff.

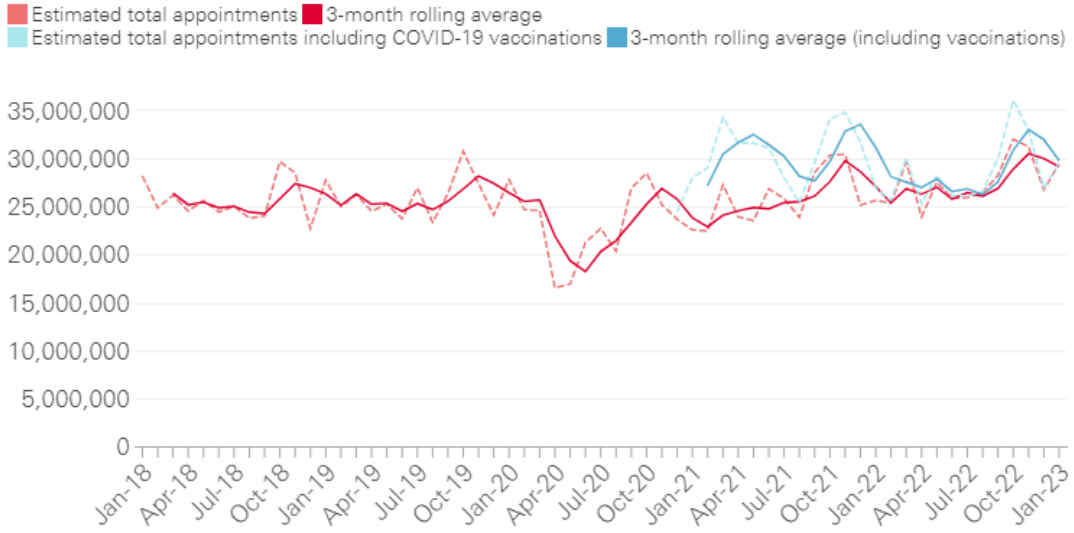
The issue

52.7% found it easy to get through to someone on the phone at their GP practice (67.6% in 2021).

26.5% said that they avoided making an appointment because it was too difficult, compared with 11.1% in 2021.

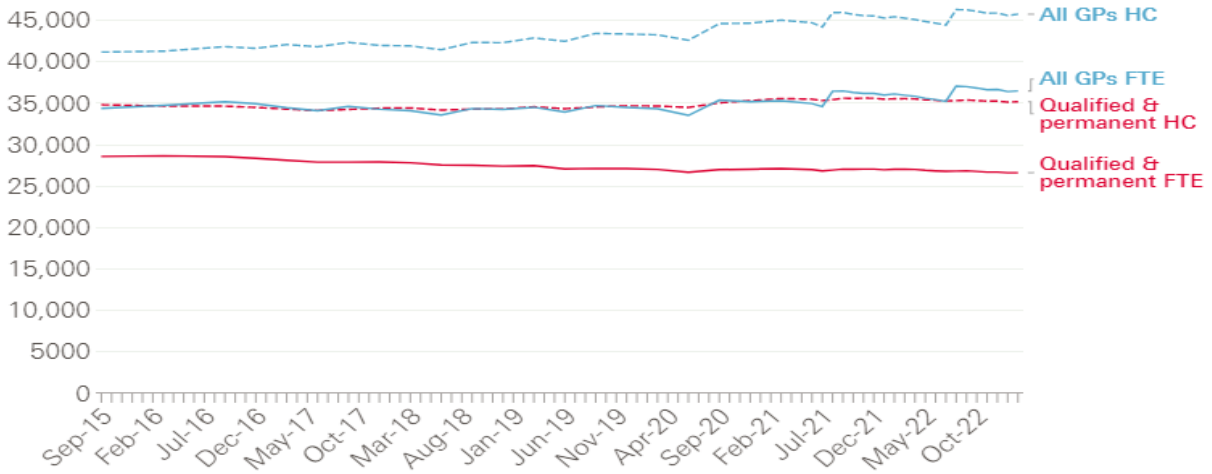
The increasing trend in appointments in general practice continues, with 29 million appointments in January 2023

The monthly estimated total count of general practice appointments in England and 3-month rolling average, including and excluding COVID-19 vaccinations



The total number of GPs has increased since 2015, but there are fewer qualified and permanent FTE GPs

The full-time equivalent (FTE) and headcount (HC) of all GPs and qualified and permanent GPs per quarter



Most patients continue to be positive about their experience during their last appointment, for example, nine in ten patients reported feeling confidence and trust in their healthcare professional (93.1% in 2022, 95.6% in 2021).

The Plan Headlines

Primary Care Access Recovery Plan

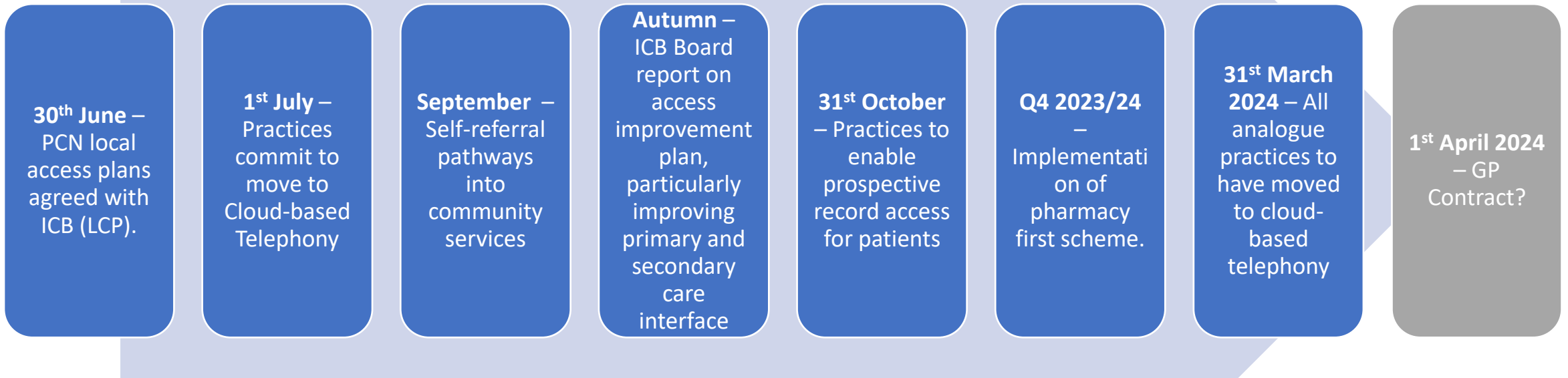
South East London Integrated Care System

The Delivery Plan for Recovering Access to Primary Care is one of three recent NHS strategic recovery plans addressing priority areas alongside elective recovery plan and urgent and emergency care recovery plan.

1		**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy
2		**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity • Rapid assessment and response
3		**Build capacity**	• Growing multi-disciplinary teams	• More new doctors	• Retention and return of experienced GPs • Priority of primary care in new housing developments
4		**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Reducing IIF indicators and freeing up resources

Primary Care Access Recovery Plan

Timelines 2023/24



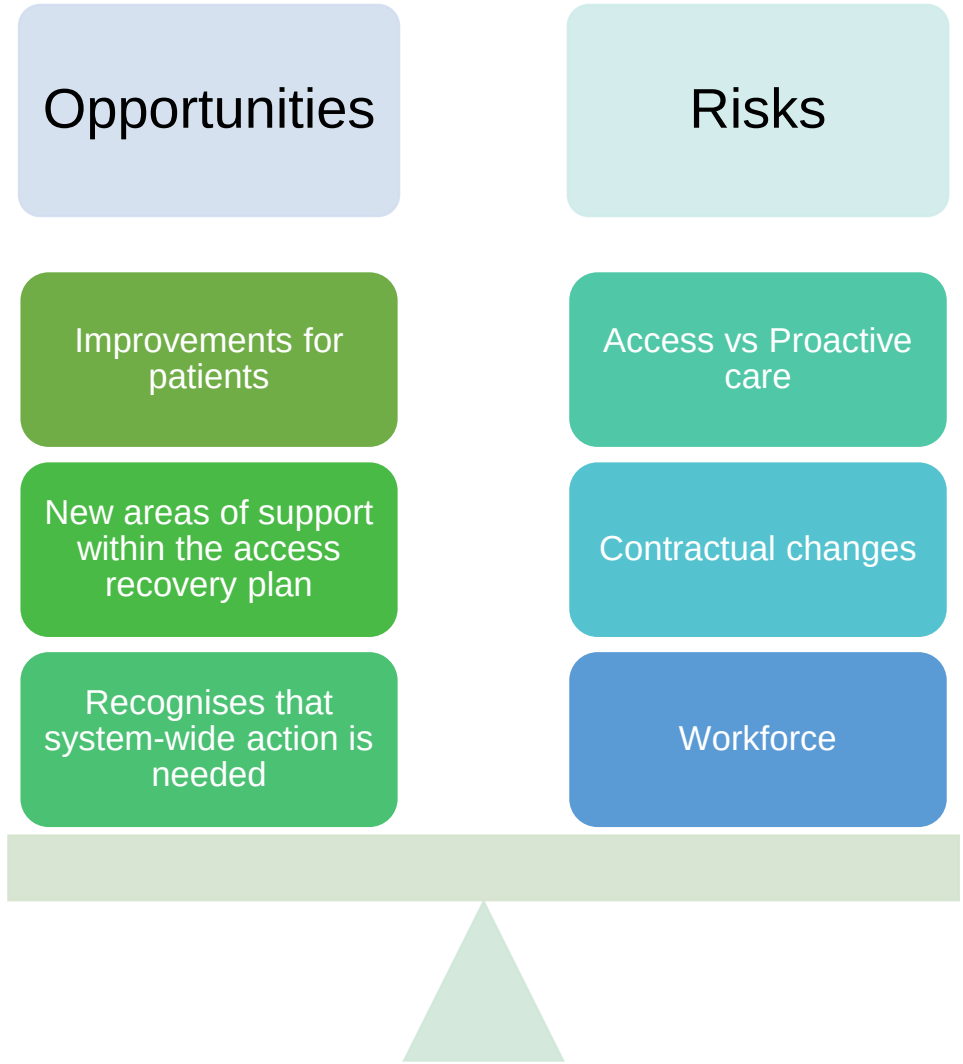
Our Response

Primary Care Access Recovery Plan

South East London Integrated Care System

Getting ourselves organised	Borough Focus	SEL Focus
• Sharing information • Establishing governance arrangements • Developing plans to ensure roles and responsibilities are understood • Working as part of London to share good practice • Communication Planning	• Practice/PCN nominations for national transformation support • Practice support identification • Care navigation training and digital transformation training • Practice/PCN access improvement plans • Baseline data	• Digital telephony • Digital tools • PCN/Practice Capacity IIF baseline • System level access improvement plan • Enabler co-ordination • Self referral pathways • Primary and secondary care interface

Key Opportunities, Risks and Challenges



How do we adapt national plans to fit SEL?

How do we make the most of the opportunity that the delegation of pharmacy, dental and optoms give us?

How do we generate and maintain momentum and support for change and transformation within our practices and PCNs

How can the wider system support primary care?

Fuller Report Recommendations

The Fuller Stocktake Report outlines a new vision for primary care that reorientates the health and care system to a local population health approach through integrated neighbourhood teams. The vision requires bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations and expects Integrated Care Systems to:

- Build on the primary care network (PCN) structure by coming together with other health and care providers within a local community to develop integrated neighbourhood 'teams of teams' at the 30,000-50,000 population level.
- Work together to share resources and information dedicated to improving the health and wellbeing of a local community and tackling health inequalities.
- Realign services and workforce to communities and drive two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach
- Put in place the appropriate infrastructure and support needed to build these multi-disciplinary teams with the aim of having universal coverage of neighbourhood teams by April 2024

Fuller Report Recommendations

South East London Integrated Care System

Delivering integrated neighbourhood teams will require cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods. A system-wide approach will be required to ensure:

- Full alignment of clinical and operational workforce from health providers to neighbourhood ‘footprints’, working alongside dedicated, named specialist teams from acute and mental health trusts
- Making available ‘back-office’ and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (e.g. GP federations, supra-PCNs, NHS trusts)
- System-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

Community Pharmacy Clinical Services

South East London Integrated Care System

Access – supporting urgent care

- **Community Pharmacist Consultation Service (CPCS**). Minor illness triage, assessment and treatment. Referrals from **urgent care settings & general practice.**
- Supply of **urgent medicines** to ensure ongoing care and managing repeat dispensing working with general practice to identify patients at risk.
- **Pharmacy first schemes** (locally commissioned) to supply OTC or pharmacy medicines for common ailments

Prevention - improving outcomes

- **Weight** management, safeguarding antibiotics, management of respiratory disease, health inequalities.
- **Blood pressure check service** - case finding and regular checks and access to ABPM.
- **Smoking cessation** service to support QUIT journey post discharge from hospital including community services and mental health.
- **Contraception Service** to support access to regular oral contraception including annual health checks.
- **Cancer checks** pilot will continue to develop and test the optimum pathways for referral into secondary care for further assessment and diagnostic pathways.
- **Immunisation** for Covid and flu
- **Substance misuse,** methadone and needle exchange services (locally commissioned)
- **Vaccine champions service**, developed into a health and wellbeing (vital 5) champions service, social prescribing (locally commissioned)

Long-term conditions

- Pharmacy quality scheme to support management of **respiratory disease** through inhaler checks.
- **New Medicine Service to support adherence** to medicines when first prescribed including any change in therapy
- **Anticoagulation** monitoring (warfarin) (locally commissioned)

NEW – for Community Pharmacy

South East London Integrated Care System

Primary Care Recovery Plan, May 2023

- **£645m** invested into new community pharmacy clinical services (current national contract is £2.592 billion a year)
- Pharmacy common conditions, expansion of NHS Pharmacy contraception and NHS Blood Pressure service
- With investment, “Pharmacy can do so much more”
- IT system connectivity – interoperability between pharmacy and general practice.

