



South East London Integrated Care System: Implementing the NHS Long Term Plan

**Final version
January 2020**

A partnership of NHS providers and Clinical
Commissioning Groups serving the boroughs of
Bexley, Bromley, Greenwich, Lambeth, Lewisham
and Southwark

Responding to the NHS Long Term Plan – south east London integrated care system

The Long Term Plan for the NHS in England sets an ambitious and challenging agenda for the development of health and care and I am delighted to share south east London's response to delivery within our local context.

As a plan for the NHS, our response is complementary to our local strategies and plans, developed by partnerships that extend right across health and care both very locally and across south east London.

We are responding as London's first integrated care system and as such we outline plans that:

- **Respond as a partnership to the health and care needs of south east Londoners** – our integrated care system represents a 'System of Systems' that prioritises action at the scale at which it has best effect.
- **Focus on addressing the real health inequalities found across our system** – inequality in health outcomes, access and service offers for our population: some of the most diverse communities in England.
- **Prioritise system improvement** – we are proud of many of the outcomes and care we deliver for our residents today, whilst recognising a clear and urgent need to improve key areas of quality, performance and sustainability of our system.
- **Emphasise the collective accountability that our partners have taken for health and wellbeing of our residents** – we must live within our means and that requires a system orientation toward best value, preventative action, innovation and enhanced collaboration across our partners.

Our aim is to deliver a clinically and financially sustainable system for the future.

We will deliver this aim according to the needs of our populations and the ambition of the NHS Long Term Plan by focusing action within and across:

- Our neighbourhoods and the 35 new primary care networks that have emerged within them.
- Our six boroughs and the well-established local government and wider Local Care Partnerships found in each of them.
- Our system, underpinned by changes to both the commissioner and provider ways of working across south east London.
- The city-wide partnerships to which we belong, and London's ambition to be the healthiest global city and the best place to receive care in the world.

The document covers four main areas:

- Our strategic transformation priorities until 2024/25.
- How we will deliver the Long Term Plan commitments over the next five years.
- How we will deliver the finance, activity and workforce components of the Long Term Plan, setting out the main milestones and risks to achievement.
- The key enabling strategies and approaches we will take in respect of workforce, finance and incentives, digital and estates.

Responding to the NHS Long Term Plan – south east London integrated care system (continued)

The development of this response has been underpinned by the following principles:

- Locally owned and co-developed as a partnership across our CCGs, six local authorities and provider trusts and organisations.
- Clinically led with programmes of work each having identified clinical leadership, overseen by our Clinical Programme Board.
- Analysis of population needs, both analytical and through engagement with local people.



Andrew Bland

ICS Lead and Accountable Officer – NHS South East London Commissioning Alliance

January 2020

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Executive summary

Introduction

As the south east London integrated care system our ambition is to deliver a clinically and financially sustainable system for the future, taking collective action to improve outcomes and address health inequalities in our population. We are pursuing our vision by adopting a population health management approach and taking action at different geographical levels – very locally in our neighbourhoods, in each borough, and across south east London. We operate as a ‘System of Systems’, bringing partners together to take action at the optimal scale to effect change.

This document provides our system’s response to the NHS Long Term Plan, setting out how we will deliver nationally agreed priorities, including reducing health inequalities, personalising care and preventing ill health. Our response does not present our strategy for south east London, but is one of a suite of plans, across south east London and in each borough, that collectively support the delivery of our goals.

Our response is clinically led, and our approach continues to be informed by engagement with the public. Whilst the Long Term Plan is an NHS plan, we continue to progress work as an integrated care system that responds to our different populations, includes our six local authorities as partners, and recognising that the challenges we face cannot be addressed by health services alone.

Within this response we have set out a number of actions to be delivered between now and the end of 2023/24. To support the achievement of our ambitions we will develop detailed implementation plans, and in doing so we will continue to engage with stakeholders – including residents and our workforce – and assess the impact that our actions will have, expanding on the equality impact assessment we have undertaken on our overarching response. We are committed to continuing our ongoing engagement with patients and the public as we further shape and implement our plans.

Our ambition (chapter one)

The south east London integrated care system brings together all the organisations involved in planning and delivery of health and care for the 1.9 million people who live in our six boroughs. These include local authorities, CCGs, and providers of primary, community, mental health and acute services. We also provide specialised services to people living across a much wider geography, and we work in partnership with neighbouring systems to deliver priorities across the capital.

The organisations in south east London have a strong history of collaboration and together we are committed to delivering our ambition – a stretching vision that responds to the significant challenges our system currently faces, many of which are longstanding and require a more transformative approach to resolve. Significant health inequalities are found in our system – we have a vibrant, diverse and mobile population with extremes of deprivation and wealth. There are a range of risk factors that impact the health and wellbeing and life expectancy of south east Londoners, and the most significant of these align with the risk factors identified nationally within the Long Term Plan.

In 2016 we published a sustainability and transformation plan, outlining a number of system challenges which remain relevant today. Our historical approaches to addressing these challenges, often on an organisation specific basis, do not go far enough to deliver the changes we seek or to derive resulting benefits at the right scale and pace. However, by finding new ways of working as an integrated care system we will ensure that: we are driving and owning the required changes at a system level; we are clear on what each part of the system needs to deliver; and we have the governance and processes in place to hold each other to account for delivery.

Executive summary (continued)

Our population's needs (chapter two)

South east London is diverse, and the population's needs are complex, requiring a combination of consistent and reliable core offers to residents in some aspects of care and very bespoke and locally responsive approaches in others. Like much of the country our population is both growing and ageing, and we have significant health inequality across our system. Life expectancy at birth can vary within a borough by up to nine years between the most and least deprived areas; healthy life expectancy can vary within a borough by up to 13 years. Wider determinants of health including deprivation, the local environment, housing, crime, education, employment and social isolation have a significant impact, and people's individual lifestyle choices also directly impact their health.

Through our wider engagement and planning our residents tell us what is important to them about their health and the care they receive, and about how we can work together as an integrated system to support them to stay well; this feedback will continue to shape our implementation of the Long Term Plan over the next ten years. The views of our residents will continue to be at the forefront of how we shape and deliver services at all levels of the system throughout implementation.

