# Integrated Care Partnership

13.00 to 15.00, Thursday 26 October 2023

Venue: Assembly Hall, Lambeth Town Hall 1 Brixton Hill, London SW2 1RW

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

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

## Agenda

| No. | Item | Paper | Lead | Timing |
|---|---|---|---|---|
| | **OPEN 13.00** | | | |
| **1.** | **Welcome and introduction – opening business.**<br>*Receive apologies.*<br>**Minutes of the previous meeting and matters arising**<br>*Minutes of the meeting on 24 June 2023 for acceptance as a record.* | **A** | RD / KW | 13.00 |
| **2.** | **Focus on Elective care**<br>*Update and discussion of challenges linked to increased waiting times facing a range of non-urgent services following the Covid 19 Pandemic, and plans in place for the future.* | **B** | SC | 13.05 |
| **3.** | **Final South East London Voluntary, Community and Social Enterprise (VCSE) Charter**<br>*To review and agree the Partnerships revised VCSE Charter to support effective partnership working with the VCSE sector.* | **C** | TR/AB | 13.25 |
| **4.** | **Our Integrated Care Strategy**<br>*To review and agree plans for cross system action to deliver our five strategic priorities relating to prevention, early years, children's and adults' mental health and primary care / long term conditions.* | **D** | JH/BC | 14:05 |
| **5.** | **Questions from the public**<br>*An opportunity for questions from members of the public.* | **-** | RD / KW | 14:45 |
| | **CLOSE 15.00** | | | |

**Presenters**

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| AB | Andrew Bland | ICB Chief Executive Officer |
| SC | Sarah Cottingham | ICB Director of Commissioning and Improvement |
| JH | Dr Jonty Heaversedge | ICB Joint Chief Medical Officer |
| TR | Tal Rosenzweig | Director of Voluntary Sector Engagement and Partnership |
| BC | Ben Collins | Director of ICS Development |

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# Integrated Care Partnership

**Minutes of the meeting on 24 July 2023**

**Coin Street Neighbourhood Centre, 108 Stamford St London**

**Present**:

| Name | Title and organisation |
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| Richard Douglas [Chair] | Chair, NHS South East London ICB |
| Cllr Evelyn Akoto | Cabinet member for Health and Wellbeing London Borough Southwark |
| Cllr Paul Bell (item 4 onwards) | Cabinet Member for Health and Adult Social Care, London Borough of Lewisham |
| Mike Bell | Chair, Lewisham and Greenwich NHS Trust |
| Andrew Bland | Chief Executive Officer, NHS South East London ICB |
| Tal Rosenzweig | Director of Voluntary sector collaboration and partnerships. |
| 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 |
| Folake Segun | Director South East London Healthwatch |
| 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 |
| Clare Fernee | AD of Medicines Optimisation |
| Holly Eden | Director of Commissioning Improvement |
| Mike Fox | Chief Financial Officer, NHS South East London ICB |

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| **1.** | **Welcome** |
| 1.01 | Richard Douglas welcomed members to the meeting. Apologies were received from Cllr Kieron Williams, Jill Lockett and Catherine Mbema, Andy Trotter. Cllr Paul Bell was unable to join the first part of the meeting. |
| 1.02 | The minutes of the meeting on 26 April 2023 were approved as an accurate record. |

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| 1.03 | Richard Douglas thanked Dr Gavin McColl for his contribution during his term as representative of primary care services and networks. |
| **2.** | **Focus on Primary Care in the south east London health and care system** |
| 2.01 | Holly Eden reminded the partnership that the first contact patients had with health and care was often through primary care, which covered a wide range of services and partners. Although there had been several policy interventions over the last ten years some themes could be seen: a need to shift towards at-scale working, integration locally and between health and care, diversification of the workforce and introduction of new types of role, equalisation of the funding of offer, reduction of variation in outcomes, increasing digitisation of services, and a shift in funding towards working more with Primary Care Networks rather than ICBs or individual practices. |
| 2.02 | Challenges facing primary care included the pressure of growing demand and a deterioration of patient experience despite increased activity, although there was evidence of patients having a good experience of care once received and a strong bond with their GP. The challenges in workforce capacity included limited growth and large numbers of GPs retiring and leaving the profession. The introduction of new roles could help but required changes to ways of working and patient's expectations. Development of estates and IT were a problem for many practices. It was difficult to balance the need to increase convenience of access to react to demand for care with the need to provide proactive care for those requiring it. |
| 2.03 | A national plan for recovering access to primary care included not just general practice but a range of system partners including the voluntary sector, with a particular reliance on a greater role for community pharmacy. It was important to remember that the plan was phased over two years, with the contract with community pharmacy still under negotiation and the new GP contract unknown. In south east London the plan would substantially rely on Local care partnerships to focus on improvement work and providing training for primary care networks and practices, whilst at across south east London as a whole the focus was on the enabling areas such as IT and estates, as well as facilitating links with larger health and care organisations. |
| 2.04 | Although the plan recognised that access issues were a symptom of demand exceeding capacity rather than an isolated issue, there was a danger that focusing on access for example via phone would be at the expense of proactive care need for those at risk. |
| 2.03 | The Fuller review provided greater focus on proactive care centred around the neighbourhood level, as a vision for the system rather than primary care only, with acute, mental health and community health partners required to contribute to meeting the needs of patients in a proactive and personalised care approach. |
| 2.04 | Clare Fernee illustrated the potential of community pharmacy to support other services to manage the populations health by noting that the 300 pharmacies in south east London provided 80% of the population with a local pharmacy within a 20 minute walk of their home, including good provision in the most deprived areas. Pharmacies has demonstrated their resilience by staying open for communities during the pandemic and participating in an award winning Covid-19 vaccination champion scheme. The plan to increase access recognised this contribution by earmarking £645m investment on Pharmacy First (allowing pharmacies to provide medicines for seven common conditions), an expansion of |

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| | successful blood pressure checks schemes and plans to increase the skills mix and number of independent prescribers in pharmacies. The delegation of the commissioning of Pharmacy Optometry and Dentistry to ICBs would provide further opportunities. |
| 2.05 | Andrew Bland welcomed the Fuller report and made some suggestions for partnership discussion about how its recommendations might be developed into actions. In implementing the recommended development of Primary Care Networks into neighbourhood teams there was strong evidence for the effectiveness of care delivered for groupings of 50,000 people, however the enabling support in digital and transformational capacity was most optimally provided at a wider scale. Larger organisations in the partnership might offer the infrastructure support that would allow local teams to focus to the specific needs in their neighbourhoods. To deliver the recommended integration of urgent care the partnership could sponsor a system-wide 'core offer' that patients could expect in relation to same-day care. The workforce challenges facing primary care and the need to integrate additional role types might be best addressed by a working together as a system to allow people to rotate through placements in organisations to provide experience and increase retention. In strengthening primary care leadership there had already been steps by the joint medical directors to provide system leadership development focusing across disciplines in health and care rather than limited to primary care or general practice. |
| 2.06 | Dr Gavin McColl noted that there was a need for system responses to the challenges facing primary care, but noted there may be concern within for example the General Practice profession on the implications of some of the plans, as well as a certain fatigue with the number of policies and initiatives over the years. |
| 2.07 | Mike Bell in welcoming the paper pointed out that some work was already underway such as joint investment by Trust and ICB in population health management support for primary care in Lewisham and Greenwich, as well as opportunities such as the creation of Community Diagnostic Hubs. The partnership should challenge the inequalities still being experienced by patients which often started in primary care and was amplified through the rest of the health system. General practice access appeared to be worse for those who needed it most with disproportionately high numbers of GPs in wealthier areas. |
| 2.08 | Michael Nutt asked if the ICB had sufficient control over digital funding and whether the level of funding was sufficient to produce the transformation required. |
| 2.09 | Folake Segun suggested that engagement with patients as stakeholders was particularly important when developing solutions to the challenges in primary care, which included equitable access to dental care. |
| 2.10 | Cllr Evelyn Akoto emphasised the importance of south east London communities being part of the journey, pointing out that despite work already being done local people may not be feeling the impact. |
| 2.11 | David Quirke-Thornton asked if the increased use of private GPs risked amplifying inequality even if it potentially reduced demand. It would be helpful to be transparent on what services GP's may have to stop providing as part of the changes proposed, and to be clear about what south east London aspired to and |

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| | expected in terms of integration of services including health, care and the voluntary sector. |
| 2.12 | Cllr Jim Dickson welcomed the approach of safely increasing access, and asked if it would be possible to quantify the impact that a greater role for community pharmacy would have on absorbing demand in other areas, and whether commissioning powers were being fully used to support the changes described. |
| 2.13 | Sir Norman Lamb asked for data on the variation of GP services between most deprived and wealthier areas and highlighted the apparently enormous variation in consultations between boroughs. There was a need to do more to provide mental health support to children which did not require them to be put on a waiting list. Poor dental care for children could also produce lifelong consequences. He pointed out that plans needed to be flexible enough to accommodate potential changes for example following a general election. |
| 2.14 | Tal Rosensweig noted that the VCSE was a key part of primary care and that working with small local VCSE community groups often provided the best way for primary care to address problem of trust. |
| 2.15 | Cllr Denise Scott-McDonald welcomed the proposals but warned that the implementation of technology solutions would need to consider the inequality issues related to technology particularly for elderly and poorer people. |
| 2.16 | Charles Alexander pointed out that the distinction between 'primary' and 'secondary' care was eroding. For example, a significant number of patients in emergency departments were effectively being provided primary care, but this was not necessarily reflected in inclusion of primary care as part of Trust board discussions. It was important to provide local people with the services that were needed, as well as focussing on survey results in relation to existing services. |
| 2.17 | The Partnership received the update. |
| **3.** | **Developing our Integrated Care Strategy** |
| 3.01 | Toby Garrood reminded the partnership of the strategic priorities agreed by the partnership and gave an overview of the work to explore the main challenges and drivers behind each priority. |
| 3.02 | Ben Collins noted that progress had been made to narrowing the key factors within each area. There were examples of excellent work already ongoing in boroughs and work planned at borough and across SEL. The next steps were to further narrow down the key challenges over August, hold discussions with key stakeholders in September and in October bring to the Partnership a proposed approach to the five priority areas. |
| 3.03 | Sir Norman Lamb welcomed the process described but pointed out that an accepted principle of developing effective services for children and young people was the involvement of young people themselves, and suggested that this engagement started as soon as possible. He stated that none of the prioirties could be effectively addressed without the redirection of resources upstream. Wider determinants such as loneliness, and increasingly, debt, should be considered, as well as the potential of employment to provide meaning and improve mental health. |