Ambition

- Pharmacy First will supply prescription only medicines for 7 common conditions without the need to visit GP.
- BP service currently delivers up to 120,000 checks per month - expand to further 2.5 million blood pressure checks prevent over 1,350 cardiovascular events such as heart attacks and strokes. **Savings of around £13 million would be seen from the reductions in these events across primary, secondary and social care**.
- Contraception initiation - estimate a quarter of women taking oral contraceptives could be using this service by 2024

Community Pharmacy Independent Prescribing Pathfinders, 2023

- All ICBs have applied and will test delivery of **Independent Prescribing (IP) in community pharmacy.**
- Currently one independent prescribing (IP) pharmacist per 10 community pharmacies. HEE 2021 community pharmacy workforce survey
- NHS England funding up to 3,000 IP training places to end of March 2024. Includes training of the Designated Prescribing Practitioner (DPP).
- GPhC is responsible for the initial education and training standards that were revised to include from 2021 the requirements for IP.
- From September 2026 newly registered pharmacists will be designated IPs**. Expectation is 2,000 IP pharmacists newly qualify per annum.**

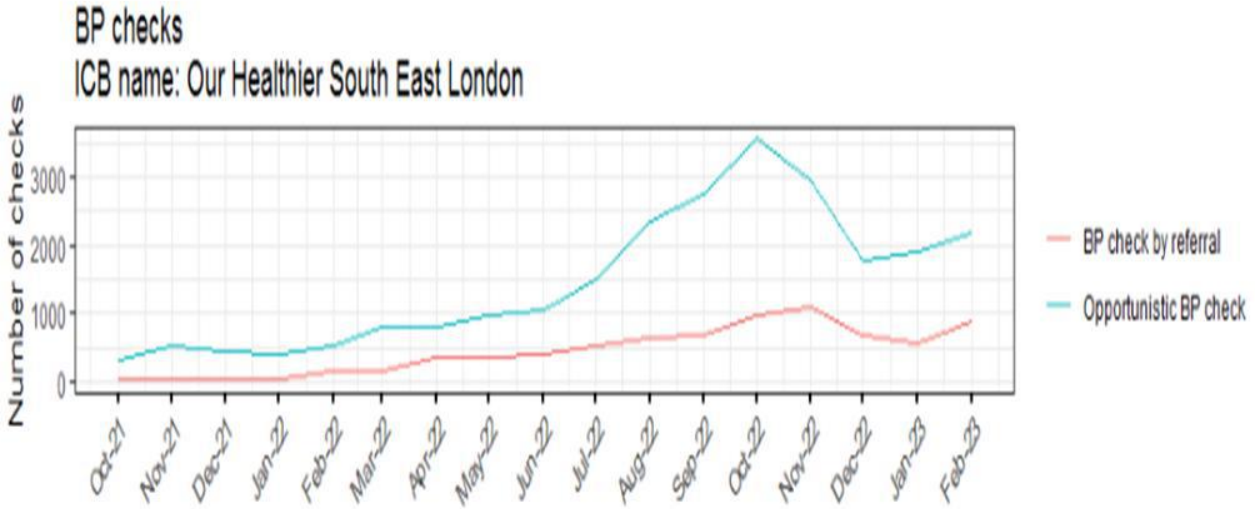
Community Pharmacy Workforce

- Opportunities in apprenticeships and training pharmacy assistants and pharmacy technicians. DHSC consultation on **skill mix** .
- Allows pharmacists to move to mainstream independent prescribing role.
- DHSC consultation for pharmacy technicians to legally supply prescription medicines under Patient Group Directions (e.g. vaccination, contraception).

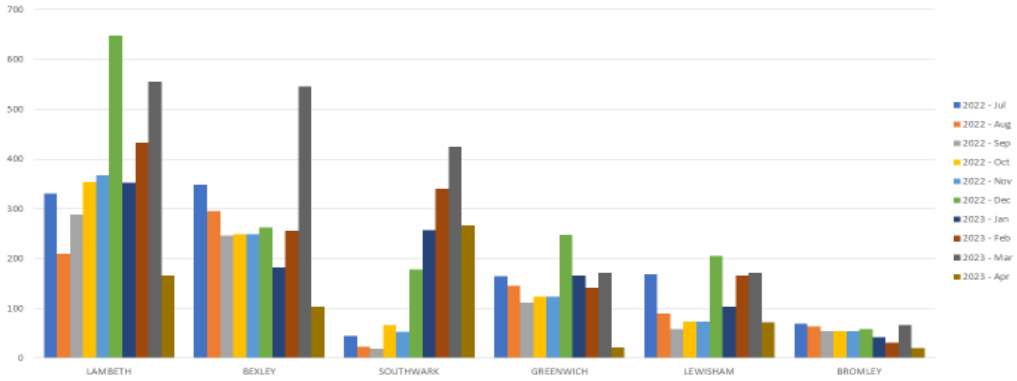
No. of flu vaccination doses administered in pharmacies in SEL

The % figures show year on year change in doses administered

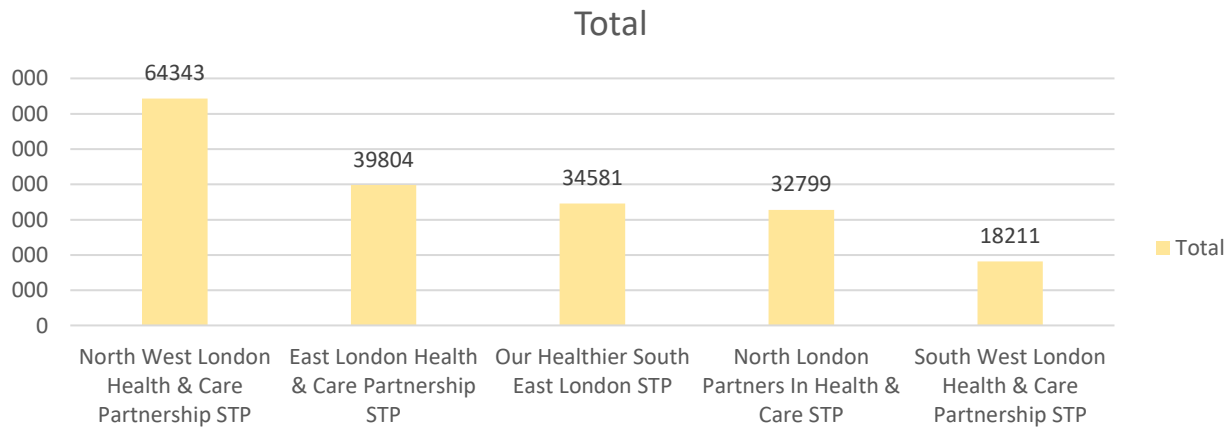
Number of BP checks in pharmacies in SEL



GP-CPCS referrals for SEL (July 2022-April 2023



Total BP & ABPM checks (October 2021-February 2023)



South East London
Integrated Care System

Integrated Care Partnership

Item 3
Enclosure C

Title:	**Developing our South East London Integrated Care Strategy**
Meeting Date:	24 July 2023
Authors:	Ben Collins, Maria Higson, Jessica Levoir
Executive Leads:	Jonty Heaversedge and Toby Garrood (Joint medical directors)

Purpose of paper:	To update Partnership members and seek their steers on the proposed focus and ambitions for each of our five strategic priorities as well as advice on the potential solutions we should explore before the next Partnership meeting in October.	Update / Information	X
		Discussion	X
		Decision	X
Summary of main points:	• In our strategy publication of February 2023, we committed to action across SEL to address five priorities: prevention, early years, children's and adults' mental health and primary care and long-term conditions. • This paper sets out proposals for the specific challenges we should address within each of these five priorities and statements of ambition setting out the improved outcomes we are seeking to achieve. • The paper also provides an overview of the data relating to each challenge, our hypotheses on the main underlying issues, and what work is already in train across our system. • There is already a huge amount of work happening across our system to address aspects of our five strategic priorities, in our Local Care Partnerships, our providers and in transformation programmes. The challenge is therefore to identify the areas where taking collective action as a system might allow us to go further faster. • The paper provides a summary of the types of intervention that are likely to gain traction on the challenges in each of our priority areas, an initial discussion of the action we might take together in each area, and we might coordinate action in the five areas as a coherent strategic approach.		

Recommendation:	• We would welcome the Partnership's reflections on our description of the challenge and the proposed ambitions for each of the five priorities. We are hoping to reach agreement on these in the meeting. • We would value the Partnership's reactions to our assessment of the underlying issues relating to each of the five challenges. Are there any important issues we have missed? • We would welcome Partnership members' reflections on our analysis of the evidence on successful approaches and our current thinking on the type of strategic approach we might take at SEL level for the five priorities. This will help us to focus work to develop actions before the next partnership meeting in October 2023. • Finally, we would welcome members' thoughts on the proposed next steps and how they would like to be involved in the next phase of the work before the next Partnership meeting in October.

South East London Integrated Care System

Development of the SEL Integrated Care Strategy

Update for SEL Integrated Care Partnership

24 July 2023

Contents

Overview

South East London Integrated Care System

- In February 2023, we published a **vision** for the future of health and care in South East London and set out **five strategic priorities** for prevention, early years, mental health, primary care and long-term conditions. These are important areas for partners across our system and our residents, where we saw scope for faster progress through working together, while respecting the principle of subsidiarity and delegation to partnerships in our system.
- Since publication, we have held further discussions and reviewed evidence on the needs of our communities and performance of our services. This has allowed us to **clarify the challenges** we believe we should focus on collectively within each of the five priorities and the **ambitions** we should set for improved outcomes. We are hoping we can refine these statements with the IC Partnership in July, as a basis for the next phase of the work.
- Since publication, we have also deepened our understanding of the **underlying reasons for the challenges we have identified** – the reasons why we are struggling to gain traction on them given our current approaches to delivering services.
- While each of the priorities is different, there is **a striking number of common themes**, for example the need to intervene earlier, to develop models of service delivery that sustain relationships and build trust and understanding, to bring health, social care and VCSE support together, and to build up the community-led support alongside public services.
- In tandem, over the last six months, we have also developed our Joint Forward Plan which gives an overview of the **range and extent of work** to improve care across our system.
- There is **a huge amount of activity to address our five strategic priorities** already planned in our Local Care Partnerships and our providers, so the challenge is to identify where concerted action across South East London might allow us to **accelerate progress**.
- In some cases, there is exciting work in parts of South East London to address the challenges in our strategic priorities, but there is scope to do this **more systematically** across our system and **address gaps.**
- In many cases, partnerships across our system are pursuing similar initiatives, for example introducing effective team working in primary and community care, but there may be scope for **more structured sharing of learning and collaboration** to implement change successfully.
- As well as statements on the challenge and proposed ambitions, and our hypotheses about the most important underlying reasons in each area, we provide a discussion (mainly in the Annex) of **the evidence on successful approaches and models**.
- We also give a flavour of **the sorts of strategic approaches we might develop** for the five areas (slides 10 to 14) and how this might add up to a coherent strategic approach for all the priorities (slides 15 to 16).
- For example, for all our priorities, there are opportunities to **focus on those most in need**, to **reorient around neighbourhoods**, to integrate care (as well as linking services up better), and to build stronger partnerships and ecosystems of statutory services and community-based organisations.
- We also give a sense what action this might lead to (slide 17), e.g. increasing funding, mobilising our IC Partnership's resources, spreading innovation, making changes to SEL-wide services or investment in infrastructure.
- We need to do more analysis and engagement with our partners and communities on the options and the type of action that would best complement work already in train in our system. But **your steers on our current thinking will help us deliver the next phase of work effectively**.
- In the next phase, we will also need to agree what action to take at different levels, ensuring that partners in our system can shape implementation.

Our mission and strategic priorities

South East London Integrated Care System

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

Our priorities

Prevention and wellbeing

Improving prevention of ill health and helping people in South East London to stay healthy and well.

Early years

Making sure that children get a good start in life and there is effective support for mothers, babies and families before birth and in the early years of life.

Children's and young people's mental health

Improving children's and young people's mental health, making sure they have quick access to effective support for common mental health challenges.

Adults' mental health

Making sure adults have quick access to early support, to prevent mental health challenges from worsening.

Primary care and people with long-term conditions

Making sure people have convenient access to high-quality primary care, and improving support and care for people with long-term conditions.

We now need to develop our five Strategic Priorities into a shared set of ambitions, to be delivered through solutions which build on and go further than our existing projects in these areas.

Questions for our Integrated Care Partnership

South East London Integrated Care System

- We would welcome the Partnership's reflections on our description of the challenge and the proposed ambitions for each of the five priorities (slides 10 to 14). Are members happy with how we have sought to clarify the focus of the strategic priorities? Are our proposals for the ambitions sufficiently concrete and stretching?

- We would value the Partnership's reactions to our assessment of the underlying issues relating to each of the five challenges (summarised in slides 10 to 14 and covered in more detail in the Annex). Do members feel that we are getting to the most important underlying problems or are there important issues we have missed?