Our clinical leaders have identified priorities to progress at pace in south east London, further shaping how we deliver our plans.

Improving outcomes and addressing health inequalities is the consistent focus within our Long Term Plan response and vision for the future. To support a systematic approach to this across our integrated care system, we are developing a population health management approach to personalise care and ensure a targeted approach to the delivery of evidence based interventions. Our approach to population health will help us to ensure that we identify and address unwarranted variation across all levels of the system, whilst ensuring that we meet our population's needs in a coherent and responsive manner and that we work collaboratively with our partners to help address the wider determinants of health.

Service transformation priorities (chapter three)

The priorities set out nationally align with our local transformation priorities and needs of our system. We are committed to delivering on these priorities to ensure we capitalise on the opportunities set out in the Long Term Plan, in a way that best meets the needs of our local population. This will help us to ensure that we deliver high quality services and reduce inequalities in access, service offer and health outcomes.

For each transformation priority we have described our key challenges, vision for the future, objectives and priority actions to the end of 2023/24. We also summarise the impact we aim to achieve and enablers that will underpin our plans. For the foundational commitments of the Long Term Plan we have provided more detail on key milestones and how we will measure success within the appendices provided.

Driving progress in all areas is our system governance, comprising representation from across all partners, including patient and public voices. Importantly, our governance structures include clinical leadership from executive teams and from frontline staff, who work to better support the practical delivery and implementation of our strategic objectives. Further supporting programme delivery is our network of Clinical Leads and Senior Responsible Officers, roles undertaken by subject matter experts from across south east London.

Executive summary (continued)

Enabling transformation (chapters four, five and six)

1. System development

Many of the transformation plans set out in this document are not new endeavours for south east London. However, delivery is not within the gift of any single organisation and the transformation agenda we have set out can only be delivered through organisations working together and in different ways.

We need to ensure that our system infrastructure supports organisations to do this, and to do so we will move forward at pace to develop our system ways of working, bringing together local organisations to redesign care and improve population health, creating shared leadership and action.

Becoming an integrated care system is not an end in itself for south east London, but it is the key vehicle and infrastructure through which we will deliver our system transformation and achieve our goals of reducing health inequalities and achieving system sustainability. Developing our system – its governance, infrastructure and ways of working alongside its delivery mechanisms, capacity and capability – is therefore a key element of our response to the Long Term Plan.

2. Finance

To support the Long Term Plan commitments, NHS commissioners have been notified of growth allocations up to 2023/24. Our financial plans are based on national and local planning assumptions including inflation, efficiency, activity growth and expected price and cost changes by service areas. Annual financial improvement trajectories have been issued to all SE London CCGs and providers, which we have aggregated to form a single SE London system trajectory. This sets out the national expectation for annual financial outturn, annual efficiency and financial improvement for our system.

Our starting financial position is an underlying deficit across south east London of £265m. Addressing our underlying recurrent deficit and moving towards a financially sustainable future for south east London is a key strategic objective. Our assessment is that it will not be possible to fully address the deficit in the lifetime of this strategic plan. This is recognised in our issued financial improvement trajectories, that seek to improve, rather than eliminate, our deficit to £121.9m by the end of 2023/24.

Our strategic plan commits to meeting the financial improvement trajectory by 2023/24, and our focus will be on accelerating delivery of savings during the next three years (2020/21 to 2022/23) at a scale and pace that is more challenging than the base requirement in the Long Term Plan, without compromising our commitment to achieving Long Term Plan targets.

In chapter five we set out our local financial context, our approach to meeting the five national tests and savings, our planning assumptions, our financial commitments, the scale of financial challenge, and our commitments to ongoing programmes of work to secure long term and sustainable financial improvement in a very challenging environment.