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| 3.04 | Michael Nutt suggested the aspirations should be more ambitious and that there was a need to inspire change in the partnership organisations. |
| 3.05 | Cllr Evelyn Akoto noted that the document might need to highlight the wider determinants of health and have tighter definitions of success in each area. The successful Nest project had the result of co-production with local people in Southwark from the way the services were delivered to the name. The service was staffed in a way that reflected the local community which increased the likelihood of young ethnic minority people using the service to seek help early. Health ambassadors were also key in Southwark. |
| 3.06 | Cllr Jim Dickson pointed out that the partnership needed to treat a fine line between recommending change across the ICS and recognising importance of delivery at Place with local people. Well targeted investment in local opportunities would be needed, bearing in mind a constrained financial environment. |
| 3.07 | Folake Segun proposed that the partnership would need to get comfortable with being uncomfortable: it may be necessary to move away from traditional KPIs and focus on success measures defined by local communities. |
| 3.08 | Cllr Denise Scott-MacDonald agreed that space was needed to let the community to judge success. For example the benefits of social prescribing were difficult to measure quantitatively. |
| 3.09 | The Partnership received the update. |
| **4.** | **Draft South East London Voluntary Community and Social Enterprise (VCSE) Charter** |
| 4.01 | Tal Rosensweig noted that following Partnership's call to develop a VCSE charter, the draft document presented set some high level commitments as well as some more concrete actions to enable better partnership working with the VCSE sector. |
| 4.02 | Cllr Paul Bell expressed concern referring to section 5.6 that clinical services should normally only be delivered by the NHS. Local Councillors would be reluctant to agree to budget increases without clarity on what the money would be spent on. Procurement regulations were clear that where certain thresholds were met a procurement process was required. |
| 4.03 | Mike Bell welcomed the investment pointing out that there were a number of partnerships for delivering care with voluntary sector organisations. As part of considering an equal voice for the voluntary sector, factors such as funding attendance at meetings may be required, in the same way clinicians may be supported with backfill. Although it was important to support smaller grassroots organisations, larger national organisations also undertook some fantastic work. |
| 4.04 | Cllr Denise Scott-MacDonald supported the need to work with smaller local organisations. In Greenwich it had been necessary to employ a person to help groups through the funding process. In relation to the level of ambition a question had been raised at a recent Greenwich forum on the number of Black or Asian led groups that had been funded, and a request for to support groups working with the large local Vietnamese community. |

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| 4.05 | Folake Segun suggested that discussions take place with the VCSE sector itself on the role it would wish to have in decision making spaces and agreed that receiving payment to support attendance would help bring VCSE organisations in line with other attendees. Although it was important to follow procurement procedures organisations should reflect in line with their anti-racist stance that this often tended to result in contracts for larger organisations, national rather than local and often led mostly by white people. |
| 4.06 | Cllr Evelyn Akoto pointed out that voluntary groups often had access to rich data but needed infrastructure and funding support to turn this into a usable resource. |
| 4.07 | David Quirke-Thornton suggested that direct payments had been a transformational innovation in social care, and similar innovation should be brought to dealings with the voluntary sector. There may be a role for grant aiding and small procurements as well as space to provide a prospectus of the priorities and allow others to help develop solutions including businesses in south east London. |
| 4.08 | Sir Norman Lamb supported greater use of direct payments, and commented that these mechanisms involved conceding power to people which may explain why they had not yet become widespread in health. He had recently spent an insightful day in Lewisham with Black-led community organisations. NHS Mental health services were often not trusted by communities, and working with trusted community groups was a key way to rebuild this trust. |
| 4.09 | The partnership endorsed the progress made so far on the draft VCSE charter. |
| **5** | **Questions from the public audience** |
| 5.01 | *A comment was made welcoming the VCSE section, noting that following Covid-19 and it's disproportionate effect on Black ethnic and Caribbean people a community interest company had been set up to bring together Black led community organisations. A conversation about how to improve representation in the partnership would be useful and engagement could be helped by measures such as earlier circulation of meeting papers.* |
| 5.02 | *A comment was made that the voluntary sector organisations across the 6 boroughs had an opportunity to build on each others strengths and avoid reinventing the wheel and help deliver the strategic priorities the partnership had set out.* |
| | **CLOSE** |

# Integrated Care Partnership

## Item 2
## Enclosure B

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| **Title:** | **Planned Care Update** |
| **Date:** | 26 October 2023 |
| **Authors:** | Harriet Agyepong – Associate Director of Performance |
| **Executive Lead:** | Sarah Cottingham Executive Director of Planning and Deputy CEO |

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| **Purpose of paper:** | This paper provides a mid - year update on our Operational Planning deliverables in respect of planned care and elective recovery. | Update / Information | x |
| | | Discussion | |
| | | Decision | |
| **Summary of main points:** | As part of the Operational Planning process for 2023/24, systems submitted plans to deliver increased activity above pre pandemic levels and reduce the backlog of long waiters.<br>SEL has made good progress in minimising the number of 104 week wait breaches, however progress on eliminating 78 week waits, and treating the cohort of potential 65 week waits continues to be challenging. Ongoing industrial action is one of the main drivers of our current performance.<br>A set of improvement strategies are underway aimed at maximising the use of all of our capacity, including the use of community based alternatives, outpatient redesign, theatre productivity and mutual aid. Alongside this, work has taken place to analyse waiting lists to understand any inequalities that may exist and develop plans mitigate this.<br>We expect to continue to experience challenges in our delivery of additional activity. Ongoing industrial action, competing demand with cancer and emergency care, the EPIC patient record implementation, and the willingness of patients to take up mutual aid have all been identified as ongoing risks. This will therefore impact on our ability to deliver the maximum waiting times target over this year. | | |
| **Recommendation:** | That the Integrated Care Partnership note the update. | | |

# Planned Care Update

## Integrated Care Partnership – 26 October 2023

### 1. Context

1.1. This paper provides a mid-year update on our Operational Planning deliverables in respect of planned care and elective recovery.

### 2. Plans for 2023/24

2.1. For planned care, the requirement was to continue with the recovery of elective care - to achieve volumes of activity above pre-pandemic levels and reduce the backlog of patients awaiting treatment.

**Activity Target**

2.2. Each system was set a level of activity to be delivered over the course of 2023/24, and for SEL this was set at 109%, later reduced to 107% of the 2019/20 baseline year. NHS England made a reduction to targets for all systems, to take account of the impact of the industrial action. Systems received funding for the additional elective activity via the Elective Recovery Fund (ERF), these monies were allocated to providers up front as part of start year contracts.

**Waiting list milestones**

2.3. Alongside the above, all systems were expected to achieve specific milestones relating to maximum waiting times:

- Maintain zero 104 week waiters across 2023/24.
- Eliminate and maintain zero 78 week waiters from April 2023
- Eliminate 65 week waiters by end March 2024

2.4. To note, there is no direct correlation between the ERF activity target and the waiting list milestones, i.e. it would be possible to achieve the ERF activity target and miss the waiting list milestones and visa-versa.

2.5. The SEL ICB Operational Plan set out activity trajectories and supporting narrative on the delivery of the above. The SEL activity plan, showed that as a system we would meet our ERF activity target, once adjustments had been made for the impact of the rollout of EPIC (a new electronic Patient Record) at Guy's & St Thomas' Hospital NHS FT (GSTT) and King's College Hospital NHS FT (KCH). In respect of waiting times, we expected to have a residual 50 patients waiting more than 65 weeks at the end of the financial year in Spinal Paediatrics. These paediatric spinal pathways were as a result of the complexity and specialist nature of the patients seen in this service,

resulting in insufficient capacity in SEL and across London, despite the continuation of outsourcing arrangements in SEL. We have been further seeking specialist mutual aid to support improved access and capacity for this service.

## 3. Progress to date

3.1. NHS England has recently shared their initial assessment of our delivery of additional elective activity in the first quarter of this financial year. The national assessment is that as a system we are delivering 110.5% more activity than the baseline year, a positive position, albeit one we are still validating locally.

3.2. The table below shows the number of long waiting patients across SEL's providers and for SEL residents, based on the latest published data.

| Long waiters more than: | SEL trusts | SEL ICS |
|---|---|---|
| 104 weeks | 7 | 8 |
| 78 weeks | 328 | 308 |

*Figure 1: Long waiter performance as at August 2023*

3.3. The chart below shows the cohort of 65 week waiters at SEL trusts. These are the patients that need to be treated by March 2024, to avoid becoming 65 week breaches. This shows good progress in reducing the number of patients in this cohort. There were approximately 118,000 pathways at the beginning of the financial year, which had reduced significantly to approximately 35,000 at the end of August.

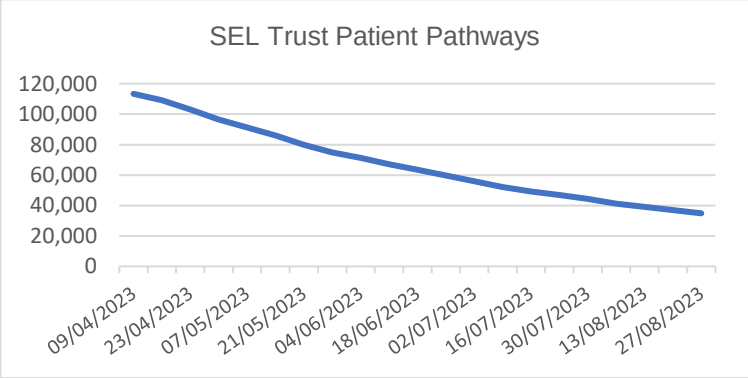


*Figure 2: Number of patients who will breach 65 weeks if not treated by March 2024*

## 4. Drivers

4.1. Over the course of 2023/24, SEL has successfully minimised the number of patients waiting more than 104 weeks. Breaches relate to patient choice, or complexity/ capacity issues.

4.2. Whilst we have made significant progress in reducing our 78 week wait cohort, we have not yet been able to eliminate long waiters in this cohort. The delivery of this target has been significantly impacted by the ongoing industrial action in terms of junior doctors and consultants. Trust teams have needed to undertake a significant level of patient rescheduling to take account of industrial action and to prioritise available capacity for more urgent cases including cancer.

4.3. Whilst good progress has been made in reducing the cohort of patients that need to be treated by March 2024, to avoid 65 week waiting breaches, ongoing industrial action

will continue to impact on the delivery for 65 week waiters meaning there are increasing risks associated with this cohort of long waiters as well.

## 5. Improvement Work Underway

**Community based alternatives and outpatient redesign**

5.1. We continue to enhance our community services. These service developments move activity identified as appropriate for delivery in community settings out of acute hospital capacity, releasing capacity on acute sites, particularly within outpatients but it will also have a knock-on impact on admitted care. Community services being embedded, implemented or enhanced in 2023/24 include Dermatology, Ophthalmology and Ear, Nose and Throat (ENT).