- We would welcome Partnership members' reflections on our analysis of the evidence on successful approaches and our current thinking on the type of strategic approach we might take at SEL level for the five priorities? We would also welcome members' reflections on how this might add up to a coherent strategic approach (slides 15 to 17).

- This is still work in progress, but your steers at this stage will help us to shape the next phase of the work to focus on the right issues and opportunities.

- Finally, we would welcome any thoughts on the process and next steps (slides 6 to 8 and 18). For example, are any specific issues you would like us to consider as we develop our analysis and engage more broadly, and how you would like to be involved in the next phase of the work before the next Partnership meeting in October?

The process we are following (1)

From SEL IC Strategic Priorities to implementation plan with outcome metrics and business cases

Phase 1 ***Spring 23*** ***July 23 - ICP*** ***Oct. 23 – IC Partnership***

- ✓ Mission and vision statements
- ✓ Five strategic priorities (areas of focus)
- ✓ Some system-level evidence to support the priorities
- ✓ Conditions for change
- ✗ Targets/ metrics
- ✗ Solutions
- ✗ Implementation plan
- ✗ Business case

Define & describe

- Describe the challenge, supported by an initial data analysis and evidence review
- Review ongoing work set out in the Joint Forward View
- Set out and test hypotheses on the key underlying issues, including through stakeholder interviews
- Propose ambitions and outcome/ output metrics for each priority
- Identify examples of best practice/ possible solutions
- Set out the emerging strategic approach and areas of greatest need.

Deep-dive into solutions

- Refine the description of the challenge and ambitions, including through further data analysis
- Discussions with stakeholders and experts including leaders across our ICS, staff leading service delivery, Healthwatch, VCSE and community groups
- Review of evidence base (within UK and other countries)
- Engagement with our residents and service users
- Develop or refine the process and output metrics for each potential solution

Test and refine options

- Test options based on agreed criteria
- Agree a logic model and process and output metrics for preferred solutions
- Systematic scan of existing activity (including R&I) to identify and link in existing teams and initiatives

Implementation approach

- Develop overall implementation approach, roles of partners, approach to spread or improvement.
- Set approach to learning and measuring impact, aligned to agreed metrics
- Engage with industry/ innovators/ HIN/ etc.
- Set out the resource implications and outline business cases for IC Partnership to consider

Delivery

- To be defined

The process we are following (2)

From SEL IC Strategic Priorities to implementation plan with outcome metrics and business cases

Spring 23 → ***July 23 - ICP***

Define & describe

	SEL ICS partners (excl. VCSE)	SEL partners	London or National organisations

Engagement through the Define & Describe phase	• Strategy steering group, with membership including:
	  • NHS Trust Directors of Strategy
	  • Borough Place Executive Leads
	  • Public Health
	  • Healthwatch
	  • ICB executive sponsors and leads
	• ICB colleagues including ICB Executive member and relevant Directors and Programme Leads
	• Priority-specific engagement within relevant groups (e.g., Early Years Priority Workshop, Mental Health Transformation Programme Board, Evelina London Consultant)
	• Director of SEL Healthwatch
	• Lead Director of Public Health
		For example:
		• VCSE Director and SEL VCSE strategic alliance
		• Mum's Aid
		• Young Mums Support Network
		• Mosaic Club House
		• LEAP Programme, National Children's Bureau
		• Surrey Square Primary School
			For example:
			• Centre for Mental Health
			• Birth Companions
			• Place2Be
			• Bromley by Bow Centre, Tower Hamlets
			• Churchill Gardens Wellbeing Programme, Pimlico
			• Nuffield Trust
			• Hope Citadel, Oldham
			• Focused Care Greater Manchester
			• NAViGO, Grimsby

For further discussion

The process we are following (3)

From SEL IC Strategic Priorities to implementation plan with outcome metrics and business cases

Phase 1 *Spring 23* — *July 23 - ICP* — *Oct. 23 – IC Partnership*

	Define & describe	Deep-dive into solutions	Test and refine options / Implementation approach	Delivery
Engagement overview	1. Engagement with partner organisations within the system, including VCSE partners, and experts from outside SEL 2. Group and one-to-one engagement *(See next page)*	1. Online engagement, placing materials online (could use previous online platform from Phase 1) 2. Group and one-to-one engagement as appropriate per priority	1. Group and one-to-one engagement with stakeholders and experts as appropriate per priority 2. Face to face session for each of the five priorities 3. Communication with ICP members (including 1:1s as requested) 4. Presentations to other forums 5. Two online engagement sessions with the public	
Target groups	1. Colleagues in the ICB, colleagues from other health and care organisations 2. VCSE partners, Healthwatch 3. Experts from outside of SEL	1. Public, VCSE partners, Health and care staff 2. Colleagues in the ICB, colleagues from other health and care organisations, VCSE partners, Healthwatch	1. Colleagues in the ICB, from other health and care organisations, VCSE partners and Healthwatch 2. As (1), plus ICB and ICP leaders 3. ICP members 4. Other key stakeholder groups e.g., ICB 5. Public, VCSE partners and health and care staff	
Purpose	• Develop problem statements based in data • Understand ongoing work • Propose ambitions and metrics	• Gather ideas on potential solutions • Understand different lenses to our challenge and ambitions statements • Test prioritisation	• Test and agree shortlist of options to be worked up • Develop implementation plans • Recommend the implementation plan to the ICP	

The process we are following (4)

South East London Integrated Care System

	Define & describe	Deep-dive into solutions	Test and refine options	Implementation approach	Delivery
Aim	**Describe the challenge and propose ambitions**	**Identify potential interventions for each priority**	**Build consensus on SEL-wide actions per priority**	**Develop implementation approach**	**Deliver within our system-of-systems with metric tracking**
Activities	• IC Strategy and JFV review • Interviews • Data analysis	• Data analysis • Literature review • Workshops • Public engagement	• Deploy prioritisation process • Online and in person events for all partners	• Develop options and overall approach to implementing the change	• Implement solutions
Outputs	• Challenge description for each priority, with data • Review of the JFV • Proposed ambitions and outcome metrics • Examples of best practice and possible solutions • Emerging strategic approach	• Refined description and ambition statements • Set of potential solutions with evidence • Process and output metrics for each solution • Prioritisation process to select recommendation	• Identify small no of actions per priority • Process and output metrics with clear relationship to outcomes (through a logic model) • Report of existing activity against the solutions	• Determine actions at different levels • Overall approach to delivering change. • Funding and outline business case • Approach to learning and measuring impact	• To be set out in approach to learning and measuring impact
Resourcing	• Subject matter experts • ICB system development team • PPL consultancy support • Nuffield Trust support	• Subject matter experts • ICB system development team • Consultancy support • Public engagement support • Metrics support from KHP	• ***ICP members (actively involved at this stage)*** • Subject matter experts • ICB system development team • Public engagement support	• Subject matter experts • ICB system development team • Consultancy support • Public engagement support	• To be determined – business case required
Timing	Up to IC Partnership, 24 July 2023	17th July – 25th August (6 weeks)	August – September 2023	September – October 2023	November 2023 onwards

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Description of the challenge

- We are struggling to deliver a set of proven preventative health services including vaccinations, health checks and health screening to some deprived and disadvantaged people and communities within South East London.
- This means that people from these groups are exposed to avoidable disease, diagnosed late for major health conditions, and do not receive the right treatment or support, leading to significant and preventable lost years of life and years of healthy life.

Proposed ambition*

- We will reduce the current disparity in uptake of proven health screening and prevention programmes for people from deprived and disadvantaged groups, so that we reduce unwarranted variation in health outcomes from cancer, infectious and other diseases.
- We will meet, or exceed, key immunisation and screening rate targets over the next 10 years.
- We will close the existing gap in accessing these interventions for deprived and disadvantaged groups over the next 10 years.
- We will tackle this in the first instance by developing more targeted, evidence-based approaches to increase uptake amongst the most deprived and disadvantaged communities in South East London.

* Initial thinking on metrics in annex

A possible strategic approach

- Our data points to low take up of preventative services within some deprived groups, contributing to lost years of life.
- In fact, the situation is likely to be worse, as many people from the most deprived communities don't show in our data.
- We know a fair amount about the reasons such as low trust, inaccessible services and competing priorities.
- However, there is a lot we don't know for specific groups. Often the reasons can be specific for a particular community and vary from one preventative services to another.
- There is a lot of work being planned across our system to improve take up of vaccinations, health checks and screenings and other preventative services.
- In general, the approach is oriented around delivery for relatively large populations for a specific preventative services, but with a focus on addressing health inequalities.
- Alongside this, there are beacons of innovative practice in SEL and other systems (e.g. Lambeth Portuguese Wellbeing Alliance or the Fast Track Cities HIV programme). Many successful approaches focus on building close relationships with a neighbourhood, understanding exactly what local people need, and orienting services around them.
- One option for a strategic approach might be to seek to learn from and spread these approaches to a larger number of our most deprived neighbourhoods, supporting community organisations to connect with local people and primary care to deliver prevention in more effective ways.

Notes: Reflects the focus agreed in our strategy publication on core health prevention. We have proposed to focus initially on the most deprived and disadvantaged service users, where uptake is lowest and there is greatest scope to improve outcomes and address health inequalities.

Priority 2: Ensuring a good start in life in the first 1001 days

Description of the challenge

- We are not currently identifying some highly vulnerable parents and babies early enough (e.g. before birth) and do not always give sufficiently intensive or effective support to ensure a good start in life in the first 1001 days from conception to age two.
- This is leading to poor health outcomes for some highly vulnerable mothers, and avoidable physical, emotional, developmental and mental health problems for some children, in particular in black and other ethnic minority groups.

Proposed ambition*

- We will reduce the disparity in birth complications and still births for highly vulnerable mothers and their babies in comparison with the general population.
- We will demonstrate a measurable improvement in key measures of maternal health for highly vulnerable mothers and of a good start in life for their babies, such as healthy birth weight and school readiness.
- We will do this by identifying and engaging with highly vulnerable parents and babies before birth and ensuring that each family receives intensive and effective support during the first 1001 days of life.
- We will monitor and publish maternal outcomes across our partner organisations, ensuring any disparities in outcomes as a result of race, ethnicity or socioeconomic status are identified and actively addressed.

* Initial thinking on metrics in annex

A possible strategic approach

- While we need to support all families in the first 1001 days, there is a particular need to support highly vulnerable mothers and families, who are likely to have the much worst health and childhood outcomes.
- Providing highly vulnerable families with very early, intensive and effective support should help us increase safe births, reduce mortality after birth and improve other outcomes
- At present, we know there is significant variation in access, resourcing and the nature of support for the most vulnerable families in SEL in the first 1001 days, with cuts to some budgets over a period where acuity of needs has increased.
- There is a vast amount of work in our Forward Plan to improve maternity and early years support, including through the maternity and neonatal network, family hubs and children's centres, but less specifically on how to improve non-medical support for highly vulnerable mums and babies.
- We have some fantastic services in SEL which show the key components of effective support, for example experienced staff who build sustained relationships and offer flexible support for families with many health and social challenges.
- One option might be to review resourcing and availability of intensive support for highly vulnerable families and raise standards across SEL through collaborative learning.
- The neighbourhood approach discussed in relation to prevention provides an opportunity to identify and support families earlier, including those not known to health services.

Notes: Reflects focus agreed in our strategy publication on the first 1001 days. We have proposed to focus cross system work specifically on the most vulnerable families, where there are gaps and variability in access and quality and where there a major opportunities to improve outcomes.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Children's and young people's mental health

Description of the challenge

- Since the pandemic, we have seen a deterioration in the mental health and wellbeing of children in our schools.
- Some children, young people and families are also unable to access rapid and trusted early support for their mental health and emotional wellbeing or are unable to access the most effective early support.
- This is leading to more serious mental health problems for some children and young people, which can have a significant impact on educational attainment and health and wellbeing later in life.

Proposed ambition*

- We will reduce the numbers of children and young people in South East London developing emotional and mental health problems and, in doing so, increase school attendance and improve educational attainment. Through this, we will also reduce waiting times for more specialist mental health support.
- We will do this by working with partners to ensure that every child has access to a broad range of support, through schools and other hubs, for resilience and mental wellbeing and for mental health challenges, starting with children in the most deprived and disadvantaged parts of South East London.

* Initial thinking on metrics in annex

A possible strategic approach

- We know that we have very significant numbers of children and young people struggling with wellbeing and mental health challenges post pandemic, in particular from deprived groups.
- Mental health charities argue for a partnership approach bringing together schools, public services and the VCSE to create healthy environments and ecosystems of support, addressing food, exercise, relationships, social challenges and mental health.
- While we are still gathering information, it is clear the availability of support from health, schools and the VCSE is highly variable across SEL, with some strong local systems and other areas with little except primary care and mental health services.
- The VCSE has a critical role to play in helping to deliver a broad range of culturally appropriate mental health and social support for children and families. At present, though, it is less well funded and less established than for adults. There is also scope for closer working between VCSE and public services.
- While there are many streams of work to improve children's mental health services, including i-Thrive in schools, there is less on how to build effective partnerships and ecosystems or investment for VCSE complements to public services.
- Action across SEL might focus specifically on developing effective partnerships and ecosystems of support, accessible from school and other hubs, building on existing assets, and developing VCSE or community led support in these systems.
- As for prevention, one option might be to focus initially on the partnership between schools, health, social services, VCSE, police and others in targeted disadvantaged neighbourhoods.