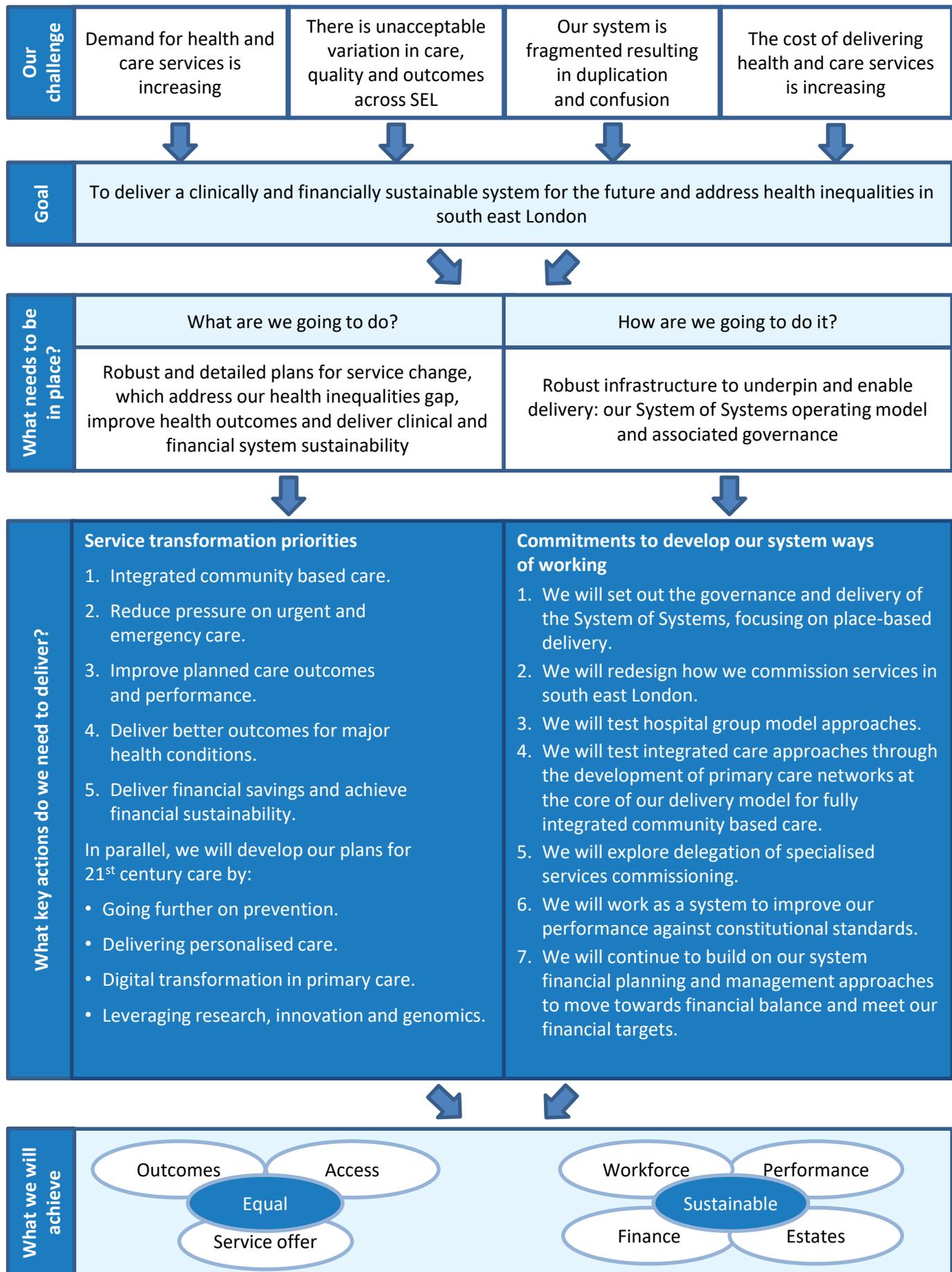
3. Enabling strategies

Our service transformation priorities are underpinned by strategies for digital, workforce and estates, without which our ambition will not be realised:

Executive summary (continued)

- Digital – We want to provide integrated digital solutions to improve the quality of care and experience of our patients when interacting with health and care services and to support our clinical workforce in providing safe and efficient care with the latest technology, digital solutions and integrated data.
- Workforce – We want to develop the right people, with the right skills and behaviours, at the right place, at the right time to deliver high quality, personalised, integrated care across south east London. Our workforce plans will be further developed upon release of the full People Plan.
- Estates – We want to have a flexible, high quality property base that provides the right capacity, in the right place and at that right time, responding to the needs of our patients by improving access and ensuring safe, standardised care regardless of location or provider. To support this vision our estates strategy will be refreshed.

Overview of how we will deliver the Long Term Plan



Our plan responds to Long Term Plan guidance

NHS England & NHS Improvement (NHSE&I) set out guidance that outlined what a response to the NHS Long Term Plan may cover; below we have set out how we have incorporated this guidance:

Area of focus	NHSE&I guidelines	Our response
Outline and plan for achieving key transformation priorities	<ul style="list-style-type: none"> Describe local transformation and major service change priorities. Overview of approach to delivering Long Term Plan foundational commitments. Plans for improving prevention and addressing health inequalities. Plans to develop both the provider and commissioner landscape. System approaches to key enablers. Major milestones, plans for monitoring achievement. 	<ul style="list-style-type: none"> ✓ Chapter 1 ✓ Chapter 3 ✓ Chapter 3 ✓ Chapter 4 ✓ Chapter 6 ✓ Chapter 7
System development activities	<ul style="list-style-type: none"> Outline expected trajectory to become an integrated care system. Plans to build local partnership coalition and to ensure ongoing engagement, including with patients and public. System governance and arrangements for collective decision-making. 	<ul style="list-style-type: none"> ✓ Chapter 4 ✓ Chapter 4 ✓ Chapter 4
Key assumptions and supporting narrative for finance, activity and workforce plans	<ul style="list-style-type: none"> Outline key assumptions underpinning finance, activity and workforce plans. Confirmation that system partners have agreed the finance, activity and workforce plans and have a shared commitment to deliver them. Key risks to delivery of the five-year plan and mitigating actions (including service quality, operational performance, transformation, finance). Approach to workforce planning. 	<ul style="list-style-type: none"> ✓ Chapters 5 & 6 ✓ Chapters 5 & 6 ✓ Chapters 3 & 5 ✓ Chapter 6
System financial management	<ul style="list-style-type: none"> System approach and actions to achieve financial recovery. Plans to embed system financial management, including arrangements to support management of collective financial resources. Approach to payment reform and description of any planned contractual changes. Plans to drive system-wide efficiency programmes, including how system partners will work together to deliver them. 	<ul style="list-style-type: none"> ✓ Chapter 5 ✓ Chapter 5 ✓ Chapter 5 ✓ Chapter 5