- Dermatology - all boroughs in SEL now have a community dermatology service, delivered by GPs with an Extended Role. These services reduce the number of new referrals to secondary care dermatology services. We are also implementing single points of referral at the acute trusts, with referrals triaged and diverted to the community where appropriate. Tele-dermatology for routine and 2 week wait pathways have also been implemented, lesions recorded by a medical photographer are clinically reviewed by a consultant, and appropriate next steps are put in place.
- Ophthalmology - we have established community ophthalmology services which are delivered by optometrists and well utilised by GPs. Single points of referral ensure that referrals are seen in the most clinically appropriate place, and community services are being expanded to cover patients with learning disabilities and those who reside in care homes.
- ENT - the SEL ENT network has developed a proposal for a community ENT service which will triage all new routine GP referrals from SEL. We are in the process of tendering for this service.

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**Theatre productivity**

5.2. SEL overall capped utilisation is 77% based on recent model hospital data. This makes SEL the third best performing system in the region and in quartile 3 nationally. System performance has held at 75% or greater since the middle of January and is in line with regional peers and the national median. The key aims of the theatre programme are to:

- Strive for 85% theatre utilisation (known as capped utilisation – the % needle to skin time within the total session) for 2023/24 for all sites.
- Reduce on the day cancellations to 5% or less.
- Achieve 85% day case rates.
- Deliver over 95% utilisation of available lists.

5.3. Alongside this is focused targeted work with specialties, teams, and lists that have the greatest opportunity for improvement - as well as continuing to embed and refine improvements made last year for example in scheduling processes. SEL theatre dashboards are being developed to support this targeted work.

**Mutual aid approaches**

5.4. clinical and management colleagues across trusts have worked together cohesively to identify mutual aid requirements and opportunities. The aim is to deliver support needed to treat our longest waiting patients and specifically to reduce the inequalities in waiting times across our system. This includes:

- Transferring pathways in specific challenged specialties between SEL trusts
- Using the elective hub at Queen Mary's Sidcup for general surgery and gynaecology as a green site, meaning that this site will not be impacted by emergency pressures.
- Utilising the Orpington site to significantly reduce the inequalities in waiting times through transfers of long waiting orthopaedic patients.
- Increasing the use of Independent hospital capacity for treating current long waiting patients at our SEL trust via pathway transfer.

**Health inequalities**

5.5. We have developed an elective care inequalities dashboard to support us in assessing any inequalities in our waiting list both at an aggregate trust level and a SEL ICB level. The main inequality noted to date is that for certain specialties there were differences between waiting times across our system. This has driven our approach to the use of mutual aid to address long waits as highlighted above. Further analysis on inequalities is underway including:

- An analysis of DNAs to understand if there are any disparities based on age, sex, ethnicity, or deprivation.
- Assessing whether industrial action has worsened inequalities in the profile of patients waiting.
- Assessing whether there is equitable access to mutual aid at Queen Mary's Sidcup and Independent Sector Providers (ISPs).
- Assessing whether there are disparities in waiting times between children and young people and adults.

5.6. The results of the above analysis will be used to develop actions and update plans, so that they mitigate any identified inequalities.

## 6. Challenges and risks

6.1 Ongoing industrial action - the anticipated ongoing industrial action will continue to impact on the ability to maximise elective activity across SEL. Each episode of industrial action results in not only large volumes of elective cancellations during the strike period, but also significant amounts of administrative disruption. Ongoing industrial action means that planning and forecasting end of year positions is challenging.

6.2 Competing demands - continues to be an on-going challenge. For example, one of the impacts of industrial action is the displacement of urgent and cancer work which needs to be prioritised ahead of long waiting patients. Going into winter, the ability to deliver elective inpatient activity may be restricted by the impact of emergency workload. Our

focus on increasing day case rates and maximising the use of the Queen Mary's Sidcup and Orpington elective hubs and Independent Sector Providers will help mitigate these risks.

6.3 EPIC patient record system - GSTT and KCH successfully rolled out the new EPIC system on 5 October 2023. A reduction in activity over the roll-out period has been built into system plans. In advance of roll out, there was limited ability to make changes to systems. This has meant some transformation initiatives have been slowed down, or the scope has been adjusted to accommodate the IT developments within KCH and GSTT. It is anticipated that in the coming months these programmes will pick up again.

6.4 Mutual aid - significant amount of mutual aid takes place within SEL as providers support one another with their longest waiters, but there are also arrangements being put in place with providers outside of the system. This mutual aid is complex to arrange and relies on patients being willing to transfer to alternative providers. SEL has experience of arranging mutual aid and expects to be able to manage the challenges, with ongoing support from the 'receiving' trusts.

# Integrated Care Partnership

## Item 3
## Enclosure C

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| **Title:** | **South East London ICS Voluntary, Community and Social Enterprise (VCSE) Charter** |
| **Date:** | 26th October 2023 |
| **Authors:** | Tal Rosenzweig (Director of VCSE Collaboration and Partnership and ICP member), Jessica Levoir (Head of Partnerships), Ben Collins (Director of System Development). |
| **Executive Lead:** | Andrew Bland, Chief Executive Officer, NHS South East London ICB |

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| **Purpose of paper:** | The purpose of this paper is to seek ICP member's sign-off of the SEL ICS VCSE Charter following positive collaborative engagement over the last three months. This item will also provide an update on some key actions NHS SEL ICB propose to take in response to the Charter and seeks a discussion on next steps to further engage and embed the Charter across our ICS. | Update / Information | X |
| | | Discussion | X |
| | | Decision | X |
| **Summary of main points:** | This Charter sets out four commitments (summarised below), as well as the rationale for each and some high-level actions the members of the ICP and ICB will take:<br><br>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 of services;<br>2) We will increase funding provided for the VCSE sector and secure services in ways that deliver greater social value and support health creation and prevention;<br>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;<br>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.<br><br>Please refer to the Charter for further detail on each of these.<br><br>The Charter also proposes continued joint working between the ICB, the ICP, VCSE sector and health and care organisations in our system to implement these commitments. | | |

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| | There will be an update during the meeting on the actions NHS SEL ICB will be taking over the course of the next year or so, subject to increases in system inequalities funding, to implement these commitments. We will also present our plans for next steps for collaborative-engagement and implementation, which we would like to invite discussion on. We propose to take the Charter to various system and partner organisation's fora to raise awareness of the Charter and inform development of the 'so what' for our ICS, and work with key leads in our system to start to develop a more detailed implementation plan. ICP members support and championship during this next stage will be crucial. |
| **Recommendation:** | Following the last Partnership meeting in July, further engagement was carried out with ICP members, ICB executives and VCSE sector leaders to understand any amendments required before finalising the draft shared in July. Throughout, these discussions were positive and we received resounding support for the four commitments as set out in the Charter. However, we also heard that the 'so what' is key, and implementation is of course going to require significant time and effort. Therefore, we believe now is a good time to move on to developing implementation plans, working with partners to do so. As a result, we recommend Partnership members ratify the Charter as is so that we can progress on to the next stage. |

# 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. As a system we understand that to achieve our shared vision of a healthy, happy and resilient SEL population we must invest in health-creating and preventative care, tackle health and care inequalities and support our communities to be resilient and connected. This is what the people and communities of SEL have told us they want and need. We know that most of such services are placed within the VCSE sector, particularly within smaller, community-based grassroots organisations. Therefore, we can only achieve our shared goals through more effective collaboration and power sharing with the VCSE sector, across our system, and the appropriate resourcing of the VCSE sector to deliver its role in our system. This charter plays a vital part in driving the impact and change we want to see for the people and communities of SEL.

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, enable cross-system partnership working and enable the VCSE sector to make as full a contribution as possible, where appropriate, to delivering our shared vision for our people and communities. We know that the VCSE sector, like SEL, is wonderfully diverse and that much of the collaborative work this charter calls for will take place through the Local Care Partnerships in our six boroughs. This will require us to develop and apply a wide range of approaches to reflect the unique needs of the boroughs and the VCSE organisations operating within them. We will particularly look to support and strengthen the work of smaller, equity-led grassroots organisations, who are embedded within and have trusted relationships with underserved and marginalised communities across SEL.

1.5. This Charter commits us to collaborative action and, as the work progresses, should lead to a fundamental step change in the way we collaborate and work with the VCSE sector across SEL, enabling a greater positive impact for the people and communities of SEL. 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 SEL system to strengthen our partnership.

2.2. We know that currently our system is managing significant financial challenges, and all partners have limited resources and capacity. We are collaborating to overcome those challenges, and see the implementation of the Charter as a vital part of the solution, creating a positive and sustainable impact for our people and communities.

2.3. 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.

2.4. 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 and commitment to support each other in this work between our Board, our Partnership and the organisations in our Integrated Care System (ICS) to implement the commitments in this Charter and evaluate the impact of this collaboration.

## 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, and in particular for smaller, equity-led grassroots organisations who don't currently have an equitable strategic voice in 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. We will also need to support sector leaders to create greater opportunities for collaboration within the sector. We will need to ensure that this reflects the diversity of the sector, and that we are actively enabling grassroots and smaller VCSEs to play an equitable part, as they often represent the most underserved and marginalised groups and communities and are historically underrepresented in current partnership arrangements.

3.6. 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. A key aspect of this will be building trust and transparency between ICS partners and the VCSE sector.

3.7. 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.

3.8. 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.

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

a) follow a cross-system structured process to ensure equitable power sharing and trust building 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 its services in ways that deliver greater social value and support health creation and prevention.**

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 underserved and marginalised 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 to sustain the impactful work the sector does particularly supporting prevention, health-creation, tackling interrelated health and social challenges, delivering care in ways that work for underserved communities and reducing health inequalities.

4.4. We will need to redirect funding to achieve these objectives, whilst recognising the constraints on overall resources. If we want to enhance the impact of VCSE preventative work in SEL, 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) target its inequalities funding towards VCSE-led interventions and approaches wherever this will best meet the needs of disadvantaged populations and communities;

b) 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

c) 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 (bearing in mind some of the differences in the application of procurement law between NHS organisations and Local Authorities).

5.5. They will explore further how they can procure services in ways that enable partnership working and innovation, maximize social value and avoid unnecessary costs.

5.6. 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.

5.7. 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. 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. Large providers in our system like the NHS 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) work in partnership with the SEL VCSE Strategic Alliance to understand how we can best support VCSE sector organisations infrastructure needs, with particular focus on the needs of small and medium VCSEs, to enable greater social impact;

b) enable more effective sharing of data and insight between the VCSE sector and 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) 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.