Notes: Reflects the focus agreed in our strategy publication on early support to prevent mental health challenges developing or prevent problems worsening. We have proposed to start with action for children in the most deprived and disadvantaged parts of South East London.

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Description of the challenge

- Some adults from deprived or disadvantaged groups in South East London cannot easily access rapid, trusted or effective early support for common social and mental health challenges.
- This means that their social and mental health challenges can get worse, leading to crisis or severe mental illness.

Proposed ambition*

- We will reduce the number of people from deprived and disadvantaged groups entering crisis or developing more severe and prolonged mental health problems and close the gap between these groups and the general population.
- We will do this by ensuring that adults from deprived and disadvantaged groups can access culturally appropriate, joined-up and effective early support for social and mental health challenges which is tailored to the needs of their communities.

* Initial thinking on metrics in annex

A possible strategic approach

- As for children and young people, we have growing numbers of adults struggling with common social challenges (e.g., housing, poverty, relationships) and mental health challenges post pandemic and the cost-of-living crisis.
- We have significant populations suffering the impact of racism, isolation and disconnection. We also have extremely low levels of trust in statutory services in some groups.
- Mental health charities emphasise the need for early support and ecosystems of support including peer and community led support, social support for mental health and early help for social challenges alongside NHS services.
- We also know from examples in SEL of the importance of partnership working across health, public services and the VCSE to enable collective action and best use resources.
- Again, there is a vast amount of work planned in the next five years to improve mental health services including addressing waiting lists and moving services into the community. Most is focused on statutory NHS services.
- We recognise the key role of VCSE organisations such as Black Thrive or Mosaic Clubhouse, alongside NHS mental health services and Local Authority early help. But we have been less systematic in investing in VCSE organisations, so they can extend their reach, or developing local ecosystems.
- One option might be to focus specifically on investing in and developing the partnerships between public services and community organisations, and the capacity of community organisations, starting in our most deprived neighbourhoods.

Notes: Reflects the focus agreed in our strategy publication on rapid early support for adults and more holistic whole person support.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Primary care and people with long-term conditions

Description of the challenge

- Many people in South East London do not receive sufficiently proactive or joined-up care to manage long term conditions or to cope with significant or complex health and social challenges.
- This is leading to worsening illness, loss of independence and quality of life and lost years of life.

Proposed ambition*

- We will increase the proportion of people in South East London with long-term conditions and health and social challenges who report a positive experience of care, live independently and enjoy good lives.
- We will do this by working together to implement effective integrated neighbourhood teams which bring together primary, community and specialist staff as well as VCSE partners to deliver proactive, holistic and joined-up care for people with multiple long-term health conditions and people with significant or complex health and social challenges.

* Initial thinking on metrics in annex

A possible strategic approach

- We have a growing population with multiple long-term conditions and complex health and social needs post pandemic (e.g., health problems plus challenges with housing, poverty, relationships, isolation, etc.) with poor health outcomes and quality of life.
- Primary care is under huge pressure without the capacity or structures to deliver proactive or intensive support for people with high needs. People bounce between small more specialist services.
- National policy and successful health systems point to an integrated team-based approach for people with long term conditions and complex needs, which makes best use of staff across primary, community and social care.
- These teams draw in support from specialists where needed and work in partnership with local authorities and VCSE organisations to tackle isolation, healthy living, housing, poverty and other health and social challenges.
- We have pockets of effective multi-disciplinary team-working in our system. But like other systems, we have struggled to apply the model effectively at scale, reflecting the extent of the change needed to structures and ways of working.
- Implementing these approaches is a key priority across our local care partnerships. There may be opportunities to accelerate progress through joint work on the design of effective teams spanning health and care and collaborative learning.
- There may also be a case for action at SEL level to review the overall landscape of community-based services and the interaction with specialist services. There may be scope for faster progress in spreading well evidenced models of intensive general health and social support for people with complex needs.

Notes: Our strategy publication set out a broad priority relating to primary care and long-term conditions. Given national initiatives on access, we have proposed to focus the priority on developing effective approaches for people with long term conditions and complex health and social needs.

An emerging, overall strategic approach (1)

Focus	We are proposing a clear focus on the most vulnerable people and the most deprived or disadvantaged populations for all our strategic priorities, at least in the immediate future, because of the need to target our resources and innovation capability and the size of the opportunity to improve health outcomes for these groups while addressing inequalities.
Tailored approaches	Given this focus, we are also exploring opportunities across all the priorities to adopt more tailored approaches to the delivery of support and care for our most deprived and disadvantaged populations, which specifically address the challenges we face connecting effectively with these groups and the problems they face in accessing and using our services.
Reframing around neighbourhoods	In many cases, this exploration of more tailored services is pointing us to approaches that are based around small local neighbourhoods with high deprivation, with the focus on building relationships and understanding of the local community, engaging the local community on a range of health and social issues rather than individual diseases or programmes, and reorienting the provision of health and social support so it's delivered in ways that work for the neighbourhood (see following slides for further detail).
Whole person care	For each priority, there is a common theme of developing more generalist, whole person support for health and social issues, rather than separate services for each distinct issue, recognising the ineffectiveness of fragmented delivery for deprived groups.
Social approaches to health	There is also a common theme of strengthening the social support for people with interrelated health and social challenges, recognising a tendency in our and other health and care systems to medicalise social problems or to pay less regard to social support that can be more effective or an essential complement to healthcare.
Building from our current assets	There is a different landscape of services and community infrastructure in each of our boroughs and neighbourhoods, as well as initiatives already in progress to address some of the challenges covered in our strategy. We are not, in general, seeking new approaches to replace what is already happening, but ways of building on the existing assets within neighbourhoods and local systems (including service users and communities), sharing learning and improving faster.
Synergies	We are actively exploring potential synergies between our priorities, for example, would a relationship-based approach to health prevention focused on deprived neighbourhoods also unlock opportunities to identify vulnerable mothers earlier, identify children who aren't attending school or with mental health challenges, or better support local people managing long term conditions?
Community resilience	In each of the priorities, we are looking for opportunities to tackle the problem in ways that also help to support the economic and social resilience of our communities, for example providing employment for local people and growing community-based organisations.

N.B. These have been derived in part through reference to our vision and ambitions for our services and system, in part through reflecting on the underlying issues for each of our five priorities and how they might be addressed, and in part through reference to good practice in developing strategy and identifying opportunities to gain strategic leverage.

An emerging strategic approach (2): Focus on people's experience of care as well as outcomes

South East London Integrated Care System

The case for a strong focus on service users' experience of care

- We need to ensure a strong focus on key outcomes to improve health and care as well as key outcomes for partners such as educational attainment or community resilience.
- While our contribution to some of these outcomes may be apparent in the short to medium term, we will need to rely on some process and output measure to track impact.
- Patient experience measures provide a mechanism for testing whether we are delivering the type of care likely to deliver significant improvement in outcomes, particularly for people with multiple needs and from disadvantaged groups.
- The National Voices I Statements also provide a framework for ensuring that we are developing the type of holistic, integrated care described in our vision. They provide a counterbalance to outcome measures which risk encouraging narrow approaches rather than whole person care.
- We would therefore propose building these into our assessment of all work related to our strategic priorities.

Options we are likely to explore for cross-system action to deliver our five priorities

South East London Integrated Care System

Funding	We might seek to secure increased funding to tackle the challenges and issues identified in the strategy, so that we can improve access, improve quality or address variability across our system.
Harnessing resources of our Integrated Care Partnership	Members of the Integrated Care Partnership might commit to closer joint working across different public services or to deploying their resources differently so that we can take collective action to address shared challenges.
Developing shared understanding	We might pool expertise and work together to clarify the common principles underpinning effective approaches, so this work doesn't have to be repeated many times across our system.
Support for spread and scale	We might propose an approach to enable faster spread of effective approaches across South-East London, drawing on the well-reputed methodology we are using for our Spread and Scale Academy.
Collaborative improvement	We might propose investment in approaches that would allow more effective sharing of learning between groups of services across SEL, with access to shared expertise, reflecting the requirements of our local care partnerships and providers and designed to support them effectively, so they can make faster progress to meet agreed objectives.
SEL-wide service change	We might agree to make changes to the overall shape of some services or the interactions between services, for example between primary, community and hospital services to enable new ways of working and approaches to be implemented.
Investment in shared infrastructure	We might agree to invest in shared infrastructure across South-East London to enable new ways of working or approaches to delivering care, for example infrastructure to better enable information sharing and team working.
Reprioritisation	We might agree to refocus attention or put some other work on hold to enable different parts of our system to make progress in delivering our SEL-wide strategic priorities, alongside many other demands on organisations and services.

Next steps

South East London Integrated Care System

- Following this meeting, based on your feedback, we will refine our description of the challenge and statements of ambition for each of the five priorities.

- In August, we will review with stakeholders and refine our initial assessment of the underlying problems in each area, develop further our understanding of work in train in our system, and develop with stakeholders and partners our understanding of the range of options for SEL action in each area.

- In September, we will bring together large groups of stakeholders from across our system to assess different options to accelerate progress. We would value active participation of IC Partnership members in this.

- In October, we will develop our thinking on the resource implications and options for implementing preferred approaches for each of the five areas, in conversation with partners to ensure that the proposals support action already planned and enable organisations in our system to shape how they are delivered.

- At the IC Partnership in late October, we will outline and seek agreement to a proposed cross-system approach for each priority, the high-level resource implications, who would need to do what in our system, and a high-level plan for implementing the change.

South East London Integrated Care System

Annex: Further data, analysis, hypotheses on underlying issues, and examples of good practice for our strategic priorities

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Description of the challenge

- We are struggling to deliver a set of proven preventative health services including vaccinations, health checks and health screening to some deprived and disadvantaged people and communities within South East London.
- This means that people from these groups are exposed to avoidable disease, diagnosed late for major health conditions, and do not receive the right treatment or support, leading to significant and preventable lost years of life and years of healthy life.

Data and other evidence

- Child vaccination rates are below the WHO targets:
  - 10.9% of children aged 5-10 are not fully MMR vaccinated (WHO target is 5%)
  - 6.2% of children aged 1-9 are not vaccinated against polio
- Similarly, adult cancer screening rates are significantly below target:
  - Bowel Cancer screening rate (April 2019 - October 2022): 52.1% (national target 60%)
  - Breast Cancer screening rate (April 2019 - October 2022): 45.7% (national target 80%)
  - Cervical Cancer screening rate (April 2019 - January 2023): 66.3% (national target 80%)
- Preventative service uptake is lower for our more disadvantaged groups. E.g.:
  - MMR vaccination rates are lower in areas of higher deprivation, with the percentage of children unvaccinated ranging from 54% to 4% across SEL LSOAs
  - Breast cancer screening rates are 11% lower for our Core20 population than for the overall SEL population
  - Disparity in health outcomes by ethnicity and deprivation for mothers and birthing people and babies suggests differences in access for preventative services at pre-conception and during pregnancy.
- Evidence shows that low uptake of preventative services leads to poor outcomes. E.g.:
  - For example, booking for maternity care within the first 10 weeks of pregnancy enables proactive care planning, yet c. 20% of women in SEL do not book within this time period.
  - There is a body of evidence demonstrating improved survival rates for cancer if detected early through screening programmes

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Hypotheses on the most important underlying issues

- Ineffective communication and engagement with target populations (e.g., transient populations, people not registered with services, people with different understanding and expectations of health services, non-English speakers).
- Lack of understanding of our deprived populations and the precise reasons why they do not use services, which can vary from one small group to another for specific prevention services.
- Lack of trust in or understanding of the health system and health interventions (e.g. what's free, what's paid for, distrust of vaccines, cervical smears, physical health checks for people with SMI).
- Lack of trust in the people or services delivering the intervention (e.g., cervical smears, physical health checks for people with SMI).
- Lack of interest and low priority in people's lives (e.g., for people who have more immediate challenges such as housing or food).
- Inconvenient service delivery that imposes costs (e.g., multiple appointments, lengthy and costly travel to access services).

Approaches to addressing the problem across SEL, including in our Forward Plan*

- There are initiatives in train or planned across South East London to improve delivery of primary health prevention services.
- Across the boroughs, plans highlight a greater role for community organisations to support the identification and delivery of effective preventative programmes.
- The initiatives recognise the need to focus attention on deprived service users and address inequalities, but within the context of programmes for the general population.
- The areas of focus for prevention activities varies between boroughs (bowel and breast cancer screening, vaccinations, lung health, HIV testing etc).
- Bexley is testing a new screening programme using psychological community asset approach, whilst Bromley are exploring place-based prevention service organised around neighbourhoods.

*The Joint Forward Plan contains a collection of the boroughs top priorities and does not comprise a comprehensive list of activities planned for and currently taking place.

*For further review and testing with stakeholders from end July onwards.

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Proposed ambition

- We will reduce the current disparity in uptake of proven health screening and prevention programmes for people from deprived and disadvantaged groups, so that we reduce unwarranted variation in health outcomes from cancer, infectious and other diseases.
- We will meet, or exceed, key immunisation and screening rate targets over the next 10 years.
- We will close the existing gap in accessing these interventions for deprived and disadvantaged groups over the next 10 years.
- We will tackle this in the first instance by developing more targeted, evidence-based approaches to increase uptake amongst the most deprived and disadvantaged communities in South East London.

Metrics: during the Deep Dive phase, we will develop logic models to connect our problem statements with our proposed actions (with medium-term output metric targets) to achieve our ambitions (with long-term outcome metric targets).