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

1) Our ambition for south east London residents

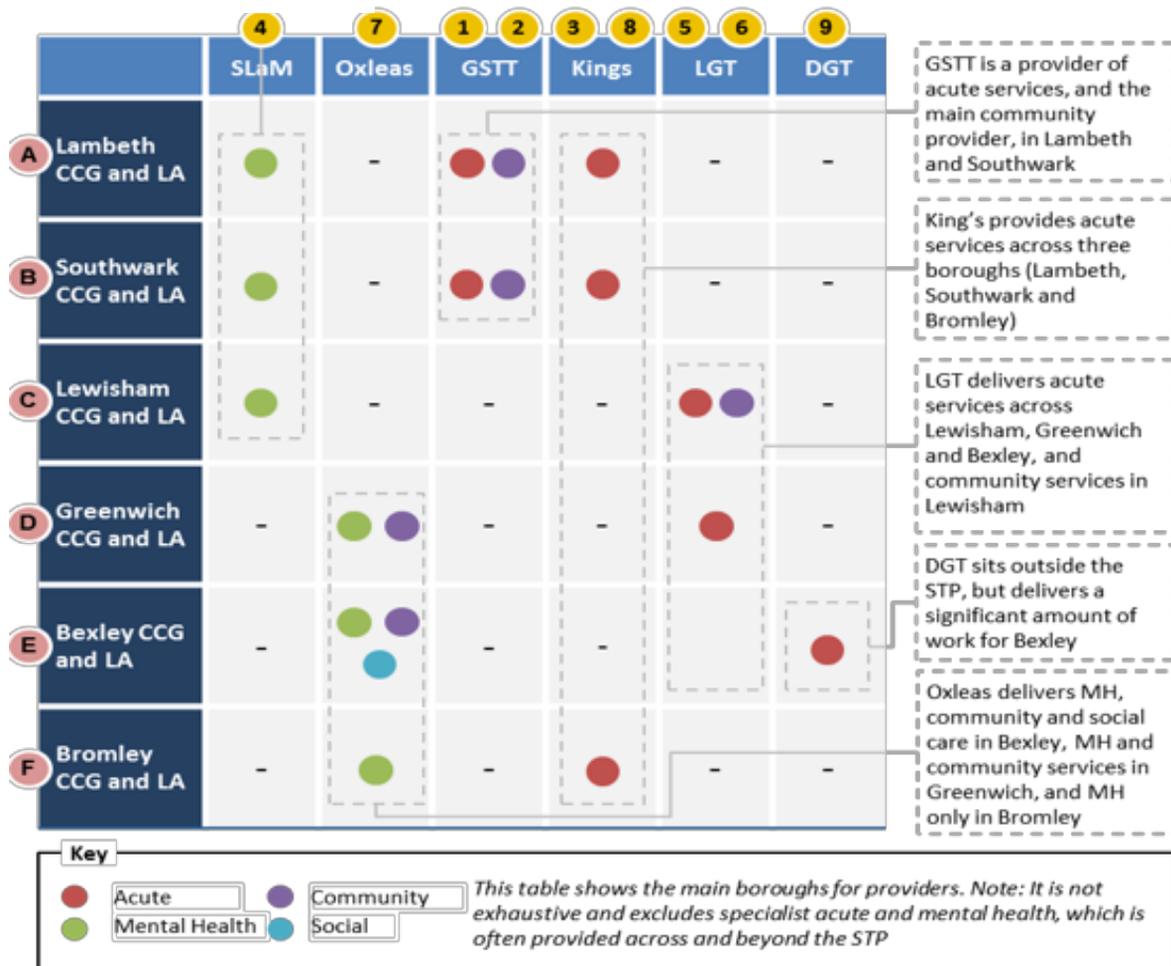


1) Our ambition for south east London residents

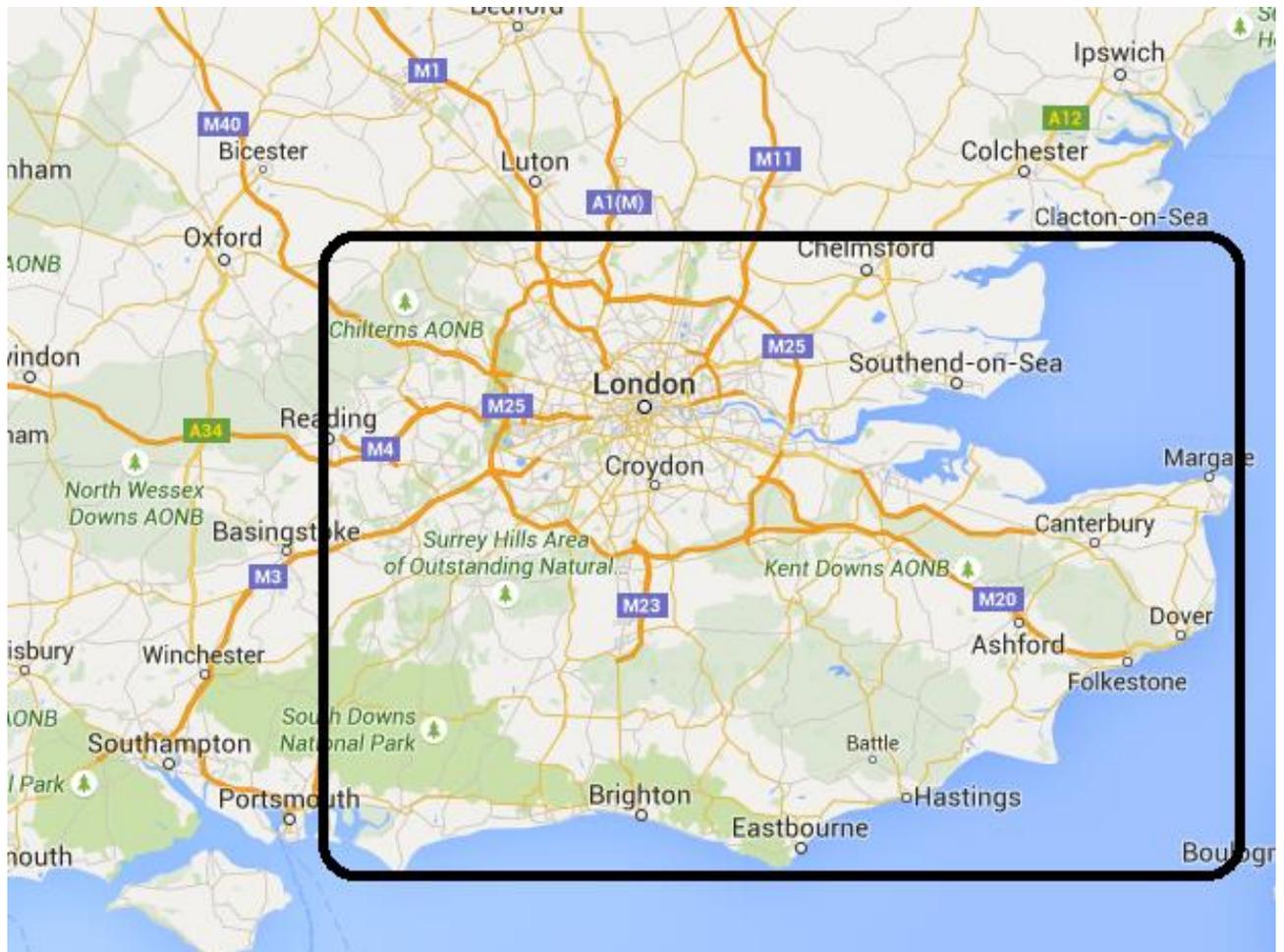
Current system overview

The south east London integrated care system (ICS) brings together all of the organisations involved in planning and delivery of health and care for the 1.9 million people who live in south east London (SEL), including:

- Local authorities (LAs): Bexley; Bromley; Greenwich; Lambeth; Lewisham; Southwark.
- CCGs (coterminous with LAs): Bexley; Bromley; Greenwich; Lambeth; Lewisham; Southwark.
- Primary care providers: 212 general practices, organised in 35 Primary Care Networks (PCNs).
- Acute, mental health and community service providers: Guy's and St. Thomas' NHS Foundation Trust (GSTT); King's College Hospital NHS Foundation Trust (KCH); Lewisham and Greenwich NHS Trust (LGT); South London and Maudsley NHS Foundation Trust (SLaM); Oxleas NHS Foundation Trust (Oxleas); Bromley Healthcare CIC.
- More than 90% of south east Londoners receive or access their care in SEL. Bexley has significant flows to Kent and Dartford and Gravesham NHS Trust (DGT) particularly – the trust is consequently an ICS associate and OHSEL Board member.
- Additionally there are hundreds of voluntary sector and community organisations that currently work in partnership with the organisations listed above to improved the health and wellbeing of our residents.



The three acute trusts within SEL also provide a broad range of tertiary and highly specialised services, including several services being delivered across a national footprint as well as to patients who live in surrounding areas: other parts of London, and Kent, Surrey and Sussex in particular:



These services include (but are not limited to): paediatrics, blood disorders (including HIV), liver, neurosciences, cardiothoracic, cancer, renal and high cost drugs. These services continue to develop in SEL; for example the provision of cardio-respiratory services through expansion of the Evelina London Children's Hospital.

Specialised services have an important part to play in many of the Long Term Plan's (LTP) ambitions, such as improving cancer survival and providing high quality mental health services. To ensure delivery of these ambitions south east London will need to work in partnership with specialised commissioners to align plans. For example, there will need to be continued collaboration between the (South) London Neonatal Operational Delivery Network and the Local Maternity System to jointly work towards halving neonatal mortality rates by 2025.

Going beyond this the SEL ICS has been working with south west London and London colleagues to consider the future of specialised commissioning in the context of our developing integrated care system. Our work is at an early stage and is taking place as part of a wider London work programme, where we are working to test approaches to delegated specialised commissioning in a London context (see also: [new model for specialised services](#)).

Additionally, as one of five ICSs / STPs in London we work in partnership with neighbouring systems to deliver priorities across the capital. This includes supporting the progression of the London Vision, as described overleaf.

Working together to make London the healthiest global city, and the best global city in which to receive health and care services.

London is a major global city that is dynamic and diverse. Like many big cities, London offers a wealth of opportunities for people to lead healthy and happy lives, but it also presents issues and challenges to health. In London, where there are significant and persistent inequalities, these issues and challenges are experienced most by those in our most deprived neighbourhoods and communities. That is why concerted and coordinated efforts are needed across public services and wider society to make the most of opportunities for good health, and to tackle the issues that cause poor health.

We are working as part of a partnership which is made up of the Greater London Authority, Public Health England, London Councils and the National Health Service (NHS) in London. It exists to provide coordinated leadership and a shared ambition to make our capital city the world’s healthiest global city and the best global city in which to receive health and care services. This is because no single organisation can achieve this alone, and shared action makes us greater than the sum of our parts. We have formed our partnership in order to address priority issues that require pan-London solutions, to support pan-London actions that enable more effective and joined-up working at the level of the neighbourhood, the borough and the sub-regional system, and to make the most of the very direct social, economic and environmental roles we each play as major anchor organisations in London. Initiatives such as the Thrive LDN mental health movement, child mental health trailblazers, School Superzones, and the London Estates Strategy show just what can be achieved when we work together.

Building on significant work between our organisations over several years, our London Vision sets out our proposals for the next phase of our joint working. It reflects the Mayor’s Health Inequalities Strategy, London Councils’ Pledges to Londoners, the Prevention Green Paper and the NHS Long Term Plan. It highlights ten key areas of focus where we believe partnership action is needed at a pan-London level. This includes issues such as air quality, mental health and child obesity, and we set out our ambition for deeper and stronger local collaboration in neighbourhoods, boroughs and sub-regional systems so that services are genuinely integrated, and Londoners can start well, live well and age well. Our Vision is not a description of the multitude of actions that are taking place locally, nor a population health plan; rather it sets out the areas where our shared endeavours seek to complement and add value to local action.

	People, places and partnerships to support wellbeing and self-care	Integration to provide joined-up community based services	Collaboration to sustain high quality specialist networks
 Start well Our environment, schools and communities promote and nurture the health and wellbeing of all children and families	Schools and health and care services work together to provide a seamless service and give families and children tools to manage their own health	Children and young people have access to high quality specialist care, with safe and supported transitions to adult services	
 Live well Our environments and local communities help us avoid unhealthy habits and eliminate homelessness and any stigma surrounding mental health	Early support for health issues is consistently available and there is true parity of esteem between physical and mental health	Londoners have access to high quality 24/7 emergency mental and physical health, alongside world-class planned and specialist care services	
 Age well Londoners are supported to manage their long term conditions and maintain independence in their community	As people grow older they are supported in their community with seamless care between organisations	Hospital care is consistent, of high quality and safe and ensures Londoners can get in and out of hospital as fast as they can	

Enabled by:

Ensuring Londoners are engaged in their own health

Digitally connecting London's health and care providers

Developing London's workforce

Transforming London's estate

London Vision (continued)

In the table below we have set out the agreed pan-London areas focus and the commitments of the London Vision alongside the key sections of this document where further work is needed to align and further develop plans. It is clear that the breadth and scale of the LTP requirements will mean an ongoing focus and refinement of our plans, with the completion of our detailed planning for 2020/21 the key priority and objective over the remainder of this year.