# Integrated Care Partnership

## Item 4
## Enclosure D

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|---|---|
| **Title:** | **Implementing our SEL Integrated Care Strategy** |
| **Meeting Date:** | 26 October 2023 |
| **Lead / Contact:** | Andrew Bland, CEO, IC Board |
| **Authors / Contributors** | Ben Collins, Director of System Development, SEL IC Board |

| | | | |
|---|---|---|---|
| **Purpose of paper:** | The paper sets out proposals for cross system action to deliver our five SEL strategic priorities. | **Update / Information** | |
| | | **Discussion** | X |
| | | **Approval** | X |
| **Brief summary of paper** | In our strategy publication of February 2023, we committed to action across SEL on five strategic priorities covering prevention, early years, children's and adults' mental health, and primary care and long term conditions.<br><br>Since February, we have clarified our priorities, focusing on people with high vulnerabilities and disadvantaged groups and communities. We have also assessed the underlying reasons why we are struggling to support these groups effectively, the work planned or in train in South East London that will support our priorities and the approaches that are gaining traction in SEL and beyond.<br><br>In light of this work and ongoing engagement with partners and the public, this paper recommends focusing funding and attention on:<br><br>• Community-led approaches to health prevention that establish sustained relationships with people from disadvantaged communities;<br>• Intensive, generalist approaches to supporting parents, babies and families with high vulnerabilities in early years;<br>• Partnerships between local communities, VCSE organisations, schools and public services to support children and families' mental health and wellbeing in disadvantaged neighbourhoods;<br>• VCSE and peer-led, socially oriented support for adults with common mental health challenges in disadvantaged neighbourhoods; and<br>• Developing 'test case' models of integrated neighbourhood teams in disadvantaged neighbourhoods, so that we can codify effective service designs and approaches to transitioning to team-based care. | | |

| | |
|---|---|
| | The paper also sets out proposals for cross-system action to enable our Local Care Partnerships and organisations across South East London to make faster progress in developing these types of support. These include:<br>• Identifying resourcing for organisations and services across SEL to deliver or extend projects in these areas;<br>• Providing access to leaders with expertise in these interventions, for example local leaders such as the Big Education Academy Chain or national charities such as Birth Companions and Rethink Mental Illness;<br>• Supporting recipients of funding to come together with other sites to follow structured processes for spreading and scaling innovation and sharing learning;<br>• Enabling consistent evaluation so that we can assess projects' impact and codify the key feature of success to support faster spread in future. |
| **Recommendation:** | That the Partnership supports the recommendations for focusing funding and attention to deliver our strategic priorities and the recommendations for cross-system action to allow our system to go further faster. If the Partnership supports these recommendations, we will seek funding through the 2024/25 planning round and develop programmes for each priority to start in early 2024/25. |

# Implementing South East London's Integrated Care Strategy

## Paper for SEL Integrated Care Partnership, 26 October 2023

## 1. Introduction

1.1. In February 2023, we published our strategic priorities for south east London for the next five years. Following conversations with partners across our system, we identified five strategic priorities covering prevention, early years, children's and young people's mental health, adults' mental health and primary care and long-term conditions. We selected these areas because of the opportunity to improve health and care and the opportunity to make faster progress through collaboration across our system.

*Figure 1: Summary of our mission, vision and priorities*


1.2. Since February, we have clarified the focus of our strategic priorities, which in some cases were originally quite broad, and how we will measure success. We have also sought to better understand the underlying problems and the strategic approaches that might allow us to gain traction on longstanding challenges for our system. We committed to bringing rigour to this process and to look carefully at the approaches that were working in our system and beyond.

1.3. As we have progressed this work, we have engaged with partners across our system including in a series of six workshops and public events in September and October. We have also worked with partners to map the extensive work happening or planned across our system in support of our priorities. There is fantastic work in train across our system to improve prevention, early years support, children's and adults' mental health and the primary care system, while at the same time there are opportunities to go further and faster through investment and collaborative working.

1.4. This paper now sets out recommendations for strategic interventions and cross-system working to help deliver our five strategic priorities, building on work happening in our

system. If these are supported by the Integrated Care Partnership, they will be put to the Integrated Care Board with the aim of securing funding through the planning round for 2024/25.

## 2. Focus of our priorities

2.1. At our last Integrated Care Partnership meeting in July 2023, we presented proposals for focusing within each of our strategic priorities on a concrete and actionable challenge for our system. In each case, this meant narrowing the focus, in general to a specific disadvantaged group or community in need of more effective care. We also set commitments for achieving impact with initial thinking on how to measure progress.

*Figure 2: Agreed priorities and commitments*

| Priority | Challenge | Ambition |
|---|---|---|
| Prevention and wellbeing | Delivering primary prevention effectively to our most disadvantaged communities | Close the gap in uptake of these services for people from disadvantaged groups |
| Early years | Supporting mums, babies and families with high vulnerabilities effectively in first 1001 days | Safer births, with fewer complications for families with high vulnerabilities, improvement on key measures of good start in life. |
| Children's and young people's mental health | Supporting children's emotional wellbeing and common mental health challenges in disadvantaged neighbourhoods | Fewer children developing emotional and mental health problems in disadvantaged neighbourhoods, higher school attendance. |
| Adults' mental health | Ensuring access to rapid, trusted and effective early support for common mental health and social challenges. | Fewer people from disadvantaged groups entering crisis or developing more severe mental health problems. |
| Primary care and people with long-term conditions | Delivering proactive, joined up support for long term conditions and people with complex health and social needs. | More people with LTCs and social challenges who report a positive experience of care, live independently and enjoy good lives. |

## 3. Mapping and engagement

3.1. Since July, we have worked closely with our Local Care Partnerships (LCPs) and providers to map the range of activity in our system that should help address our strategic priorities. There is a wide range of initiatives either in train already or planned which will have an impact in delivering our priorities, for example the development of new immunisation and vaccination programmes, new health promotion activities, the Vital Five programme, new family hubs and wellbeing centres for families in early years, the implementation of the I-Thrive framework and NHS Mental Health Teams in schools, SLAM's work to develop integrated community mental health services in Lewisham, partnerships with the VCSE to support adult mental health, as well as plans across our Local Care Partnerships to improve access and quality in primary care.

3.2. In September, we held workshops with stakeholders from across our ICS on what success would look like for our priorities, what we would need to do to get there, and what we could do at south east London level to support progress. From these, there is a broad consensus on both the challenges we need to address and the approaches that are gaining traction. While there is a lot of work in progress, stakeholders consistently argued that they could do more if there was support to deliver change at a larger scale. Stakeholders were also enthusiastic about the possibility of participating in programmes that would allow more structured sharing of expertise and learning as they implemented new approaches to care.

3.3. In October, we held two online workshops with members of the public to share work since February on the strategy, set out the work in train in our system, and highlight the types of approaches we believe are gaining traction in delivering our priorities. As in previous discussions with the public, there was general support for the priorities and the focus on disadvantaged groups and communities, as well as for the types of initiatives we are pursuing to deliver improvement. Members of the public argued that the strategy would lack credibility unless funding was allocated to delivery. They also expressed their impatience at the time it takes for ambitions and commitments to translate into visible change in how services are delivered. (See Annex One for PPL Consulting's overview of findings from this mapping and engagement.)

## 4. Our proposals for accelerating progress

4.1. Our proposals for south east London action seek to accelerate the work already happening in our system to deliver our strategic priorities. We have sought to understand in detail the underlying challenges related to each of our strategic priorities and the approaches within our system and beyond that are gaining greatest traction in addressing them. As discussed in more detail below, we are recommending that funding and attention is focused on:

- For prevention, community-led approaches to health prevention that establish sustained relationships with people from disadvantaged communities and provide support for a wide range of health and wellbeing challenges;
- For early years, intensive, generalist approaches to supporting parents, babies and families with high vulnerabilities, which support families to tackle major challenges while connecting them into support networks and local resources;
- For children' and young people's mental health, partnerships between local communities and VCSE organisations, schools and public services to develop 'Family Zones' to support children and families' wellbeing in disadvantaged neighbourhoods;
- For adults' mental health, VCSE and peer-led, socially oriented support for adults with common mental health challenges in disadvantaged neighbourhoods; and
- For primary care and long-term conditions, developing 'test case' models of integrated neighbourhood teams in disadvantaged neighbourhoods, so that we can codify effective service designs and approaches to transitioning to a team-based model of primary, community and social care.

## 5. Prevention

5.1. For prevention, we have committed to improving primary prevention for our most disadvantaged communities, so that we close the gap in uptake of these services and improve health and life expectancy for people in disadvantaged groups.

*Main underlying issues*

5.2. From our engagement and research, we know that the biggest issue to address in this area is the lack of trusting relationships between statutory services and disadvantaged communities. As a result, our services struggle to communicate effectively and fully understand the needs of disadvantaged communities. Meanwhile, people in disadvantaged communities may not fully understand or have confidence our services.

*Approaches that are gaining traction*

5.3. The most successful approaches appear to be those that build sustained relationships and ongoing dialogue into the design of services, rather than relying on one-off listening or co-design exercises. Successful approaches often use local community organisations to connect with people in disadvantaged communities, focus on building relationships with people in a specific neighbourhood, engage on wellbeing in the round rather than a single health issue, and support people with things that matter to them, such as getting their children to school or help in the home, as well as health.

5.4. For example, GPs in Stockwell have built relationships with local community organisations that support the local Portuguese community, worked in partnership with these organisations to engage people on wellbeing at community events, and hired community members to work with Portuguese families on health and social challenges. Other organisations in south east London have been developing similar peer-led, relationship-based approaches to prevention, for example Charlton Athletic Community Trust in Bexley and Greenwich.

5.5. Meanwhile Westminster City Council has hired local people to act as Community Health Workers, along the lines of the Brazilian Family Health Strategy, to work with families living in the Churchill Gardens social housing estate on their health and wellbeing. They explain prevention opportunities, provide support for long term conditions, and connect people to local health and social services. A peer-reviewed evaluation has found that, after one year, households visited by community health workers were 47% more likely to have received immunisations and 82% more likely to have received their cancer screenings and NHS health checks compared to households that had not been visited. The households receiving visits also booked 7.4% fewer GP consultations compared to the period before the pilot.

*Proposed action*

5.6. Our proposal is to make additional funding available to accelerate the development of this relationship-based approach to prevention in defined neighbourhoods, building on the work already happening across our system. We would make funding available for approaches that use local people and community organisations to build sustained relationships with people in specific disadvantaged communities, engage people on a range of health and wellbeing issues, and connect them into primary care and other forms of support and services.

5.7. We would also seek to establish a collaboration with the leaders who have developed effective relationship-based approaches to prevention in neighbourhoods, so that we benefit from their learning on developing and scaling their approaches. For example, we might approach the leaders of Westminster's Community Health Workers scheme, the Bromley by Bow Centre and leaders of similar programmes in south east London. We would bring together different sites in a collaborative programme to share learning on implementation and benchmark progress. With the Integrated Care Partnership's sponsorship, we would promote collaboration with health and council services.