Example long-term outcome metrics

Example long-term outcome metrics:

- Reduction in the number of people dying from preventable diseases e.g., improvement in 5-year cancer survival rates for screened cancer types
- Reduction in the relative difference in the prevalence of deaths from preventable disease between our the Core20Plus 5 and overall SEL populations
- Reduction in the mortality rate for women and birthing people and babies and reduction of the prevalence difference by ethnicity or deprivation.

Example medium-term output metrics

Example output metrics:

- Absolute and relative uptake rates for MMR vaccines for children aged 5-10
- Absolute and relative cancer screening rates for breast, bowel and cervical cancer
- Percentage of the Core20Plus5 population who have access to prevention and screening services within a single-point-of-contact service (e.g., a community-based multi-screening service)
- Measures of improved trust amongst communities and better relationships and understanding between services and communities.

It will be critical to select a small number of metrics in the next phase to monitor our progress in delivering the strategy.

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Examples of interesting approaches – potential inspiration and learning

Lambeth Portuguese Wellbeing Partnership

- Initial focus on Little Portugal between Oval and Stockwell, where 30% of population are Portuguese speakers.
- Sought to address low levels of registration with GPs, low uptake of prevention, low follow up for LTCs, high reliance on A&E.
- Partnership between local GP practices and Portuguese Community Centre, and now a larger network of public services and community orgs.
- Works with local churches, cafes and community centres to connect the Portuguese community with health and care services.
- Support or lead events to bring community together and engage on health issues.
- New coordinators work with local families on health issues and social challenges, including benefits and employment.

Churchill Gardens Wellbeing Programme, Pimlico

- Based on Brazilian Community Worker model, local people hired to improve health on a deprived estate in Pimlico.
- Each worker builds relationships with around 100 families. Workers engage people and families on diet, exercise, breastfeeding, falls risks, smoking cessation and connect them with other support.
- Workers explain prevention services, address concerns, encourage participation.
- Workers help address isolation, identify at risk children, vulnerable mothers and families.
- Close working with the local GP practice for the estate and liaise with social services on housing and other issues.
- Households 46% more likely to take up immunisations and 82% more likely to take up screenings and health checks.

Deep-End General Practice for Deprived Neighbourhoods

- GPs and teams build relationships with individuals and families to ensure continuity of care
- Practices typically deliver a broader range of services than for the general population to minimise referral out and the need for people to travel to other sites for care.
- Practices are often hubs for a range of social support such as food banks and community groups to address isolation.
- Practices use the support they offer as capital to engage people with preventative services.
- Practices work flexibly to deliver preventative and other services, for example encouraging people to get checks done when they are in the practice for other issues.

Fast-Track Cities Programme

- London-wide programme aiming to ensure zero new HIV infections, zero preventable deaths from HIV, zero stigma by 2030, and improve quality of life and wellbeing of people living with HIV in London.
- The work brings people already working to tackle HIV together to work on a common set of goals. The London Leadership Group includes people with lived experience, the VCSE, leaders from London Councils, Public Health and NHS services.
- The programme will achieve its aims by working in partnership to advocate for London and influence national policy, engage with similar work outside of London, deliver together through funding and behaviour change work, and engaging the HIV community in London. For example, work ongoing to support the roll-out of blood testing for HIV, hep B and hep C in London Emergency Departments.

Other examples: 100-day Challenges to reduce inequalities in CVD prevention in Greenwich; Personal Medical Services Premium for GP Practices to increase uptake in prevention screening services and proactive management of LTCs in Bexley; Community Champions in Lewisham, Charlton Athletic Community Trust.

Priority 1: Prevention and early detection of disease for deprived and disadvantaged groups

Evidence on approaches to prevention that work for deprived and disadvantaged groups*

Issue	Findings	Evidence / examples
Sustained relationships	Practitioners and teams that build long term relationships with disadvantaged service users are better able to understand precise reasons why specific groups don't use services, persuade people to engage with preventative services, and better able to deliver services in ways that work for local people.	Deep End Primary Care Practices in Scotland and many others
Reciprocity	Practitioners who do things that really matter for disadvantaged service users (e.g., help with housing or getting children to school) can use this capital to persuade them to engage in preventative services.	Hope Citadel GP Practices in Greater Manchester
Working with local people	People and organisations that represent a local community are better placed to gain trust, understand the reasons why local people don't engage with services, persuade disadvantaged service users to participate, and develop delivery arrangements that work for the community.	Lambeth Portuguese Wellbeing Partnership and many others
Allowing people to choose	Enabling people from disadvantaged groups to choose a trusted professional who they know to deliver preventative services can sometimes increase uptake (e.g., cervical screening)	Hope Citadel GP Practices in Greater Manchester
Clustering services together	Delivering a broad set of preventative services together at a single site creates opportunities to improve uptake (e.g., inviting people in to complete a set of checks together, persuading people to complete checks when visiting for another reason, warm handovers to another practitioner to complete a check)	Hope Citadel, Southcentral Foundation Alaska
Roles of key local services and sites	People from deprived and disadvantaged communities are more likely to take up preventative services when delivered at familiar locations very close to where they live. Some specific services and sites such as primary care, schools and community centres are particularly important in delivering successful prevention for disadvantaged groups, because they are familiar, trusted and easy to access or because they have contact with service users about other issues.	Deep End Primary Care Practices

*For further review and testing with stakeholders from end July onwards.

Priority 2: Ensuring a good start in life in the first 1001 days

Description of the challenge

- We are not currently identifying some highly vulnerable parents and babies early enough (e.g. before birth) and do not always give sufficiently intensive or effective support to ensure a good start in life in the first 1001 days from conception to age two.
- This is leading to poor health outcomes for some highly vulnerable mothers, and avoidable physical, emotional, developmental and mental health problems for some children, in particular in black and other ethnic minority groups.

Data and other evidence

- Maternal and early years child health is impacted by a range of challenges (including physical and mental health problems alongside social issues). E.g.:
  - Poor foetal programming (preventative action taken during pregnancy) is linked to permanent negative effects on the child. For example, the prevalence of smoking in pregnancy was 6.8% in SEL (18/19), compared to 6.0% in London region. There is notable variability across SEL (Lambeth 4.7%, Bexley 9.0%).
  - Post-birth, despite links to health benefits 24.2% of babies are not breast-fed as their first feed.
  - The crude rate of domestic violence incidents in SEL is 35.4 per 1000 (21/22), which equals the London rate but is higher than the England rate of 30.8 per 1000.
  - Increasing numbers of women facing complex mental and physical health challenges leads to increasing need for support through children's early days and years. For example, in SEL the prevalence of adult depression is 10.4% (versus a London average of (9%) and rising.
- The Fuller stocktake report highlights that children and young people are often under-served by traditional models of primary care. Issues exist across the full pathway. E.g.:
  - Identifying vulnerable parents and children requires early presentation to maternity services. However, 22% of parents book in after the recommended initial 10-week period.
  - 43% of respondents to the FiveXMore Black Maternity Experiences National Survey reported feeling discriminated against during their maternity care.
- Health outcomes for children demonstrate the need for pro-active preventative care. E.g.:
  - The infant mortality rate in SEL is 4.12 per 1000, higher than for London (3.5) or England (3.9) (2019-21). Still and pre-term births vary significantly by ethnicity (e.g., still birth rates for Black children are 17.9 per 1000, versus 5.1 per 1000 for White children).
  - No SEL Borough has achieved the national 95% target for uptake of either 12-month or 2-year vaccinations.
  - 7.3% of children and young people (CYP) have at least one long term condition.
  - 23.8% of reception-aged children are overweight (including obesity), which is higher than the prevalence in London region (21.9%) and England (22.3%).

Priority 2: Ensuring a good start in life in the first 1001 days

Hypotheses on the most important underlying issues*

- Limited staff and resources and high, narrowly-drawn referral thresholds, meaning small number of vulnerable families get intensive support.
- The pandemic and cost-of-living crisis have increased vulnerability for some families.
- Late intervention in some cases, e.g. for women in communities that are not connected to services or after a pre-term birth.
- Frequent changes in staff and transitions from one carer or service to another, with loss of relationships and understanding
- Staff with narrow remits unable to work flexibly to address the issues that really matter for vulnerable families
- Referral to many separate services and lack of capacity in these services (drugs, relationships, bonding, diet, breast feeding …)
- Deep distrust of and lack of engagement with services (e.g., some minorities, mothers with involvement from children's social care)

Approaches to addressing the problem across SEL, including in our Forward Plan*

- Several initiatives are planned across South East London to reduce inequalities and improve start in life by bringing together maternal and early years services and working closely with communities and community partners.
- Healthy feeding environments are a key part of borough plans, which include increasing breastfeeding initiation.
- The focus on groups facing disproportionately negative maternal experiences varies between boroughs.
- There are opportunities to align service provision in Family Hubs between boroughs that support preconception to 1001 days after birth.
- An opportunity exists to scale rounded family care support systems such as the co-location of Family Hubs with wider support services being tested in Lewisham.

*For further review and testing with stakeholders from end July onwards.

*The Joint Forward Plan contains a collection of the boroughs' top priorities and does not comprise a comprehensive list of activities planned for and currently taking place.

Priority 2: Ensuring a good start in life in the first 1001 days

Proposed ambition

- We will reduce the disparity in birth complications and still births for highly vulnerable mothers and their babies in comparison with the general population.
- We will demonstrate a measurable improvement in key measures of maternal health for highly vulnerable mothers and of a good start in life for their babies, such as healthy birth weight and school readiness.
- We will do this by identifying and engaging with highly vulnerable parents and babies before birth and ensuring that each family receives intensive and effective support during the first 1001 days of life.
- We will monitor and publish maternal outcomes across our partner organisations, ensuring any disparities in outcomes as a result of race, ethnicity or socioeconomic status are identified and actively addressed.

Metrics: during the Deep Dive phase, we will develop logic models to connect our problem statements with our proposed actions (with medium-term output metric targets) to achieve our ambitions (with long-term outcome metric targets).

Example long-term outcome metrics

Example long-term outcome metrics:

- Reduction in the difference in the rates of still births and pre-term births by ethnicity.
- Reduction in the percentage of reception-aged children who are overweight or have one or more (avoidable) long-term condition.
- Social value indicator improvement for community resilience with respect to support for parents and children during the first 1001 days where a community-based solution has been implemented.

Example medium-term output metrics

Example output metrics:

- Increased percentage of parents registered for maternity services within the first 10 weeks of pregnancy.
- Spread of holistic community-based solutions with increased geographic reach and capacity (as measured by the number of parents and children accessing services).
- Increase in the number of children receiving their 12-month and 2-year vaccinations to meet the 95% national target.
- Reduction in A&E attendances by children aged up to 2 years.

It will be critical to select a small number of metrics in the next phase to monitor our progress in delivering the strategy.

Priority 2: Ensuring a good start in life in the first 1001 days

Examples of interesting approaches – potential inspiration and learning

Young Mums' Support Network, Battersea

- Support network established by mothers from communities in Battersea to help young mums achieve their goals.
- Mums with lived experience aim to equip young mothers to be successful mothers and successful women.
- Focus on expectant mums or young mums from deprived areas who might lack support networks, confidence to access support, or complex issues e.g. domestic violence, mental health.
- Offers one to one counselling, advice on money, benefits, and low-income tariffs for utilities. Provides practical advice to develop parenting skills, personal development, healthier lifestyles and relationships.
- Runs support groups for young mothers, a community garden and Ladies' Lunch club, sewing club and other groups.

PACT, Southwark

- Community-led project, set up by Citizens UK, to support and empower parents and improve health / development outcomes for children.
- Combats isolation, supports physical and mental health and helps families access health and social services.
- Runs weekly workshops, support networks, groups for Spanish speakers and Black mums, clubs, a bank for clothes and equipment.
- Established a network of Parent Champions from local institutions and the local community who connect with pregnant mums and mums with young children to provide advice and connect them with PACT's support.
- 40% of mums at PACT's Mumspace group struggling with mental health. After 6 months, 68% had recovered.

Mum's Aid, Greenwich

- Provides specialist, trauma informed support for pregnant young women and young mums in its YoungMumsAid programme
- Delivered by experienced generalist practitioners who visit mums at home, stay in contact by text, lead drop-in groups and weekly therapy sessions.
- Offers holistic support focused on the issues that matter most to young mums, including help with benefits and housing.
- Helps mums develop ability to cope as a new parent and to manage anxiety, depression and other health problems
- Helps mums address social isolation, including through building social networks of peers
- Provides clothes, nappies and essential baby items.

Salford Strengthening Families Service

- Developed to provide an integrated and agile early help service unrestricted by 'agency boundaries' specifically to reduce no. of children taken into care.
- Joint team of Strengthening Families practitioners and midwives provide intensive support for parents through home visiting, one to one sessions and group work.
- Practitioners adopt an 'assertive outreach' approach, often working outside of 'normal' hours and being flexible and creative in their approaches.
- Team coordinates the specialist help that families need from children's services, health care providers, mental health services, drug and alcohol services
- Team supports parents in engagement with other agencies, e.g. housing, work, benefits, education and the police.

Other examples: Bromley Empowering parents empowering communities programme, Southwark Children and Families Centres' parenting and school readiness programmes, Bexley mindful mums five week wellbeing support programme, Bexley Incredible Years Pre-school programme (for ages 3 to 6).