Area of focus	Pan-London commitments	Relevant section of our response
Reduce childhood obesity	<ul style="list-style-type: none"> We will achieve a 10% reduction in the proportion of children in reception (age four or five) who are overweight by 2023/24, delivered through bold citywide actions and targeted support for those most at risk. 	Diabetes; prevention and reducing health inequalities
Improve the emotional wellbeing of children and young people	<ul style="list-style-type: none"> We will ensure access to high quality mental health support for all children in the places they need it, starting with Mental Health Support Teams in schools, maximising the contribution of the Mayor's / GLA's Healthy Schools London Programme and Healthy Early Years London Programme, and extending the use of digital support technologies. 	Children and young people's outcomes
Improve mental health and progress towards zero suicides	<ul style="list-style-type: none"> We will ensure that all Londoners have access to mental health care, support and treatment, especially those experiencing health inequalities. 	Adult mental health; children and young people's outcomes
Improve air quality	<ul style="list-style-type: none"> We work together to reach legal concentration limits of nitrogen dioxide (NO₂) and working towards WHO limits for particulate matter concentrations by 2030. 	Prevention and reducing health inequalities
Improve tobacco control and reduce smoking	<ul style="list-style-type: none"> We will speed up a reduction in smoking prevalence in London, especially among groups with the greatest health inequalities. 	Preventing cardiovascular disease; heart disease and stroke; respiratory disease; maternity; prevention and reducing health inequalities
Reduce the prevalence and impact of violence	<ul style="list-style-type: none"> We will work collaboratively with the London Violence Reduction Unit to develop and implement effective ways of reducing violence, including addressing its root causes. 	Prevention and reducing health inequalities
Improve the health of homeless people	<ul style="list-style-type: none"> We commit to drive action to improve, grow and innovate services that improve the health of rough sleepers, including expanding the pan-London rough sleeping services funded by the Mayor, building on existing good practice, piloting new models of care and data collection, and developing plans to build more integrated services in London. 	Prevention and reducing health inequalities
Improve services and prevention for HIV and other STIs	<ul style="list-style-type: none"> We will broaden partnership working to focus further on tackling health inequality and a wider range of sexually transmitted diseases. 	Prevention and reducing health inequalities
Support Londoners with dementia to live well	<ul style="list-style-type: none"> We will ensure that Londoners receive a timely diagnosis, ongoing support and are able to live well in their community. 	Integrated community based care
Improving care and support at the end of life	<ul style="list-style-type: none"> We will ensure that all Londoners in their last year of life have access to personalised care planning and support that enables them to die in their preferred place. 	Personalised care

The organisations in south east London have a strong history of collaboration and together we are committed to delivering our system ambition **“to deliver a clinically and financially sustainable system for the future and address health inequalities in south east London”**.

This is a stretching vision that responds to the significant challenges our system currently faces, many of which are longstanding and require a more transformative approach to resolve. We have longstanding challenges around delivery of performance standards and trajectories, and a number of service areas which face particular sustainability challenges.

The ICS financial position for 2019/20 is a system underlying deficit of £265m. Our modelling forecasts that, by 2023/24, the revenue affordability gap for the SEL system could be £670m unless we take action now to improve our long term financial sustainability. Our strategic plan commits to reducing our system deficit to £121.9m by the end of 2023/24, in line with our issued financial improvement trajectories.

There are also significant health inequalities within our system; we have a vibrant, diverse and mobile population with extremes of deprivation and wealth. Data shows us that we have significant variation in healthy life expectancy both within and between our boroughs. There are a range of risk factors that impact the health and wellbeing and life expectancy of SEL residents, and the most significant of these align with the risk factors identified nationally within the Long Term Plan.

In 2016 SEL published a sustainability and transformation plan. This plan outlined a number of system challenges:

- Demand for health and care services is increasing.
- There is unacceptable variation in care, quality and outcomes across SEL.
- Our system is fragmented resulting in duplication and confusion.
- The cost of delivering health and care services is increasing.

These challenges remain relevant to us today and contribute to the current position of our system with regard to clinical and financial sustainability and equality of outcomes. What this tells us is that our historical approaches to addressing these challenges on an organisational specific and siloed basis do not deliver the desired changes or resulting benefits.

It is for this reason that SEL is committed to moving at pace towards working as an ICS. By working as an ICS we can ensure that we are driving and owning these required changes at a system level, are clear on what each part of the system needs to deliver, and have the governance and processes in place to hold each other to account for delivery. Our ICS approach is the backdrop for this response.

As an ICS we aim to:

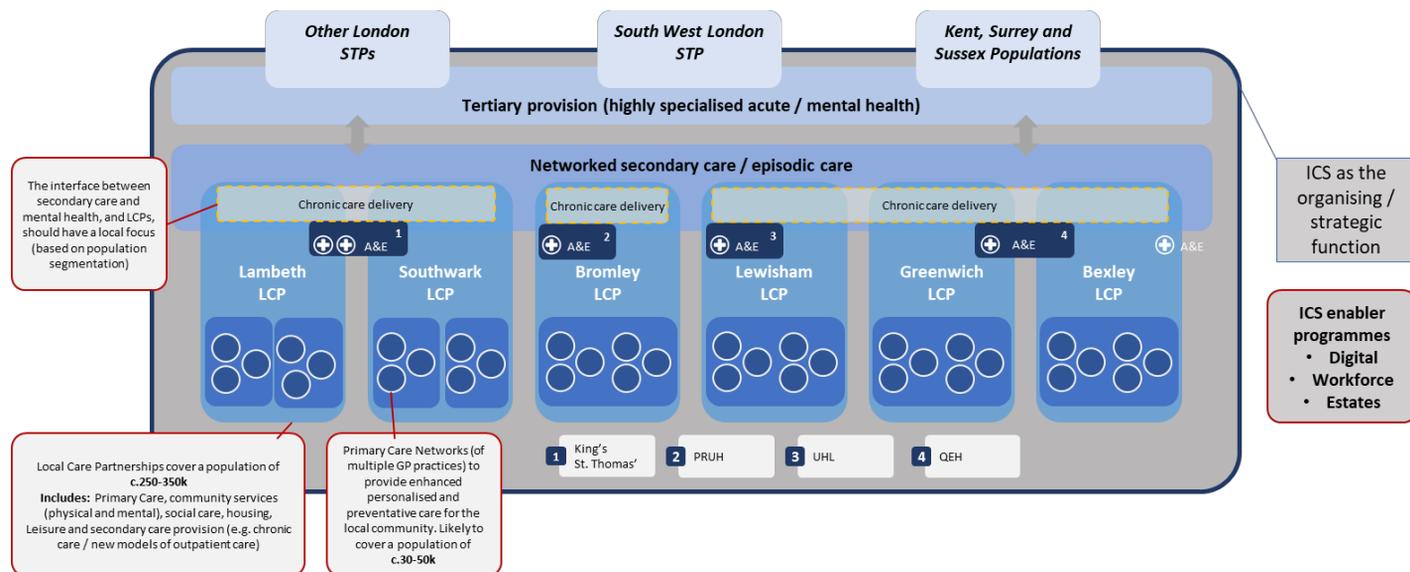
- Bring together stakeholders – including patients – to transform patient care, reduce health inequalities and improve patient outcomes;
- Develop in-depth population health management capacity and capability, including access to predictive advanced analytics, underpinned by integrated data sets from local integrated care records;
- Design new models of care and major service changes to deliver improved population health outcomes, implemented through PCNs and providers working together at place level;
- Work closely with local government to join up health and care at the appropriate system tiers;
- Engage staff, citizens, voluntary sector, multi-professional leadership development and partnership working in respect of integrated care and system working; and
- Undertake system-wide quality improvement and sharing of best practice, involving all staff groups across the system.