## 6. Early years

6.1. For early years, we have committed to improving the support for parents, babies and families with high vulnerabilities in the first 1001 days, so we ensure safer births and improvement on key measures of a good start in life. By 'high vulnerabilities', we mean parents and families facing major challenges, for example young, isolated families, people living in poverty, people struggling with drug and alcohol challenges, and people with severe mental illness amongst others.

*Main underlying issues*

6.2. From our engagement and research, we know that we have limited staff and resources to provide intensive support for parents and families with high vulnerabilities, which is reflected in restrictive referral thresholds into services. There is a lack of continuity of support for families with high vulnerabilities and support can stop soon after birth. Staff and services often work within narrow remits, only able to help with some of a family's challenges. Families often have to navigate a patchwork of micro-services that might work for the general population but not for people with complex needs. There is also deep distrust of statutory services amongst many disadvantaged groups.

*Approaches that are gaining traction*

6.3. Over the last few months, we have worked closely with the national charity Birth Companions, who have researched and piloted effective services for mums and babies with high vulnerabilities. We have also worked closely with organisations within south east London such as Mums Aid in Greenwich, who deliver nationally respected services for mums and babies with significant needs.

6.4. The most successful approaches rely on experienced case workers who develop a sustained relationship with parents and babies from before birth where possible and maintain this relationship until at least the end of the first 1001 days. These case workers provide intensive and holistic support for parents and families to address whatever matters to ensure their babies have a good start in life, not just health or mental health issues. They provide active support on benefits, housing and other social welfare challenges, engaging with services for their families rather than signposting. They bring their parents into peer support networks and connect them with family hubs and other local resources they would otherwise be unlikely to access.

6.5. In 2022, Birth Companions delivered this type of support to parents and families with high vulnerabilities in different settings in London and the south east of England. 96% of parents felt less isolated, 88% believed they had been able to give their babies a better start in life, and 87% believed they had better mental health and wellbeing. In 2020, an independent evaluation of Mums' Aid's support found that 94% of mums had improved scores for post-natal depression. The number of mums at risk of clinical depression reduced by 65%.

*Proposed action*

6.6. Our proposal is to make additional funding available for the development of new or extended services for parents and families with high vulnerabilities, drawing on learning from successful approaches such as Mums' Aid in south east London, Birth Companion's pilots and services and Changing Futures initiatives in Shefield and other parts of England. We would make funding available for approaches based on the use of experienced, generalist case workers, a model of intensive and ongoing early support, a holistic approach to supporting families with health and social challenges, empowering parents and families, and connecting them with local resources.

6.7. We would seek to establish a collaboration with Birth Companions and Mums' Aid to support the development of these new or extended services. This would allow us to benefit from their depth of expertise on the approaches that work for parents and families with high vulnerabilities and their connections with other high performing services across England.

## 7. Children and young people's mental health

7.1. For children and young people's mental health, we have committed to improving support for children's mental health and emotional wellbeing in disadvantaged neighbourhoods, so that fewer children in these neighbourhoods develop mental health problems and children achieve have higher educational attainment.

### *Main underlying issues*

7.2. Our engagement and research have highlighted the extent of the challenge of supporting children's resilience and wellbeing in highly disadvantaged neighbourhoods, where families may be struggling with poverty, housing, immigration, relationships, health and many other problems. While initiatives such as implementing the I-Thrive framework, establishing NHS mental health teams in schools and improving access to counselling should have an impact, a more comprehensive approach is needed to address the range of challenges impacting children's and families' wellbeing in our most disadvantaged neighbourhoods.

### *Approaches that are gaining traction*

7.3. While there are no simple solutions, national charities including Place2Be, the Anna Freud Centre for Children and Families and the National Children's Bureau have highlighted the need for 'whole school' and 'whole system' approaches to children's wellbeing in disadvantaged neighbourhoods. Successful approaches are bringing together a range of local partners within a local community. They are focusing on access to healthy food, the school environment, sports, exercise, arts and other activities, after-school clubs, places for children and families to go at the weekend and early help for parents to address social challenges, amongst many other issues, as well as better access to physical and mental health services.

7.4. For example, the Big Education Academy Chain has redesigned the school environment at Surrey Square Primary School near the Aylesbury Estate in Walworth so that everything the school does supports children's and families' wellbeing. This focus on wellbeing is reflected in the school's values, its support for staff, its curriculum, access to breakfast and high-quality food, partnerships with Place2Be and other charities, after school activities and youth clubs. The school also provides direct support for parents facing personal, social and economic challenges.

7.5. Big Education has also brought together residents and community organisations within the 'Old Kent Road Family Zone' to work together to create a better environment for families, with the school now opening once a month at the weekend to give families somewhere to go, access to food, clothes and living essentials. It is also trialling a pop-up restaurant for parents. The NHS is now attending at the weekend and delivering primary care, dentistry and mental health support to families who would otherwise not receive services. While this is a complex challenge, the evidence of impact is encouraging. When they start at Surrey Square, 26% of children are at the appropriate level of development. When they leave, 85% are at the appropriate level.

7.6. Similar approaches are at different stages of development in other parts of south east London. For example, the Integrated Care Board agreed in July resourcing for Black Thrive to work with five primary schools across south east London to recruit local people to act as community connectors, bring together local partners and co-design interventions to support children's mental health and wellbeing. There are also other successful partnerships and ecosystems being developed for children in disadvantaged areas in England, for example the Reach children's hub in Feltham and the Oasis Academy chain.

*Proposed action*

7.7. Our proposal is to make funding available for community organisations in other disadvantaged neighbourhoods in south east London to develop similar partnerships and ecosystems. We would offer resources to enthusiastic community organisations and schools to hire local people to act as 'community connectors', bring together residents, community organisations and public services, and develop together initiatives to improve children's and families' wellbeing. As well as working with schools, they should focus on support for children not attending school, given their very high risk of serious mental health and social challenges.

7.8. We envisage that these partnerships would work closely with existing local VCSE organisations supporting children's mental health. We would also commit to ensuring that health and other public services support these partnerships as required by the local community. For example, we would explore with the partnerships scope to deliver a broader range of core primary care services and early help for social challenges within schools and disadvantaged neighbourhoods.

7.9. We would seek to establish a collaboration with one or more organisations such as the Big Education Academy Chain, Black Thrive and Place2Be, who have experience of working with local schools and community organisations to develop these partnerships and ecosystems. Their role would be to help each partnership to apply a set of established principles for effective community asset building and to enable sharing of learning across neighbourhoods.

## 8. Adults' mental health

8.1. For adults' mental health, we have committed to improving access to trusted and effective early support for adults in disadvantaged groups facing common mental health challenges, so we reduce the number of adults in disadvantaged groups entering crisis or developing more severe mental health problems.

*Main underlying issues*

8.2. Our engagement and research have highlighted the lack of trust and connection with statutory mental health services amongst many of our disadvantaged communities. It has also highlighted the limited capacity in primary care to support adults with common mental health challenges, reliance on a narrow range of therapeutic approaches, and a lack of culturally appropriate or tailored support for some communities.

8.3. We have some outstanding VCSE organisations such as Mosaic Clubhouse, Certitude and Black Thrive who are delivering highly effective non-clinical, socially oriented support for adults with common mental health challenges and people with more severe and enduring mental ill health. These organisations are delivering a significant impact with limited resources. (90% of Mosaic Clubhouse's service users believe that it helps them stay well mentally, 80% say it makes them feel part of community, 80% say it has given them a sense of purpose and hope for the future.) However, limited funding means that these services are only available to a small proportion of our population. There is also sometimes a lack of close partnership working with statutory services, meaning that statutory services are reluctant to refer into these VCSE services or miss opportunities to support them.

*Approaches that are gaining traction*

8.4. Over the last few months, we have worked with local VCSE organisations and two national charities, Rethink Mental Illness and the Centre for Mental Health, to better understand the key features of effective social support for mental health. The most

effective organisations are often very close to the local community, with staff who come from the local community.

8.5. These organisations focus on approaches that harness the resources of service users to support each other and allow service users to recover agency and self-efficacy. They support people in building the core components of wellbeing and a good life, in particular friendship, connection and meaningful activity. They also provide active help with social challenges and effective support to bring people back into education, training or employment.

8.6. While the immediate focus of our strategy is on early intervention for common mental health challenges, these organisations also provide effective support for people with more severe and enduring mental health challenges.

*Proposed action*

8.7. Our proposal is to make funding available through micro-grants for VCSE organisations in south east London, including hyper-local community organisations, to develop culturally appropriate and socially oriented support for adults with common mental health challenges in disadvantaged neighbourhoods. There are many small community organisations supporting adults with mental health challenges in south east London who could do much more with even small amounts of funding.

8.8. Our approach would seek to support these community organisations and develop the existing assets in our communities, while at the same time enabling more structured sharing of learning and partnership working between the VCSE and statutory services. We would seek to secure support from one or more charities such as Rethink and Black Thrive to support the participating organisations and enable sharing of learning. We would also seek to build stronger partnerships between these services and primary care, mental health and local authority services.

## 9. Primary care and long-term conditions

9.1. For primary care and long-term conditions, we have committed to delivering proactive and joined-up support for people with long term conditions and complex health and social needs, so more people report a positive experience of care, live independently and live good lives.

*Main underlying issues*

9.2. At present, like other health and care systems, we face serious challenges in delivering joined-up, whole person care for people with more complex needs. Our primary care system is under severe pressure with increasing demand and workforce shortages and model of service delivery that was not designed to support an ageing population with more complex health and social needs. Meanwhile, service users need to interact with separate primary, community, hospital and social services.

*Approaches that are gaining traction*

9.3. We know that to address these challenges we will need to make significant changes to how we use staff and deliver care across primary and community services, hospital specialists, social services and the VCSE sector. The national NHS advocates the development of integrated neighbourhood teams to deliver holistic care for people with long term conditions and complex needs, with the aim of avoiding the inefficiency and lack of continuity that comes from interaction with many different services.

9.4. This approach is informed by successful international models of team-based primary and community care, where a multi-disciplinary team makes it possible to hold a

sustained relationship with people with complex needs, minimise transitions and referrals to other services, and make the best use of team members' skills, allowing doctors, nurses, social workers and community workers to focus on the activities where they can deliver the greatest value, and using specialists to upskill generalists. At present, however, we have not yet implemented the model effectively at scale in England and there are remaining questions about how to do so in our context.

*Proposed action*

9.5. Our proposal is to make funding available within each of our local care partnerships to support the development of an integrated neighbourhood team focused specifically on delivery of proactive, whole person care for people at risk in disadvantaged groups.