Priority 2: Ensuring a good start in life in the first 1001 days

Evidence on effective approaches to supporting vulnerable families in first 1001 days

Issue	Findings	Evidence / examples
Early intervention	Vulnerable mothers and families need early support from conception to maximise the chances of a safe birth	Nuffield Family Justice Observatory, 2020
Relationship based care	Vulnerable mothers and families need to have a consistent relationship and continuity of support from conception and into early years to establish trust, develop understanding of the family and deliver effective care.	Implementing better births: continuity of carer, NHSE 2017
Team-based care	Vulnerable mothers and families need a joined-up, team-based approach, with a key support worker, midwife, social worker, GP, plus others where needed sharing information and working together	Parent-Infant Foundation amongst others
Responsive, whole person care	Vulnerable mothers need a key support worker and team with the skills, experience and remit to work flexibly and responsively to help address the full range of challenges in their lives (e.g. substance misuse, domestic violence, housing, benefits, immigration, the justice system, educational needs, mental and physical health).	Lambeth Flourish Service Staying Mum: Peer research with mothers surviving domestic abuse, 2022
A strengths and family approach	Support should be strengths-based, focusing on the woman's and family's resources, capabilities and potential. Support should be oriented around and enable the mother, family and support network.	Early Years Healthy Development Review, 2021
Trauma informed and culturally competent support	Approaches to support and care need to be non-judgemental recognise and reduce the impact of experiences of trauma and racism, including trauma relating to experiences of the health and care system. Support needs to be informed by an understanding of diverse cultural practices.	Guidance: Trauma informed practice, Office for Health Improvement 2022
Community orgs and local people	Community organisations and local people can play an important role in identifying vulnerable families, connecting with families that are not engaged with health and care services and ensuring services understand and reflect diverse cultural practices.	Lambeth Leap programme

*For further review and testing with stakeholders from end July onwards.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Children's and young people's mental health

Description of the challenge

- Since the pandemic, we have seen a deterioration in the mental health and wellbeing of children in our schools
- Some children, young people and families are also unable to access rapid and trusted early support for their mental health and emotional wellbeing or are unable to access the most effective early support.
- This is leading to more serious mental health problems for some children and young people, which can have a significant impact on educational attainment and health and wellbeing later in life.

Data and other evidence

- There is a significant need for mental health services for our children and young people:
  - SLaM estimates that 1 in 10 children experience some form of mental ill health.
  - From March 31st 22 to March 31st 23 the number of children and young people in contact with mental health services in SEL increased by 10.1% to 15,385 individuals.
- Evidence shows that early intervention in C&YP mental health has a long-term impact. E.g.:
  - Around 50% of mental health problems requiring support are established by the age of 14, rising to c. 75% by the age of 24.
  - Where these develop into a long-term mental illness this is associated with a 10 to 15-year reduction in life expectancy.
  - Poor mental health in school-age children also has social impacts such as a higher level of school absence.
  - C&YP mental health is also significantly impacted by exposure to parental mental health problems including post-natal depression and psychosis. Suicide is now the highest cause of deaths for mothers and birthing people, whilst the overall prevalence of adult mental health is increasing (see Priority 4).
- Young people in SEL are not accessing mental health services when needed. E.g.:
  - In 21/22, 4.6% of children were in contact with mental health services in SEL, less than half the estimated prevalence of mental ill health.
  - In 22/23, there were 144 attendances of mental health ED by children and young people aged 0-20 years.
  - Service accessibility differs by the ethnicity of service users with children from black and mixed heritage backgrounds poorly represented in CYP mental health services.
  - Engagement with SEL young people highlights mental health service access issues including multiple referrals, long waiting times and the use of traditional healthcare settings.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Children's and young people's mental health

Hypotheses on the most important underlying issues*

- Increasing numbers of children with early mental health or wellbeing challenges given a wide range of socio-economic and environmental factors post-pandemic.
- Children in SEL in isolated families or communities, with significant health and social challenges.
- Lack of joined-up working or a whole system approach to create healthy environments and support children's wellbeing.
- Failure to identify children and families in difficulty and engage fast enough to prevent problems worsening.
- Long waiting lists and high referral thresholds for NHS services, leaving many children without support.
- Reduced funding and provision of early non-medical support to address underlying social factors (access to healthy food, exercise, friendship and activities, relationships, family).
- Lack of trusted, culturally appropriate support for children and young people from some communities and stigma relating to mental health problems and using services.

Approaches to addressing the problem across SEL, including in our Forward Plan*

- A number of initiatives across South East London are in place to improve the provision of care for CY&P by working closely with schools and communities to deliver intervention programmes, including to Core20PLUS groups.
- Borough initiatives recognise the need to reduce waiting times for access to counselling services.
- Early support and school-based planned initiatives are in place, with different focus areas and population groups targeted between boroughs.
- There is an opportunity to further develop VCS led alternative initiatives and widen the implementation of the i-Thrive needs led approach.
- A redesigned model for mental health services for transitions between children and young people services is being tested in Southwark and Greenwich, where learnings can be scaled.

*For further review and testing with stakeholders from end July onwards.

*The Joint Forward Plan contains a collection of the boroughs top priorities and does not comprise a comprehensive list of activities planned for and currently taking place.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Children's and young people's mental health

Proposed ambition

- We will reduce the numbers of children and young people in South East London developing emotional and mental health problems and, in doing so, increase school attendance and improve educational attainment. Through this, we will also reduce waiting times for more specialist mental health support.
- We will do this by working with partners to ensure that every child has access to a broad range of support, through schools and other hubs, for resilience and mental wellbeing and for mental health challenges, starting with children in the most deprived and disadvantaged parts of South East London.

Metrics: during the Deep Dive phase, we will develop logic models to connect our problem statements with our proposed actions (with medium-term output metric targets) to achieve our ambitions (with long-term outcome metric targets).

Example long-term outcome metrics

Example long-term outcome metrics:

- Reduction in the estimated C&YP mental health need.
- Reduction in the number of C&YP attending A&E services, and the number of C&YP being admitted through emergency services, due to mental health crises.
- Reduction in the difference in school non-attendance between C&YP affected by poor mental health and the school population average.
- Reduction in the difference in access rates by ethnicity of service user.

Example medium-term output metrics

Example output metrics:

- Increase in the percentage of C&YP mental health service contacts in early intervention services (with corresponding reduction in the percentage of contacts in secondary and emergency services).
- Spread of holistic and tailored C&YP mental health services, with increased geographic reach and capacity (measured by number of service locations, etc.).
- Increased involvement of C&YP within mental health service design.
- Measures to capture improved trust and cultural competency.

It will be critical to select a small number of metrics in the next phase to monitor our progress in delivering the strategy.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Children's and young people's mental health

Examples of interesting approaches – potential inspiration and learning

Mulberry Hub Young People's Health Centre, Lewisham

- Partnership between North Lewisham PCN and SLAM established in Spring 2023
- Young people from 13 to 25 can see a GP, councillor or youth worker in a safe space.
- Offers support for physical health, mental health, sexual health, support accessing dentistry, optometry and other services.
- Active outreach into local communities and high uptake from BAME and other groups less likely to use NHS mental health services.
- Focus on rapid early intervention to support mental health and wellbeing, in particular through connecting young people to local community organisations.

Lessness Heath Primary School, Bexley

- Focus on a 'whole school' approach to creating a positive environment for wellbeing as well as rapid intervention and support for children.
- Developed a more supportive school environment through language and communication with children and families and building children's self-esteem.
- Teachers supported to identify triggers and symptoms and trained to provide mental health first aid, use support strategies in classroom, and to connect children and families to other support.
- Children actively involved and playing roles as wellbeing ambassadors.
- Attention to staff wellbeing, collaboration and relationships with parents, who now report higher trust and seek support through the school.

Bromley Y, Bromley

- Provides emotional wellbeing and mental health services across Bromley as well as support into schools.
- Are an accredited Children and Young People's Increasing Access to Psychological Therapies (CYP-IAPT) service.
- Supports schools, charity-funded groups and a mentoring scheme.
- The Getting Advice team works to empower young people to understand and support themselves, to build resilience and manage their wellbeing.
- Partnered with Anna Freud Centre to bring together education and mental health professionals to be able to better identify challenges within their areas.
- Partnered with Young Carers to provide individual therapeutic support to the children and young people in their care.

Off the Record, Bristol

- Promotes health and wellbeing, as well as defending young people's rights, with young people actively involved.
- Offers NHS funded counselling, jointly delivers NHS MH support in schools with local Trust, jointly delivers crisis support with CAMHS.
- Encourages young people to join peer groups, courses and clubs as well as traditional MH services. It offers various hubs, nature and arts programmes, music and book clubs, as well as drop in hubs.
- Works intensively with local schools that want to create better environments for wellbeing.
- Wellbeing advisors talk to young people in Primary Care, youth & community groups and connect them with OTR's support.

Other examples: Surrey Square Primary School, Southwark, The New School, Lambeth, Boyhood to Manhood Foundation, Camberwell.

Priority 3: Ensuring C&YP have early, effective support for common mental health challenges

Evidence on effective approaches to early mental health support for children

Issue	Findings	Evidence / examples
Prevention and early intervention	Effective approaches built on engagement to support children and families in early years, support for resilience in primary school in preparation for transition to secondary school, and support structures that reduce the risk of mental health challenges (e.g., diet, exercise), and early intervention as soon as emotional or mental health challenges become apparent to prevent them getting worse.	Early Intervention Foundation's guidebook and evidence base amongst others
Whole systems approaches	Effective partnerships working across key local institutions at neighbourhood level (schools, VCSE, social care, police, health) important to create a local environment that supports mental health and wellbeing, ensure that all orgs participate in supporting mental health, connecting children to support and making better use of resources and approaches across organisations and sectors.	Anna Freud 'Working Together' framework
Schools and other focal points	Schools have a critically important role, working with local partners, in creating educational and broader environments that support emotional wellbeing, in identifying and supporting children needing help, and connecting children with different forms of support. Primary care and community organisations also play key role, including for children who are absent from school or distrust school.	Anna Freud, National Children's Bureau and others
Ecosystems of support	Supportive environments and effective support come in the form of broad and complex local ecosystems including school, before and after school clubs, peer support, mentoring, clubs and activities, community groups and faith organisations, primary care and mental health services.	WHO Nurturing Care Framework amongst others
Family-centred, holistic support	Approaches that seek to engage the whole family and address a range of physical health, mental health and social issues are more successful for some young people.	A whole household approach, LGA amongst others
Coproduction	Approaches to supporting children and young people's emotional wellbeing and mental health are more effective if developed with C&YP and their families and with local community organisations.	Anna Freud, Off the Record, many others

*For further review and testing with stakeholders from end July onwards.

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Description of the challenge

- Some adults from deprived or disadvantaged groups in South East London cannot easily access rapid, trusted or effective early support for common social and mental health challenges.
- This means that their social and mental health challenges can get worse, leading to crisis or severe mental illness.

Data and other evidence

- The SEL adult population faces high levels of mental health need.
  - The need for psychiatric services in South London is estimated to be 20-55% higher than the average across England.
  - From March 31st 22 to March 31st 23 the number of people in contact with adult mental health services in SEL increased by 15.2%.
  - Four of the six Boroughs in SEL score below the London average in the Mental Health domain of the Health Index.
  - SEL has the third highest rate of use of the Mental Health Act of any ICS, at c.138 per 100k citizens (20/21).
  - From April-December 2020, 64% of SEL mental health referrals were for patients in crisis.
- Barriers to service access include a lack of tailored services and long waiting times.
  - Our people and communities have described barriers including language and cultural barriers, a lack of trust in the NHS, and complicated forms and processes.
  - In 2021-22, the average wait time for first psychological therapy treatment (IAPT) was 22.8 days. This was the second-longest reported average wait amongst London CCGs.
  - As of August 2022, SEL spent £162 per capita annually on mental health versus a London average of £158 and a national average of £195.
- Often people with mental health illness have poor health outcomes; those with severe mental illness live on average 10-15 years less than the general population; this 'mortality' gap is higher in five out of six SEL's boroughs, when compared to the London average.

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Hypotheses on the most important underlying issues*

- Significant growth in socio-economic challenges in last few years leading to much higher numbers of people with mental health challenges
- Significant populations facing issues such as racism, social isolation, disconnection from communities and services.
- Poor relationships, low trust, and a lack of connection between services and many groups, making it harder to identify and support people.
- Limited time and capacity within Primary Care, and access barriers including long waiting times (often leading to high dropout rates) for more specialist NHS mental health services.
- A reliance on a narrow range of medical and therapeutic approaches in NHS services, with a focus on the person rather than the broader set of issues that contribute to many people's mental health challenges.
- Lack of capacity, fragmentation and challenges for some people in accessing early help services for housing, debt, employment, drugs, alcohol, relationships and other issues.
- Strong voluntary sector services taking social approaches to address mental health and other challenges, but in pockets with huge variability across SEL.
- Lack of culturally appropriate support for specific communities in some areas, in particular in NHS mental health services.
- Lack of shared understanding and joint working between some public services and the voluntary sector (e.g., in their processes and systems), making it harder to share insight and make best use of collective resources.

Approaches to addressing the problem across SEL, including in our Forward Plan*

- Initiatives across South East London are focused on the provision of effective mental health support by developing appropriate care pathways, collaborating with VCSEs and supporting those with complex social needs.
- Borough plans are aligned on utilising preventative community asset models and the need to work closely with VCSE's to support prevention and early interventions.
- There are opportunities to align plans on bringing care closer to home and expand the provision of more holistic support, accounting for wider determinants for individuals facing a mental health crises.
- Scaling the Thrive LDN approach that Greenwich is taking can enable closer collaboration with individuals with lived experience.