Our vision and objectives for SEL and ICS working (continued)

We have developed and agreed an end-state operating model for our ICS – this adopts a ‘System of Systems’ approach to planning, delivery and oversight. Our design reflects the fact that SEL is a complex system, which will need a number of health and care partnerships within the overarching SEL ICS. The operating model reflects:

- The work the ICS is doing with other ICSs / STPs, focused on tertiary and highly specialised provision and mental health.
- Work within the ICS to support neighbourhood, borough, pan borough and SEL-wide delivery models.
- The underpinning clinical programmes that will drive the underpinning care pathway redesign and enabling programmes that will ensure fit for purpose infrastructure.
- The ICS as the overarching governance, organising and strategic function.

Chapter 4 sets out more detail about how we will develop our ICS and move from our current structure towards our end-state ICS ways of working over the next five years.



We will use our ICS System of Systems ways of working to drive delivery and transformation across SEL. The priorities set out in the national Long Term Plan align with our local transformation priorities and needs of our system. We are committed to delivering on these priorities to ensure we capitalise on the opportunities set out in the Long Term Plan, in a way that best meets the needs of our local population. This will ensure that we deliver high quality services, and reduce the inequalities in access, service offer and health outcomes that prevail in our system.

Our priorities in response to this are:

1) Integrated community based care

We will develop our ways of working at borough and neighbourhood level so that we are delivering truly integrated and multidisciplinary care in the community for those who need it, with a consistent offer across our population. We will shift our approach from reactive to proactive care, and ensure care is driven by a systematic approach to population health management, prevention and early detection. Integrated community based care will be delivered at both “place” and “neighbourhood” levels of our system, with an aligned and consistent approach at “system” level. The vehicles for delivering our LTP ambitions are our 35 primary care networks at neighbourhood level, and six Local Care Partnerships at place level; these include representation from primary care, acute services, community services (physical and mental health), and local authorities.

2) Reduce pressure on urgent and emergency care

We will redesign our urgent and emergency care pathways to ensure patients get timely access to the right level of care for their needs, relieving pressure on A&E departments and hospital services. Our system approach will ensure that this includes in hospital changes to deliver best practice ways of working (e.g. same day emergency care and additional services to support people in mental health crisis), alongside agreement on and implementation of consistent community based care services which effectively manage the increasing demand for hospital care.

3) Improve planned care outcomes and performance

We will re-design planned care to ensure that residents in SEL have timely and consistent access to services, and that these services deliver value for the patient, the clinician and the system. We will work as a system to transform outpatient services, and to improve the performance, quality and sustainability of our planned care services. A key focus is to reduce waiting times for elective procedures which is a current challenge, requiring a collaborative approach to utilisation of capacity across SEL and demonstrable improvements in productivity and efficiency.

4) Deliver better outcomes for major health conditions

Our population needs assessment demonstrates that more people are living with three or more long term conditions, reducing the number of years lived with good health for a significant proportion of the population. The most common of these are depression, diabetes, chronic kidney disease, coronary heart disease and chronic pain. Locally, cancer and cardiovascular disease are the highest causes of under-75 mortality. In some of our boroughs, preventable mortality rates for cancer and cardiovascular disease are higher than both the London and the national average.

As a result, we will focus as a system on driving transformation change in a number of areas including: mental health, cancer, cardiovascular disease, stroke, diabetes, respiratory disease, children and young people’s services, maternity services, and learning disability and autism services. We will focus on prevention and early detection alongside changes to deliver high quality and consistent services across pathways.

5) Deliver financial savings and achieve agreed financial targets

The SEL health economy, like many others, has been under severe financial pressure for a number of years and we start this five-year planning period with both significant cumulative historical deficits and an underlying annual financial deficit. As part of the development of our ICS ways of working we will build on our progress to date around financial planning, financial risk management and delivery of system savings, including a return on investments made in community based services alongside improvements in productivity and efficiency. Through this approach we will deliver year on year improvements in the underlying position that will ensure we have a clear path back to financial balance. In parallel to progressing these priority areas, we will develop our plans for 21st century care by:

- **Going further on prevention and reducing health inequalities:** implementing a population health management approach across the SEL system to personalise care and improve the upstream prevention of ill health, and through this deliver prevention interventions that maximise the impact on reducing health inequalities at system, place and neighbourhood levels.
- **Delivering personalised care:** building on existing examples of best practice in SEL to develop and implement a comprehensive model of care which delivers a personalised approach to long term conditions. This will include embedding enablers such as personalised health budgets and social prescribing.
- **Digital First primary care:** empowering patients to use digital technology to take more control of their conditions and to offer people choice in how they interact with health and care services. We will build on progress to date and comprehensively roll out digital approaches and interfaces including e-consultations, secure messaging and video consultations.
- **Leveraging research, innovation and genomics:** ensuring our population and system capitalise on the opportunities and benefits of having a number of major research centres on our doorstep, in particular in speeding up the practical application of research for the benefit of patients, and research activities to help support the development of better outcomes for local residents.