9.6. These projects should actively involve local people in a defined neighbourhood with the aim of developing a model that reflects community members' priorities. They should also actively involve the VCSE in design and delivery of the model of care, so that we make best use of the VCSE's insights and ensure the VCSE is at the heart of these teams. As discussed above, they should focus on how to secure the full benefits of multi-disciplinary team working seen in successful international systems.

9.7. As well as funding, we propose that the ICB should provide access to insight from successful team-based primary and community services and support for leaders across the sites to discuss approaches and share learning. For example, we might seek to partner with a national charity with a strong interest in team based primary care such as National Voices or an international system with strong expertise in developing integrated teams. We also propose that the ICB should also identify a partner to support the sites in codifying their service design and approach to implementing it and in evaluating the impact, so that these projects provide a basis for more systematic spread and scale of integrated, team-based care.

## Cross-system action to deliver our priorities

9.8. As above, we are proposing that organisations and services in our LCPs should have the opportunity to seek funding to support projects meeting the criteria above. As discussed above, each project would need to meet a small number of criteria. However, there should be scope to tailor projects to build on work in train across our system and to reflect local circumstances. There might also be scope to pursue a number of projects within a particular disadvantaged neighbourhood.

9.9. As well as identifying opportunities to improve health and wellbeing, we also specifically sought to identify strategic priorities where there would be opportunities to develop collaborative practice and sharing of learning across south east London. Stakeholders across our system have made clear their support for more structured processes to share knowledge and learn together. There is also a body of evidence on the challenges of spreading and scaling service innovation and the need for structured approaches to make best use of the available evidence, codify and implement the central elements of an approach and benchmark progress across sites.

9.10. In addition to funding for projects, we therefore propose that the ICB provides access to leaders and organisations with expertise in delivering these types of projects. These leaders or organisations would provide insight and mentoring, so projects draw on the existing body of evidence and practical knowledge of how to make these service innovations work. As above, these might be local leaders such as Westminster's Community Health Worker programme and the Big Education Academy Chain or national charities such as Birth Companions and Rethink Without this support, there is a risk that projects reinvent established knowledge or repeat past mistakes.

9.11. We propose to provide support for recipients of funding to come together with other sites and services to participate in a collaborative process, to help them spread proven innovations, share learning and problem-solve together. Without a structured process, there is the risk of a ‘dilution effect’, where attempts to scale service innovation fail to deliver the impact of the originator schemes. We also propose to provide support for consistent evaluation, including community-led evaluation, so that we can assess the projects’ impact and codify the key features of success, so that this provides a foundation for future spread and scale.

9.12. The delivery of each of our priorities will require collaboration across different health, care and VCSE services. We envisage that the Integrated Care Partnership will play an active sponsorship role to ensure that system partners support these initiatives effectively, for example configuring their staff and resources to work in effective partnership with new neighbourhood-based services.

9.13. The leaders of projects will want to be able to measure progress in the short and medium term, benchmark progress and quantify their impact. Our Integrated Care Partnership will also want to be able to monitor effectively the progress of these projects and the impact of other work across our system to deliver our strategic priorities. We therefore propose to agree with local leaders a set of shared metrics for these strategy projects. We are also working on an overall framework of metrics to track delivery of our strategic priorities. (See Annex Two for a summary of our analysis, proposed action and proposed cross system support for each priority.)

## 10. Next Steps

10.1. If the Integrated Care Partnership agrees to these proposals, we will seek resources through the planning round for 2024/25 to deliver projects to support our five priorities from 2024/25 onwards. We will return to the Partnership in early 2024 to discuss the overall funding and the more detailed planning for allocating resources, identifying projects and establishing learning collaboratives. (Annex Three provides an outline of proposed next steps, for development in the remainder of Quarter 3 2023/24.)

# Annex One:

# Findings from mapping of system activity and engagement in September / October 2023

26 October 2023

# Executive summary

**There is a huge amount of work in train or planned in across the SEL system, within local care partnerships and providers, which will help to deliver SEL's five strategic priorities.**

- From the work in train across the system and engagement with stakeholders, there are a number of common themes in how partners across our system envisage making progress against our strategic priorities.
- There is also a recognition that, with greater funding and support, it would be possible to go further and faster in implementing service change to deliver our strategy, in particular by spreading and scaling approaches that are delivering proven benefits to a larger proportion of the population.
- Stakeholders are also enthusiastic about the possibility of more structured processes to enable systematic sharing of expertise and learning across South East London to support effective implementation of new approaches to care delivery, along with other actions at South East London level to enable progress within our Local Care Partnerships and Providers.
- Through our engagement process with stakeholders across each priority area, we have been able to come up with:

**1) A set of principles for the delivery of those ambitions:**

- Collaborative and shared ways of working
- Providing integrated and holistic care
- Working as equal partners across the statutory and VCSE sectors
- Working with and empowering communities
- Intervening early
- Communicating and sharing information
- Working with compassion and empathy

**2) To identify actions which can be co-ordinated at a SEL level to add value to the work of Local Care Partnerships**:

- Setting a shared purpose and positive behaviours
- Addressing barriers to collaboration
- Supporting the VCSE infrastructure
- Putting in place mechanisms to enable sharing and scaling
- Measuring and demonstrating impact
- Supporting co-production with communities

# Hearing what is important to South East London

## Our collective journey towards achieving our strategic priorities has been shaped by extensive engagement with organisational representatives from across the system as well as our local residents.

**Our objectives:**

- Recognise where we are across the system and the work ongoing to achieve our ambitions
- Identify further opportunities for value-adding work and the key characteristics of what that might look like
- Listen to the views of residents on what is important, and what outcomes we need to achieve with each of the priority areas

**Our approach:**

- We took a multi-tiered approach to meet these objectives, as shown below:

### Evidence review

- We reviewed published literature to better understand where we might have the greatest impact together.
- We produced a set of driver diagrams (see Appendix #) for each priority area, which illustrate a 'theory of change' that could help us to evaluate what activities are most important for us to work together on across the system.
- These driver diagrams are works in progress and are not exhaustive; there may be additional drivers critical to improvements unique to each local area that still need to be captured.

### Activity mapping

- **All six boroughs completed a mapping exercise** to identify what activities, live or planned, are expected to deliver the shared ambitions in local areas (see Appendix #).

### System feedback

- South East London (SEL) Integrated Care Partnership organised four online workshops with system partners between 19th-25th September 2023 to discuss Prevention & Wellbeing, Children's and Young People's Mental Health, Early Years, and Adults' Mental Health priority areas.
- These workshops were attended collectively by **139 individuals across South East London from all boroughs**, including colleagues from the voluntary and community organisations.
- Attendees represented **16 organisations**, including representatives from the SEL Integrated Care Board, Directors of Public Health for Local Authorities, NHS trusts, and Healthwatch.
- There was SEL-wide and borough level organisational representation.

### Public feedback

- In addition to the system-level workshops, two public engagement sessions were held as well on the 29th September and 2nd October 2023.
- The workshops were attended by **85 individuals across South East London from all boroughs**, including colleagues from the voluntary and community organisations.
- Attendees represented the views of a wide range of people including autistic people, older people and those struggling with mental health.

- Findings from all six workshops with system partners and members of the public were collated and analysed to determine common themes that could inform future strategy development. Results from this thematic analysis are presented in this Annex.

# What we are doing in Prevention and Wellbeing

South East London Integrated Care System

## In order to improve prevention of ill health, and the wellbeing of populations across South East London, we are already undertaking significant amounts of work, including:

**Increasing uptake of all national immunisation programmes**, particularly in marginalised communities through targeted work in low uptake schools and areas such as **Southwark's work with 10 local VCSEs** to raise awareness of the benefits of vaccines amongst marginalised communities. We are using this engagement with service users to support the focus on Core20Plus5 groups for example targeting hypertension by implementing processes such as **pulse checks during covid/flu jabs in Bromley.**

**Bringing support services closer to the communities they serve through health hubs**, such as the **PCN Health Hubs in Bromley** and the **Health Kiosks pilot in Southwark**. These help increase engagement with prevention and wellbeing services, through providing information and supporting attendance at health checks for specific groups of patients e.g., young mothers aged under 26 are targeted for support by the **Mottingham PCN Health Hub in Bromley.**

**Increasing engagement with and understanding of the communities we serve**, through initiatives such as the **Lewisham Independent Advisory Group (IAG)** which facilitates information exchange and builds trust with the community. The **Bromley Homeless Health Project** aims to understand more about the needs of the homeless population and has reduced barriers to accessing support by opening a clinic at Bromley Homeless Shelter.

**Co-designing and delivering projects in partnership with VCSE organisations**, such as the **Bromley Mental Health Hub**, which links people from marginalised communities with local VCSEs to improve their mental and physical health and wellbeing. Southwark plan to commission a **VCSE grants programme** to increase vaccine uptake in marginalised communities.

**Regularly reviewing and scrutinising our services to ensure they are delivering in line with our aims and according to best practice,** such as the **Southwark Diabetes Service Review** in line with the Fuller Stocktake principles, and Lewisham planning to review baselines for access within services.

**Improving uptake of cancer screening,** such as **Bromley learning from neighbourhood engagement** to inform its approach and Southwark aiming to achieve national targets across breast, bowel and cervical cancer screening programmes by providing a **more even coverage and reducing inequalities across the borough.**

*This information has been obtained from the mapping exercise templates completed by SEL boroughs.*
*We have not yet received mapping information from Bexley, Greenwich or Lambeth*

# What we are doing in CYP Mental Health

South East London Integrated Care System

## In order to improve the mental health and wellbeing of children and young people (CYP) across South East London, we are already undertaking significant amounts of work, including:

**Increasing the presence of Mental Health Support Teams (MHSTs) in schools –** these are already operating in 16 schools in Southwark, and 14 in Lambeth, who are planning to double this number in 2023/24. Bromley's MHSTs service reaches 75% of schools, and is provided by **Bromley Y**, a charity who are also working with Oxleas CAMHS to provide self-harm training and support to schools, as well as piloting an eating disorders early intervention approach.

**Working with partners to support children's emotional resilience and wellbeing in schools**, such as Black Thrive working to improve mental health support for black children and those from poor families in Lambeth. Another notable piece of work is **DISCOVER**, a workshop-based initiative delivered by SLaM, to address anxiety and depression amongst 6th form students in Lambeth and Lewisham.

**Improving diagnostic and support services for children with ASD and ADHD –** for example Southwark is using local population data to improve equality of access to support and services, and Bromley is undertaking a needs assessment to understand the potential benefits of reducing inequality and inform future work in this area.