*For further review and testing with stakeholders from end July onwards.

*The Joint Forward Plan contains a collection of the boroughs' top priorities and does not comprise a comprehensive list of activities planned for and currently taking place.

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Proposed ambition

- We will reduce the number of people from deprived and disadvantaged groups entering crisis or developing more severe and prolonged mental health problems and close the gap between these groups and the general population.
- We will do this by ensuring that adults from deprived and disadvantaged groups can access culturally appropriate, joined-up and effective early support for social and mental health challenges which is tailored to the needs of their communities.

Metrics: during the Deep Dive phase, we will develop logic models to connect our problem statements with our proposed actions (with medium-term output metric targets) to achieve our ambitions (with long-term outcome metric targets).

Example long-term outcome metrics

Example long-term outcome metrics:

- Reduction in the adult suicide rate and use of the Mental Health Act.
- Reduction in the number of adults attending A&E services, and the number being admitted to hospital, due to mental health crises.
- Reduction in the percentage of mental health service referrals due to crisis.
- Reduction in the healthy life expectancy gap for deprived or disadvantaged groups

Example medium-term output metrics

Example output metrics:

- Increased access to early intervention mental health services within the community, with increased geographic reach and capacity.
- Improvement in service user survey responses in relation to access to and suitability of early intervention mental health services.
- Reduction in the waiting time from referral to first contact point, and from first contact to first treatment, within appropriate service(s), (when improved service access to early intervention services is included).

It will be critical to select a small number of metrics in the next phase to monitor our progress in delivering the strategy.

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Examples of interesting approaches – potential inspiration and learning

Mosaic Clubhouse, Brixton

- VCSE-led 'clubhouse' funded by Local Authority, NHS and donations for adults living with mental health conditions.
- An entirely social approach to supporting people with a wide range of challenges, offering friendship, opportunity, group activities and practical support.
- Harnesses the skills and contribution of members in running the organisation, inc. its cafeteria and gardens and in supporting each other.
- Supports people in starting education and employment and helps people with housing, benefits and other challenges.
- A flexible model for people needing early support, people in crisis and people with enduring mental health challenges.
- A club rather than a pathway – many people move on, but people can stay for as long as they like.
- Evening crisis service and programme for young adults from 16 to 30

Integrated community mental health, Bradford

- Social workers lead combined social care and community mental health teams to deliver joined up support for people with social and mental health challenges.
- These team members work closely with police, including working as part time special constables, to share knowledge and develop a more coordinated approach to supporting people in difficulty.
- A VCSE org, the Cellar Trust, works in close partnership with statutory services to offer early support, crisis support and more intensive support for people with mental health and social challenges.
- This includes trained local people with lived experience delivering crisis support, one to one and group peer support, and intensive one to one support for people with SMIs to meet personal goals.
- Community mental health team supports these services (e.g. Crisis) where needed.

NAViGO, Grimsby

- Social Enterprise running community and more specialist mental health services for children and adults NE Lincolnshire.
- Actively involves service users in running org. from setting strategy to delivering catering, gardening and support services.
- Focuses on a social model of mental health, ensuring people have 'somewhere to live, someone to love and something to do'.
- Has acquired and set up businesses to give training opportunities to its members, rent guarantees for tenancies, and invested in housing.
- In more specialist services, has focused on addressing power imbalances, removing stigma and avoiding inflicting harm (e.g. out of area placements, restraint, seclusion, tranquilisation).

Other examples: Southwark Service Users Network; Bromley Mental Health Hub; Live Well Community Hub in Greenwich; Lambeth Talking Therapies; Bridge Support in Bromley and Greenwich, Blackfriars Settlement, Southwark

Priority 4: Ensuring adults have early and effective support for social and mental health challenges

Evidence on effective approaches to early mental health and social support for adults*

Issue	Findings	Evidence / examples
Early support	Effective systems are capable of identifying and connecting with adults at an early stage in development of mental health problems and offering rapid early support to prevent escalation.	Early Intervention Foundation's guidebook amongst others
Medical and non-medical support	Effective ecosystems provide access to a broad range of support for early mental health problems including social support that creates friendship, connection and opportunity alongside counselling and talking therapies.	NAViGO, Mozaic Clubhouse
Community-led support	Local community orgs. can play a key role in connecting with people who are less likely to be identified by or engage with statutory services and delivering effective support for local communities. Members of local communities, peer support workers and peer groups can also be effective forms of support.	Pembroke House, Black Thrive
Culturally appropriate support	All the key organisations and services within the ecosystem need to deliver culturally competent support that recognises the impact of racism and trauma, (reflects the needs and perspectives of local communities) and avoids inflicting further trauma or stigmatisation. Partnerships with community organisations and involvement of community members can help to ensure this.	Black Thrive, Kinara, Rethink Mental Illness, Centre for Mental health and others.
Early help for social issues	Local systems need to be able to connect people quickly and easily with effective early support for housing, money, benefits, relationships, drugs & alcohol and other issues. This also needs to be delivered in safe and supportive environments, without stigmatisation, and in culturally appropriate ways.	Mental Health Foundation and many others
Partnership working	Effective ecosystems bring together a broad partnership of local authority, health and VCSE organisations with shared objectives that work together to provide effective early support. Within these models, VCSE often provides support on social isolation, meaningful activity, employment and housing. These may be underpinned by contracting arrangements support flexible collaborative working.	Lambeth Alliance Model, Bradford's health, social care and VCSE partnership, many others.

*For further review and testing with stakeholders from end July onwards.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Primary care and people with long-term conditions

Description of the challenge

- Many people in South East London do not receive sufficiently proactive or joined-up care to manage long term conditions or to cope with significant or complex health and social challenges.
- This is leading to worsening illness, loss of independence and quality of life and lost years of life.

Data and other evidence

- SEL has a high prevalence of long-term conditions with many people developing two or more.
  - The rate of long-term conditions ranges from 190.4 per 1000 in Bromley to 163.0 per 1000 in Southwark.
  - The prevalence of multimorbidity in SEL adults has been estimated at 21%.
  - Common entry points to multimorbidity trajectories are musculoskeletal disorders, morbid obesity and substance abuse.
  - Factors independently associated with an increased risk of transition from one to two long term conditions include deprivation, female sex and black ethnicity.
  - As an example, the prevalence of diabetes by ward ranges from 3.0% at its lowest to 7.7% at its highest. 39.7% of those with diabetes are also obese.
- Older people have worse clinician-reported, patient-reported and process-related outcomes.
  - Twice as many people aged over 65 have surgery compared to those under 65
  - Poor post-operative outcomes for this cohort have been linked to the complexity of patients including social factors and well as physical and mental health.
- Whilst 92% of GP practices are rated as Good or Outstanding, access issues exist. E.g.:
  - In May 2023 74.7% of SEL GP appointments were taken within 7 days of booking, and 70.8% of appointments were face-to-face or home visits, with 26.2% by telephone.
  - 48.7% of 2022 GP Survey respondents reported it being ‘not very easy’ or ‘not easy at all’ to get through to their practice by phone, varying from 2% to 84% by practice.
  - 28% of respondents described the process of making an appointment as either ‘Fairly poor’ or ‘Very poor’, varying from 2% to 80% by practice.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Hypotheses on the most important underlying issues*

- Increasing numbers of people with LTCs and complex needs whose health and wellbeing has worsened during the pandemic
- Health and care services have limited contact with some people with LTCs or complex needs from deprived groups (e.g., those not registered with services)
- Primary care practices under huge pressure and struggling to deliver proactive, intensive support for people with LTCs and more complex needs.
- Primary & community care for people with LTCs and complex needs is highly fragmented, with multiple small, narrowly drawn services, with duplication, inefficiency and lack of continuity of care.
- Disconnect between the primary and community care, urgent care and hospital services means poor communication, inefficient use of resources, inaccessible care for vulnerable people, and lack of whole person care.
- Even where they provide proactive, intensive support, services may struggle to influence how people live their lives.
- Over-reliance on medical approaches and separation between medical and social care mean services do not provide the most effective forms or support or are unable to provide holistic support for complex health and social needs.

Approaches to addressing the problem across SEL, including in our Forward Plan*

- Initiatives across South East London are focused on developing and embedding neighbourhood structures to better support communities and ensure effective management of long-term conditions across the lifespan.
- The power of community was recognised as an effective way to support management of LTCs and stronger links with primary care.
- Borough initiatives recognise workforce and estates are key enablers to work effectively across organisations.
- Neighbourhood development is a key area of focus in borough plans, with varied approaches being taken.
- Neighbourhood development and reducing inequalities can be supported by scaling Bromley's model of collaborative spanning multiple sectors and disciplines.

*For further review and testing with stakeholders from end July onwards.

*The Joint Forward Plan contains a collection of the boroughs' top priorities and does not comprise a comprehensive list of activities planned for and currently taking place.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Primary care and people with long-term conditions

Proposed ambition

- We will increase the proportion of people in South East London with long-term conditions and health and social challenges who report a positive experience of care, live independently and enjoy good lives.
- We will do this by working together to implement effective integrated neighbourhood teams which bring together primary, community and specialist staff as well as VCSE partners to deliver proactive, holistic and joined-up care for people with multiple long-term health conditions and people with significant or complex health and social challenges.

Metrics: during the Deep Dive phase, we will develop logic models to connect our problem statements with our proposed actions (with medium-term output metric targets) to achieve our ambitions (with long-term outcome metric targets).

Example long-term outcome metrics

Example long-term outcome metrics:

- Reduction in the prevalence of long-term conditions with targeted action for those areas facing higher levels of long-term conditions.
- Reduction in the speed and likelihood of transition from one long-term condition to multiple, and reduction of difference by deprivation, gender and ethnicity.
- Increase in the proportion of people in SEL with long-term conditions who can live independently and enjoy good lives (I-statements using baseline from targeted areas).

Example medium-term output metrics

Example output metrics:

- Increased access to community-based primary care services as a first and ongoing contact point (as measured by geographic reach and the number of individuals accessing non-GP primary care services).
- Increased involvement of our people, communities and VCSE partners in the design and delivery of community-based primary care.
- Improvement in diagnosis and treatment for specific diseases at early stages of disease (e.g., for cardio metabolic diseases and cardiovascular disease).

It will be critical to select a small number of metrics in the next phase to monitor our progress in delivering the strategy.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Primary care and people with long-term conditions

Examples of interesting approaches – potential inspiration and learning

MDTs for Frail Elderly, Greenwich

- Set up as a 12-month pilot offering a care co-ordination service for moderately frail older people
- Team comprises of Case Managers, Care Navigators a pharmacist and Consultant Geriatrician support.
- Case managers focus on proactive care planning for patients so the team can respond quickly if people's challenges worsen.
- Care Navigators work with patients to connect with services and support networks that reflect their needs and interests.
- A 53% reduction in A&E attendance for the cohort compared to previous six months.
- A 31% reduction in in-patient stays and a 30% reduction in bed days for the cohort in comparison with the previous six months.

Bromley by Bow Centre, Tower Hamlets

- VCSE organisation supporting healthy and connected communities, working closely with a GP practice in its main community centre.
- Seeks to deliver a social model of health, with focus on connecting people, providing opportunity and supporting with social challenges, with health services where needed.
- Focuses on the centre as a hub using the traffic to GP practices and other services to connect people into the support they need.
- Centre and GP practice work closely to connect people into the support collocated on the site, and now to create a joined-up health creation network at neighbourhood level.
- Offers advice on health and wellbeing, gardening, sports, arts, cooking groups, support for young families, advice on benefits, housing, debt, energy, jobs, support to start a business.

Focused Care, Greater Manchester

- Focused Care staff offer personalised support for people and families struggling with significant health and social challenges.
- Staff are based in primary care practices and work with people and families for as long as they need to deliver change in their lives.
- Rather than rigid methodologies, they focus on building trusting relationships and understanding people's own priorities.
- They start with practical support, such as negotiating with the benefits office or housing association, or finding school uniforms.
- Over time, they help people to address the issues preventing them from living a fulfilling life, such as managing their finances, coping with poverty, alcohol and drug use or abusive relationships.
- They engage people on preventative health and bring them into the practice for screening and support for long term conditions.

Other examples: Bexley: Personal Medical Services Premium, joint working between paediatricians at Evelina Hospital and local GP practices in Lambeth.