**Improving awareness of, and access to, support and prevention services**, such as **Lewisham's "Open Your Mind" campaign** in collaboration with other mental health providers, and Southwark's creation of **an Emotional Wellbeing and Mental Health Services Directory** for families and young people. Lambeth is also improving access to services via its **Single Point of Access (SPA) initiative** (which Bromley plans to replicate), providing a multi-agency single point of access that draws together a range of services seeking to support CYP and their families.

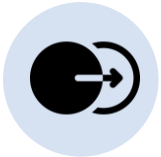
**Delivering holistic prevention programmes aimed at reducing the incidence of Severe Mental Illness (SMI)**, such as the **Lambeth Children's & Young Person Alliance (CYPA)** which champions holistic emotional and mental well-being for children and young people, by focusing on early-stage mental health issues, promoting inclusivity, and ensuring cultural and situational sensitivities. Another such example is the **Cues-ED** universal approach to prevention and early intervention for primary school children delivered by SLaM in schools across South East London.

*This information has been obtained from the mapping exercise templates completed by SEL boroughs.*
*We have not yet received mapping information from Bexley or Greenwich*

# What we are doing in Early Years

South East London Integrated Care System

**In order to improve support for mothers, babies and families before birth and during the early years of life in South East London, we are already undertaking significant amounts of work, including:**



**Supporting the transition to parenthood** through initiatives such as **the EPEC (Empowering Parents, Empowering Communities)** programmes operating in Bexley and Lambeth, and **Bromley's 'Mindful Mums'** 5-week wellbeing support groups offered both ante and post-natal. **Greenwich offers a universal parenting programme** as well as increased health visitor support during the antenatal period (also offered in Lewisham and Southwark).

**Supporting maternal and family mental health** through initiatives such as **Bexley's 'Co-parent pads' guide** for non-birthing parents in how to support their birthing spouse and includes information of mental health, post-natal depression. Greenwich employs a specialist mental health midwife and makes grants to VCSEs providing mild-to-moderate perinatal health support, and **Lewisham has established a Perinatal Mental Health and Parent-Infant Relationship Steering Group and Delivery Plan**.


**Supporting wellbeing and language development** through initiatives such as **ECHO (Early Communication at the Heart Of) Bexley** and **REAL (Raising Early Achievement in Literacy)** in Lambeth and Lewisham. This area is also addressed through the **EarlyTalkBoost programme** in Bexley and Greenwich. Lambeth, Lewisham and Greenwich are embedding work in this area across family hubs and children's centres, in order to improve access and bring this work into the community.

**Supporting breastfeeding** through initiatives such as drop-in sessions in Bromley and Greenwich, as well as peer-support groups in Bexley and Lewisham. Lambeth offers a tiered model of support, including community midwives, enhanced peer support and specialist support for those with complex breastfeeding needs

**Supporting healthy weight and nutrition**, through community-based initiatives such as **Greenwich's Nourishing Nippers** and the **HENRY Healthy Families Growing Up programme** in Lambeth and Lewisham. Bromley, Lambeth, Lewisham and Southwark take part in the healthy start scheme, providing vitamins and healthy food vouchers.

*This information has been obtained from the mapping exercise templates completed by SEL boroughs.*

# What we are doing in Adult Mental Health

South East London Integrated Care System

## In order to improve access to early support for adults with mental health challenges in South East London, we are already undertaking significant amounts of work, including:

**Reducing the number of people from marginalised communities entering crisis**. **Bromley is delivering a range of MH and wellbeing services through their Bromley Mental Health Hub** which include inpatient services, community teams, talking therapies, rehabilitation support, and **early intervention services** to support residents. **Lambeth's CAPSA service** provides culturally appropriate services to residents and is working to reduce inequalities in marginalised communities, whilst **Southwark is rolling out cultural appropriateness training** to reduce restraint and seclusion of Black service users.

**Increasing the number of physical health checks in people with severe mental illness (SMI).** Southwark will continue to report on the delivery of physical health checks whilst Lewisham are working with South London and Maudsley University Hospitals Trust (SLaM) to increase uptake in their patients.

Working collaboratively across organisations to support patients on needs beyond just health. **Bromley is working with a range of partners to provide a range of additional support services** including employment support, housing advice, drug and alcohol abuse support, benefits advice, support groups for mums with MH challenges to name a few. **Lewisham is expanding Individual Placement & Support (IPS) offer** across community teams (SMI focus), and **Southwark's neighbourhood outreach via the Wellbeing hub** where staff are employed by the VCSE provider, and many have lived experience of MH. They are based within primary care and work closely with social prescribers, seeing patients with a range of needs including social, financial and emotional.

**Implementing a holistic, place-based approach**, as in the case of **Southwark's Community Mental Health Teams (CMHT) programme** developing shared local resources to deliver their borough-level plan and aligning this to that of SLaM. Southwark plan to build on this, working with system colleagues around an integrated neighbourhood (INT) footprint. SLaM are implementing DIALOG outcome recording to help review satisfaction scores for quality of life and plan to invest in improved population health management (PHM) capabilities and expertise across Lambeth and Lewisham.

*This information has been obtained from the mapping exercise templates completed by SEL boroughs.*
*We have not yet received mapping information from Bexley or Greenwich*

# What we are doing in Primary Care and LTCs

South East London Integrated Care System

**In order to improve experience and management of long-term conditions (LTC), and delivery of primary care services across SEL, we are already undertaking significant amounts of work, including:**

**Establishing multi-disciplinary teams (MDT)** such as **Southwark's MDT**, **Lewisham's multidisciplinary case management approach, and Bromley's MDT** that will shift outpatient activity with consultant capacity and enable care closer to home. These initiatives will aim to improve care coordination and support the delivery of better care close to home.

**Integrated neighbourhood teams** established such as those in **Bromley and Southwark** that include partners from across the system. This will facilitate local models of care such as **Bromley's Neighbourhood Diabetes model of care** which will support practices in coming together to form a neighbourhood team of excellence to optimise care through problem-solving, early treatment interventions and community service referral avoidance.

**Supporting people with long-term conditions (LTC)** such as **Bromley's community-level clinics for LTC** management and monitoring, and **Southwark's plan to review and use Additional Roles Reimbursement (ARR) roles** to develop a workforce capable of enabling consistent points of contact and personalised care for people with LTCs.

**Providing community-based support for people to manage their LTC**, such as **Lewisham's community based atrial fibrillation detection initiative** that uses technology in community pharmacies, and **Bromley's remote monitoring of hypertension** to improve the management of LTC's and engage people through convenient self-management route that supports a reduction in the need to visit a healthcare setting.

**Expanding primary care provision**, including **Bromley's dedicated primary care service for residents in older people**'s care homes and extra care housing settings, **Southwark's practice-level and at-scale investment in GP expansion,** implementation of **primary care recovery plans**, and the **South East London primary care transformation strategies**.

**Reducing unnecessary urgent care admissions,** such as **Lewisham's virtual ward targeted monitoring for admissions avoidance** which is targeting the top 100 patients most at risk of hospital admissions so that clinical care can be deployed as quickly as possible. **Southwark's' urgent community response (UCR)** development will deploy rapid community response teams to prevent unnecessary hospital admissions.

*This information has been obtained from the mapping exercise templates completed by SEL boroughs.*
*We have not yet received mapping information from Bexley, Greenwich or Lambeth*

# What good looks like going forward (1/2)

South East London Integrated Care System

**Plenary discussions in the stakeholders' and the public engagement workshops explored perspectives on what good would look like, and how will we know we've got there. Key high-level themes that emerged included:**

## Collaborative and shared ways of working

- Agreed set of **principles and ways of working**, supported by the ICS.
- Working collaboratively on projects, with **linked resources**, **shared budgets**, and an **integrated commissioning process**.
- Building **trust between organisations** and **challenging each other** to ensure the right support is provided at each stage of the pathway.
- **Upskilled workforce** focused on coaching, motivational interviewing and health literacy training to empower residents.
- **Sharing best practices** and establishing **multi-agency training** to create a learning community within the system.

## Providing integrated and holistic care

- **Greater integration between all partners in the system** (VCSEs, social care, housing etc) with less barriers and more fluidity.
- Consideration of the impact of **wider determinants of health**, **racism, poverty, trauma and discrimination on communities.**
- **Integrated care and continuity** where service providers can see the bigger picture, and **patients don't have to repeat themselves**.
- Accounting for **physical and mental health**.
- **Personalised care** that helps to build trusted relationships with staff and institutions.
- More **accessible services** (digital /non-digital, clinical vs. non-clinical settings, varied hours etc.)
- **Clear pathways** throughout an individuals' life**.**

## Working differently with our VCSE partners

- We **value our VCSE colleagues as equals** and create enough time to develop and mature outcomes together.
- **Established interoperability between all partners**, from statutory services to VCSE organisations.
- Have **sustainable funding** to avoid service interruptions.
- **Strengthened connections and shared data** between VCSE's and statutory partners.
- Increased **focus on collaborative and innovative working** rather than creating a competitive market through small funding pots.
- We **remove hierarchy** where peer support workers and VCSE workers feel on equal footing with NHS staff.

## Working with and empowering communities

- Having **strong connections** with and **understanding** of our local communities.
- **Mapping out the scale of unmet need** and **co-creating services** with individuals that are catered to their experiences.
- **Trained staff** who deliver **culturally-informed care.**
- **Using community assets** and building on existing assets.
- **Using anchor institutions** to invest in local communities, providing routes out of poverty through employment and building trust by employing members of the community.
- **Closing the feedback loop** to support building trust with communities and empowering them to take preventative actions for themselves.
- **Meeting people where they are**, and not waiting for them to come to us.

# What good looks like going forward (2/2)

South East London Integrated Care System

**Plenary discussions in the stakeholders' and the public engagement workshops explored perspectives on what good would look like, and how will we know we've got there. Key high-level themes that emerged included:**

## Intervening early

- **Focused on prevention** as most people who become unwell are already known to local services.
- **Fewer people accessing services at point of crises** by working collaboratively to deliver proactive care and early intervention.
- **Delivery of tailored preventative actions** for people who need them **at key stages in people's lives**, such as when pupils leave school, when people have children, when people are about to retire etc.
- **Building awareness of all support available** and help people to access it and inform others.
- **Screening to facilitate early diagnosis**, followed by proactive and tailored support.

## Communication and information sharing

- **How information is communicated** and **who is driving it** should be shared to establish **more trusting relationships**.
- **Focusing communication on the desired audience** and considering whether there is a more effective or collaborative way to deliver the information.
- **Improved communication between different areas of primary and secondary care** to support trust building and avoid patients repeating their story.
- **Acknowledge gaps in roles due to recruitment challenges** so that service users know what to expect.
- **Better access to GP data and health records** to ensure they are accurate; this will support building trust and knowing their voices are heard.

## Working with compassion and empathy

- **Working with empathy and reducing stigma** in the system so that service users feel less judged and stigmatised.
- **Following through with commitment on actions** in a **transparent and empathetic way** to establish and maintain trust.
- **Patients don't feel judged and don't need to relive any trauma** to receive proper care.

# Opportunities to collaborate across South East London

South East London Integrated Care System

**Plenary discussions in the stakeholders' workshops explored participant perspectives on where there are opportunities to work better together and generalise good practice. Key high-level themes that emerged included:**

## Shared purpose and positive behaviours

- **Healthy and positive behaviours** showcased and encouraged by leadership.
- **Leadership support to establish a shared purpose** with funding dedicated to support collaboration in SEL.
- **Leadership to enable and empower people** and **allow space for new areas** to emerge.
- Foster a **culture of "*being curious* and *experimental*"**.
- Enable or give "***permission to try to do things differently***".

## Key components for collaboration

- "***Collaboration has to be everyone's role***".
- **Genuine and equal partnerships** between statutory an VCSEs.
- Address the **power imbalance** between systems and people to avoid working in silos.
- **Expand working relationships with health and non- health partners across the sectors**, e.g., community housing teams, police.
- **Forge ongoing institutional relationships** which are not dependent on individual relationships.
- **Remove barriers to collaboration**, e.g., commissioning silos and improve information sharing.
- **Shared KPIs** (qualitative and quantitative) to demonstrate impact during collaborative work.

## Working with VCSEs and smaller organisations

- "***Less ring-fencing of services and funding***" and shared budgets between organisations to facilitate a collaborative approach to initiatives.
- **Community led programmes can help alleviate capacity issues**, enabling less reliance on services struggling with staffing - recurrent funding is paramount
- **Greater accessibility of data and information**, particularly for funding applications – to *"bring statutory and VCSE services together to join up information and data*".
- **Support grassroots and small organisations** with governance, safeguarding, and processes to meet statutory duties.
- **Examine how money flows to the local levels** and how to **support the broader infrastructure.**

## Share, scale and spread

- **Map assets and understand what we are doing well** and consider "*where are the pockets of good practice*?".
- **Share learning on our successes** to encourage the replication of good ideas.
- **Define the overarching offer and how we can "*spread across South East London*"** but still "*maintain tailoring*" to local communities.
- **Having more neighbourhood-based partnerships** and being able to continue sharing learning and successes with each other.

# Delivering change with confidence

South East London Integrated Care System

**Plenary discussions in the stakeholders' workshops explored participant perspectives on how we track and measure progress to support delivering change with confidence. Key high-level themes that emerged included:**

## Measuring and demonstrating impact

- **Expand the type of metrics** used to showcase our commitment to working with communities differently.
- **Set appropriate baselines** and **standards of collaboration**, considering support groups that are less likely to come forward.
- **Consider other factors as well as 'hard' KPIs** that tell us more about outcomes.
- **Building case studies** to demonstrate and showcase impact.
- **Feed success indicators and outcomes back to the community.**
- **Be rigorous and consistent** in the way we **collect and manipulate data.**
- **Agree on common datasets** to enable comparison or identify proxy measures to reduce siloed working.
- **Sustainable funding must accompany this element**, as funding usually ends when programmes start to demonstrate true impact.

## Working with VCSEs and our communities

- **Seek feedback from communities**, informing them of actions taken and demonstrating their impact.
- The **process of feedback** and change should feel like an "***ongoing, holistic dialogue with communities***".
- We need to **make people feel heard and empowered**, which will encourage continued engagement with our services.
- **Build understanding and trust with service users and their communities** – "*focus on what really matters to people, and health metrics and improvement will follow*".
- **More weight given to social interventions**, with the VCSE sector being measured on an equal footing as statutory services
- **Be mindful of resource requirements of data collection** on smaller organisations and residents.
- **Establish appropriate and effective data sharing relationships.**

## Meeting the needs of communities through effective co-production

- Ensure services provide a diverse offering which **aligns to the needs of the communities** they serve.
- **Investing time and resources in effective co-production**, as we know that interventions and services have a differing impact on different communities.
- **Co-producing metrics with service users**, letting them define what success would look like to them.

# What does this mean in practice and next steps

Subject to agreement today, we will continue to work with stakeholders and existing groups from across the system to co-develop the project plan for each ambition, taking into account actions already in place at local level.

We will also co-design and put in place the infrastructure and governance arrangements required to go further and faster with the cross-system actions identified, common across all priorities.

It should be noted that although some of these actions are associated with tangible changes to systems and processes – e.g., agreeing funding allocations and setting metrics – others are much more about developing new ways of working together culturally and are likely to require both leadership commitment and OD support to succeed.

# Annex Two: Summary of analysis, proposed action and proposed cross-system support for our strategic priorities

| Priority | Ambition | Key issues to address | Proposed approach | Criteria / principles | Mode of action |
|---|---|---|---|---|---|
| Delivering primary prevention effectively to our most disadvantaged communities | Close the gap in uptake of these services for people from disadvantaged groups | • Lack of trusting relationships<br>• Lack of understanding of disadvantaged communities<br>• Ineffective communication<br>• Inconvenient service delivery | • Invest in VCSE and community led approaches to prevention focused around specific disadvantaged neighbourhoods | • Use of VCSE and local people to build sustained relationships.<br>• Engaging for long term on a range of wellbeing issues, not just health issues.<br>• Close partnership between VCSE, primary care, early help etc | • Access to resourcing for 'community health worker' VCSE roles in specific neighbourhoods.<br>• SEL wide collaborative to share learning and support effective partnership working. |
| Supporting parents and families with high vulnerabilities effectively in first 1001 days | Safer births, with fewer complications for families with high vulnerabilities, improvement on key measures of good start in life. | • Lack of staff and resource<br>• High referral thresholds<br>• Services with narrow remits<br>• Lack of intensive support and continuity of care<br>• Lack of trust in statutory services | • Develop intensive, generalist, relationship-based support for mums and families with high vulnerabilities | • Experienced generalist case workers<br>• Intensive support covering at least first 1001 days.<br>• A holistic approach to help with whatever matters for mums, inc early help for social challenges.<br>• Connecting families with local resources and support networks | • Access to resourcing for development of new services within SEL that reflect best practice, along lines of changing futures programme.<br>• Sponsorship from Birth Companions or another national charity |
| Supporting children's and young people's mental health and emotional wellbeing in disadvantaged neighbourhoods | Fewer children developing emotional and mental health problems in disadvantaged neighbourhoods, higher school attendance. | • Extent of challenges faced by children and families in disadvantaged neighbourhoods<br>• Need for concerted action to address multiple issues | • Support development of 'family zones' including schools, VCSE, local people, statutory services to support children's and families' wellbeing in disadvantaged neighbourhoods | • Led by local community groups and residents<br>• Based on strong partnerships with schools, local VCSE, health, early help and others<br>• Focus on entire ecosystem of support to protect children's and families' wellbeing.<br>• Focus on connecting and developing local assets | • Resourcing for leadership and community connectors to start developing new family zones<br>• Micro-finance to develop local VCSE<br>• Leadership and coaching from exemplars |
| Ensuring access to rapid, trusted and effective early support for common mental health and social challenges. | Fewer people from disadvantaged groups entering crisis or developing more severe mental health problems. | • Lack of capacity in primary care<br>• Limited range of therapeutic approaches<br>• Lack of culturally appropriate support for some communities | • Develop VCSE and peer-led socially-oriented support for adults with common mental health challenges in disadvantaged neighbourhoods<br>• Draw on existing local assets. | • Seek to harness resources of service users, and help recover agency and self - efficacy<br>• Focus on core components of a good life<br>• Support back into training, education and employment and social welfare help<br>• Led by local community and tailored to needs of local community | • Access to resourcing to support spread of effective models of VCSE-led socially oriented mental health support, building on effective models in SEL and local assets.<br>• Support for collaborative improvement (e.g. Rethink, Black Thrive) |
| Delivering proactive, joined up support for long term conditions and people with complex health and social needs. | More people with LTCs and social challenges who report a positive experience of care, live independently and enjoy good lives. | • Workforce constraints and lack of capacity in primary care<br>• Poorly designed models of care for people LTCs and complex needs.<br>• Highly fragmented primary, community and hospital outpatient services<br>• Limited social support | • Develop test case models of integrated neighbourhood teams in disadvantaged neighbourhoods<br>• Codify effective service design and effective change models to enable spread. | • Based in specific neighbourhoods<br>• Actively involving VCSE and other public services as well as bringing together healthcare.<br>• Co-produced with local community members and reflecting what matters for local people.<br>• Focus on developing and securing improvement through effective multi-disciplinary team working.<br>• Focus on holding relationship with person and family, minimising referrals and transitions. | • Resourcing for development of test case models in specific neighbourhoods<br>• Access to insight from successful systems and support for sharing learning across the sites.<br>• Support for evaluation and codifying the service design and approach to delivering change. |

## Annex Three: Proposed next steps to allocate funding and establish collaborative programmes to support our strategy

| Quarter | Objectives | Key actions |
|---|---|---|
| Quarter 3 2023/24 (remainder) | Establish financial envelope, leadership, delivery arrangements for programmes | • Agree available funding and division between strategy programmes<br>• Develop high-level costings for projects within each programme and for delivery of collaborative learning<br>• Identify potential learning partners |
| Quarter 4 2023/24 | Identify and allocate resources to organisations and projects | • Agree minimum criteria for accessing funding for strategy projects<br>• Agree method for selecting participants and allocating resources to them<br>• Agree metrics and outline evaluation approach<br>• Bring together stakeholders to explain each programme and discuss participation<br>• Invite and assess proposals<br>• With learning partners, agree structure for collaborative learning across SEL |
| Quarter 1-2 2024/25 | Design and establishment of strategy projects | • Recruitment into roles to deliver strategy projects<br>• Design of overall approaches to each project<br>• Start of implementation of projects<br>• Start of collaborative learning programmes |
| Quarter 3 - 4 2024/25 | Delivery of strategy projects | • Early implementation of projects<br>• PDSA cycles to test impact of changes and enable rapid adaptation<br>• Continuation of structured collaborative learning across sites<br>• Ongoing evaluation focusing initially on approach to design, co-production and transition<br>• Reporting to IC Partnership on progress |
| Quarters 1 – 4 2025/26 | Embedding projects, collating learning and review of impact, decisions on future investment. | • Continuation of iterative improvement across each of the sites<br>• Ongoing collaborative learning across sites<br>• Evaluation to focus on codifying the final approaches developed, the methods used and learning on effective transition, impact and value for money.<br>• Reporting to IC Partnership on progress and impact in time to inform decisions on continuation and spread of these models from 2026/27 onwards. |