Priority 5: Ensuring effective care for people with LTCs and significant health & social challenges

Evidence on effective approaches for people with LTCs and significant health and social challenges

Issue	Findings	Evidence / examples
Identifying people early	Effective services use a range of approaches to identify and engage people in need of support at an early stage, including data analysis and engaging with people who may not be registered with services or whose records may not be up to date.	Successful Accountable Care Organisations amongst others
Proactive approaches	High performing services take a proactive approach including active monitoring people's health and wellbeing, developing precise and actionable care plans with service users, carers and families, and intervening quickly with more intensive support when people's conditions get worse.	Successful Accountable Care Organisations, Canterbury NZ, many others.
Team-based care	Effective approaches depend on close collaboration between a core multi-disciplinary team and the service user and family, with defined roles, regular communication and attention to workflow and team working, so they make best use of resources and staff can operate safely at the 'top of their licence'.	Primary care medical home and similar models
Partnership with broader services	The core multi-disciplinary teams can draw in specialist expertise where needed and have effective processes for communicating and coordinating with urgent care and hospital services, so they avoid unnecessary referrals and travel to other services and preventable A&E visits and hospital stays.	Primary care medical home and similar models, Canterbury NZ
Relationship-based care	The most effective teams build a close relationship with the service user, carers and family and sustain this relationship over time (rather than people engaging with many services or bouncing from one service to another) so they develop deep understanding of the service user's needs and situation and can influence how they live their lives.	Deep end GP practices, Royal College of GPs and others.
Holistic care	Effective approaches combine support for people's physical and mental health with support for people's broader wellbeing, including effectively connecting people to peers, networks, activities and to early help for social challenges.	Bromley By Bow Centre, many others
Intensive support	Effective services are able to offer much more intensive wrap-around support for people with the most complex health and social needs (e.g. vulnerable families, people with SMI, people struggling with addiction, asylum seekers). This often relies on an experienced case worker able to help with a wide range of health and social challenges, an adaptable and flexible approach, and close joint working with health, social care, housing, benefits and other services).	Many successful 'extensivist' services (Montefiore, Focused Care, Chen Med)

*For further review and testing with stakeholders from end July onwards.

South East London
Integrated Care System

Integrated Care Partnership

Item 4
Enclosure D

Title:	**Draft South East London Voluntary, Community and Social Enterprise (VCSE) Charter**
Date:	24 July 2023
Authors:	Tal Rosenzweig (Director of VCSE Collaboration and Partnership and ICP member), Ben Collins (Director of System Development).
Executive Lead:	Andrew Bland, Chief Executive Officer, NHS South East London ICB

Purpose of paper:	The purpose of this paper is to update Integrated Care Partnership members on the progress of development of the SEL VCSE Charter for ICS, share the latest version of the draft charter, and seek Partnership members' views on the draft as it currently stands. This will inform the next stage of the charter's development, which will include further engagement, with a view to a final version coming to October's Partnership meeting for decision and ratification.	Update / Information	
		Discussion	X
		Decision	
Summary of main points:	Following discussions at the last Partnership meeting in April, work began on the development of a VCSE charter for SEL. The charter sets out commitments our system will sign up to in order to enable and support the VCSE sector to collaborate with us fully, as key system partners, in the delivery of our priorities and objectives for local people in South East London. This draft charter sets out four, high level commitments (summarised below), as well as the rationale for each and some specific actions the members of the ICP and ICB are invited to take: 1) We will treat the VCSE sector as a full strategic partner in setting strategic direction and in system planning, in addition to its role in delivery services; 2) We will increase funding provided for the VCSE sector and secure services in ways that deliver greater social value; 3) We will ensure proportionate procurement and contract monitoring processes that will reduce the transactional burden for commissioners and providers and ensure a level playing field for VCSE organisations; 4) We will invest in strengthening the VCSE sector's infrastructure so that it can play an effective role in the strategic leadership of our system and service delivery.		

	The charter also proposes continued join working between the ICB, the ICP and the organisations in our ICS to implement these commitments. ICP members are asked to provide their views on the initial draft, developed following engagement with partners, to inform a version that will be further engaged on over the coming months. The final version of the charter will be brought to the ICP in October for decision and ratification.
Recommendation:	Partnership members are asked to provide their views on the current draft charter. We also ask members for their support and championing of the charter as we progress work and engage with their organisations further over the next few months.

DRAFT

Charter for partnership with the voluntary, community and social enterprise sector

1. Purpose

1.1. The voluntary, community and social enterprise (VCSE) sector in South East London (SEL) is a vital source of knowledge and expertise for our health and care system. Organisations within the sector have unique relationships with and understanding of our communities and innovative perspectives on how to deliver care. As partners we have worked well with the sector and tested new ways of working, not least during the pandemic.

1.2. However, we believe that achieving our collective goals of improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and supporting broader social and economic development can only be accomplished through more effective collaboration and power sharing with the VCSE across our system and ensuring appropriate resourcing for the VCSE sector to deliver its role in our system.

1.3. The sector is eager to support our Integrated Care Board (ICB) and Integrated Care Partnership (ICP) in delivering these objectives. There are already many examples of effective partnership working between the statutory sector and the VCSE sector. However, there are a number of obstacles currently holding us back. The sector has identified in particular:

a) a need to collaborate consistently with the sector as an equal strategic partner, so that it can bring its expertise to the table in strategy and planning as well as in service delivery;

b) a short term and unpredictable approach to funding for some contracts, which undermines the sector's ability to act as a full partner and risks excluding smaller organisations from delivering services;

c) the complexities of transacting with the public sector in relation to some services, which reduces the resources available for frontline provision and restricts the sector's ability to innovate;

d) the need for the VCSE sector to have sustainable and resilient infrastructure.

1.4. This first Charter is designed to remove or mitigate the impact of these obstacles and enable the VCSE to make as full a contribution as possible, where appropriate, to delivering our objectives for our residents and service users. It is designed to support effective partnership working with the VCSE across our system, recognising that much of the most important joint working between public services and the VCSE happens within the Local Care Partnerships that oversee health and care in our six boroughs.

1.5. Twelve months into operation, we will review implementation and modify, amend or enhance this Charter as required.

2. Approach

2.1. Our approach has been to work together to identify the obstacles to better collaboration and define actions that can be taken by all organisations in the South East London system to strengthen our partnership.

2.2. Neither our ICB nor our ICP has the statutory powers to impose requirements on the organisations in our system, all of which have their own constitutions, governance and legal requirements. However, senior leaders from across organisations and sectors in our system are members of the Board and Partnership and have the authority to influence their organisations' and sectors' approaches.

2.3. This Charter is constructed to reflect this reality. In order to do this:

a) it makes four high level commitments in **bold** that aim to set a clear overarching direction for the system that all partners can sign up to but can be implemented in a way that respects democratic and other institutional mandates;

b) describes the rationale for making the commitment and the intent behind it to help in the formulation of action by partners to meet the commitment;

c) sets out some specific actions that the members of the ICP and the ICB are invited to take subject to approval through their own governance processes; and

d) Proposes continued joint working between our Board, our Partnership and the organisations in our Integrated Care System (ICS) to implement the commitments in this Charter.

3. Developing a Strategic Partnership

We will treat the VCSE Sector as a full strategic partner in setting strategic direction and system planning, in addition to its role in delivering services.

3.1. VCSE organisations bring unique expertise and insights about the needs of our populations and how they can best be met. If we are to deliver our shared vision, as detailed in the Integrated Care Strategy, we will need to harness the VCSE sector's full contribution to the strategic leadership of our system.

3.2. This should include helping to develop our understanding of the needs of our population, contributing to discussions on allocation of our resources and planning of services, and actively participating in work to reshape services and transform care.

3.3. To do this, we will need to ensure that there are greater opportunities for VCSE partners to participate in strategic leadership and share decision-making. We will need to create new leadership opportunities and provide funding for the VCSE to participate in the leadership of our system.

3.4. We will also need to support VCSE leaders so that they can participate as equal partners and help to develop the infrastructure that will allow the VCSE sector to contribute effectively to strategic decision-making.

3.5. Meeting this overarching commitment will require changes in culture and approach by the ICB and the organisations represented in our Partnership and our Integrated Care System.

3.6. The VCSE sector will need to develop effective arrangements for bringing the breadth of expertise of different types of VCSE organisations to support addressing our strategic challenges.

3.7. The Board and the Partnership commit to championing:

a) an active VCSE role in the strategic leadership and planning of our system in all relevant aspects of our system's work including SEL-wide arrangements and within our Local Care Partnerships;

b) diversifying our strategic collaboration with the VCSE sector, broadening the range of organisations we collaborate with, including smaller community-led organisations, to ensure it represents SEL's diverse communities;

c) continued funding and equitable access for VCSE leaders to opportunities for training and development in system leadership and innovation;

d) fair remuneration for VCSE organisations' contribution to the strategic leadership of our system.

3.8. The ICB and the members of our ICP will:

a) follow a structured process to ensure equitable power sharing with VCSE organisations (with a particular focus on grass roots and "by and for" organisations), including ensuring VCSE organisations have equitable influence in decision-making on strategy and planning at different levels;

b) ensure full cost recovery for the VCSE sector for its participation in the strategic leadership of our system; and

c) ensure infrastructure support for the VCSE sector as detailed under section 6 of this charter.

4. Providing Fair and Sustainable Funding

We will increase funding provided for the VCSE sector and secure services in ways that deliver greater social value

4.1. Our Integrated Care Strategy commits our system to action to: improve how our system protects people's health and prevents illness; develop more holistic, whole-person care that addresses people's health and social needs; address health inequalities and to use our economic power as an employer and purchaser to improve the resilience of our communities.

4.2. Our strategy also highlights the need for closer joint working with our communities to develop more tailored and culturally appropriate services that better meet the needs of women, marginalised and disadvantaged communities.

4.3. At present, however, only a small amount of our funding is directed to VCSE organisations and activities that will enable us to deliver our vision and strategic priorities. To deliver the strategy, we will need to increase funding for VCSE organisations including their work to support prevention, early detection and intervention, tackling interrelated health and social challenges, delivering care in ways that work for disadvantaged communities and reducing health inequalities.

4.4. We will need to redirect funding to achieve these objectives, whilst recognising the constraints on overall resources. We also need to provide funding for VCSE organisations in

ways that allow them to hire staff, invest in infrastructure and work in effective partnership with public services.

4.5. To help meet these challenges, the ICP will commit specifically to champion:

a) a longer-term strategic approach to funding for VCSE organisations where this would enable more effective partnership working and better care for our communities;

b) providing funding for local "by and for" VCSE organisations where these are best placed to connect with and deliver effective care for local communities; and

c) innovative ways of commissioning and contracting including through alliances of statutory and VCSE organisations, where this can deliver improved outcomes and integrate care.

4.6. The ICB and ICP will:

a) agree a minimum and increasing proportion of its budget to be spent with the VCSE;

b) target its inequalities funding towards VCSE-led interventions and approaches wherever this will best meet the needs of disadvantaged populations and communities;

c) increase the use of arrangements that offer multi-year funding for partner organisations where this will allow them to work in better partnership with public services and deliver better support for local people; and

d) provide funding in ways that allow organisations to bring their own insights and apply innovative approaches to supporting our communities, rather than replicating traditional approaches to delivering public services.

5. Reducing bureaucracy and supporting innovation

We will ensure proportionate procurement and contract monitoring processes that will reduce the transactional burden for commissioners and providers and ensure a level playing field for VCSE organisations

5.1. In addition to targeting resources effectively, we need to allocate resources in ways that allow us to engage the most effective organisations within our system, support the development of strong partnerships and enable innovation.

5.2. While competitive tendering can be an effective tool for awarding some types of contracts, other forms of public procurement may be more suitable in particular circumstances. Some approaches to procurement can undermine partnership working and innovation, exclude smaller organisations (such as grassroots VCSE organisations) or impose unnecessarily high costs, rather than effectively securing the most effective providers and value for money.

5.3. Given these challenges, the ICB will review current approaches to tendering for contracts and develop policies and frameworks to ensure that we deploy the most effective procurement processes for different types of services, with the aim of ensuring the most effective use of public funds.

5.4. The Board and Partnership will develop their understanding of the range of options for procuring services within the current legal framework and the circumstances in which different procurement routes would be most beneficial. They will explore further how they can procure services in ways that enable partnership working and innovation, maximize social value and avoid unnecessary costs.

5.5. The ICP will sponsor a project with the VCSE alliance to better understand the challenges that VCSE organisations, in particular smaller VCSE organisations, face in bidding for funding and delivering contracts.

5.6. The ICB and the ICP will develop a set of principles or framework for our Integrated Care System to enable the most effective procurement of health and care services. This should seek to:

a) enable partnership working between public services and partner organisations including the VCSE in delivery of services;

b) enable innovation in approaches to delivering services, for example to better meet the needs of deprived populations;

c) help to level the playing field for VCSE organisations and allow smaller VCSE organisations to bid for contracts and deliver services where they would best meet the needs of our communities;

d) secure local VCSE providers where they would best meet the needs of our communities and maximise social value;

e) avoid unnecessary costs for commissioners and providers while ensuring value for money and appropriate oversight of public funds.

6. Building supporting infrastructure

We will invest in strengthening the VCSE sector's infrastructure so that it can play an effective role in the strategic leadership of our system and service delivery

6.1. In order to be able to play an effective role in the strategic leadership of our system and in delivering health and care services, the VCSE sector needs to be able to access the type of infrastructure that is available to NHS organisations and other partners.

6.2. The NHS organisations in our system have access to infrastructure including communications systems, data systems, analytics capability and estates which can be utilised to strengthen the VCSE sector and enable it to make a greater contribution to delivering our objectives.

6.3. The ICB and NHS organisations within our Integrated Care System will:

a) provide access or support for the VCSE sector to access communications infrastructure where this is needed for the VCSE to play its role as a strategic leader and partner;

b) enable the VCSE sector to access NHS data and share data and digital infrastructure with the NHS, subject to data protection and other legal requirements, where this would enable the VCSE to work in more effective partnership with public services and deliver better care;

c) support the VCSE sector with access or resources for to data analytics and insights where this would enable the VCSE to work in more effective partnership and deliver better care;

d) provide the VCSE sector with access to NHS estate at affordable rent or for free wherever this is practically feasible and where it would enable the VCSE sector to work in stronger partnership with public services and better serve our people and communities;

e) provide easier access for the VCSE sector to HR infrastructure where this is needed for the VCSE to play its role as a strategic leader and partner in our system.