These priorities will support us to deliver our shared goal of a clinically and financially sustainable system for the future which address health inequalities in south east London.

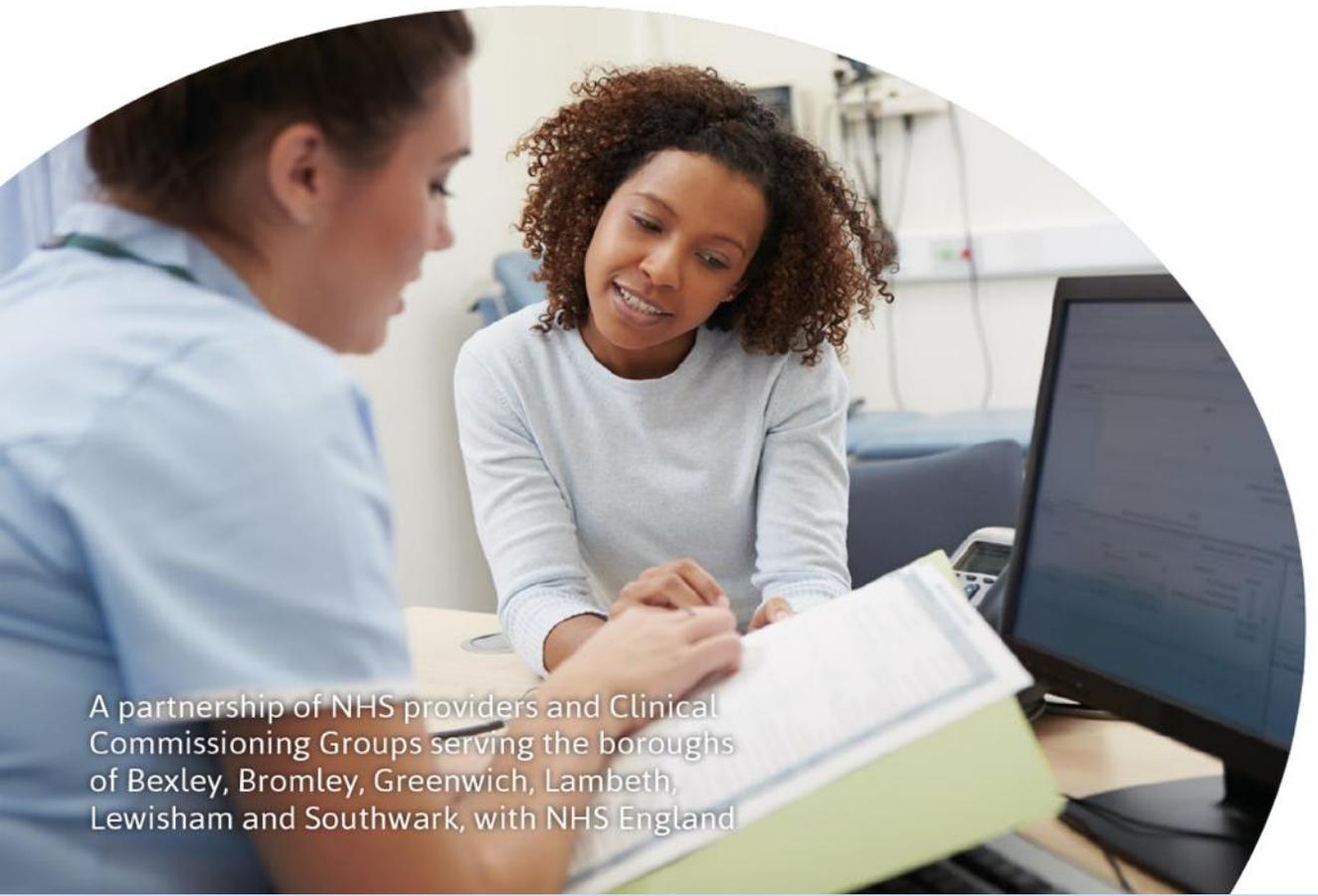
As part of this journey we will move...

...From a system which...

- Is driven by historic provision, rather than an understanding of population health need.
- Treats people once they are ill.
- Is focused around traditional organisational boundaries and can work in silos.
- Has a clear understanding of our current challenges but struggles to deliver on our plans.
- Has examples of good collaborative practice around workforce, estates and digital capability but has opportunities to go substantially further.

...To a system which...

- Is driven by a systematic approach to population health management which informs and drives our planning and delivery agenda.
- Focuses on prevention and proactive care, with a particular focus on health inequalities and tackling the major disease burdens in SEL.
- Works in a truly integrated way, taking collective responsibility for delivering our agreed commitments and making best use of the system's resources to secure improvements in population health outcomes.
- Collaboratively delivers on our agreed service improvements, and can demonstrate improved clinical and financial outcomes.
- Has a systematic approach to maximise the value of our estate, using digital approaches to transform care and redesign the workforce to address our longstanding challenges.



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

2) Understanding our population's needs



2) Understanding our population's needs

Our population characteristics

Growing and ageing

South east London has a highly diverse population of around 1.85 million. The population is growing and is predicted to increase by 9.5%, exceeding 2 million, over the next ten years to 2029. The expected growth in the older population far outstrips the overall population growth rate (by three times in 65-80 years and 80+); this is likely to lead to increasing demand for care across the system overall.

Highly diverse

The proportion of the population who are black and minority ethnic ranges from 19% in Bromley to 46% in Lewisham.

South east London has a higher than average proportion of residents that identify as LGBTIQ+. Lambeth and Southwark have the second and third largest lesbian, gay and bisexual communities in England.

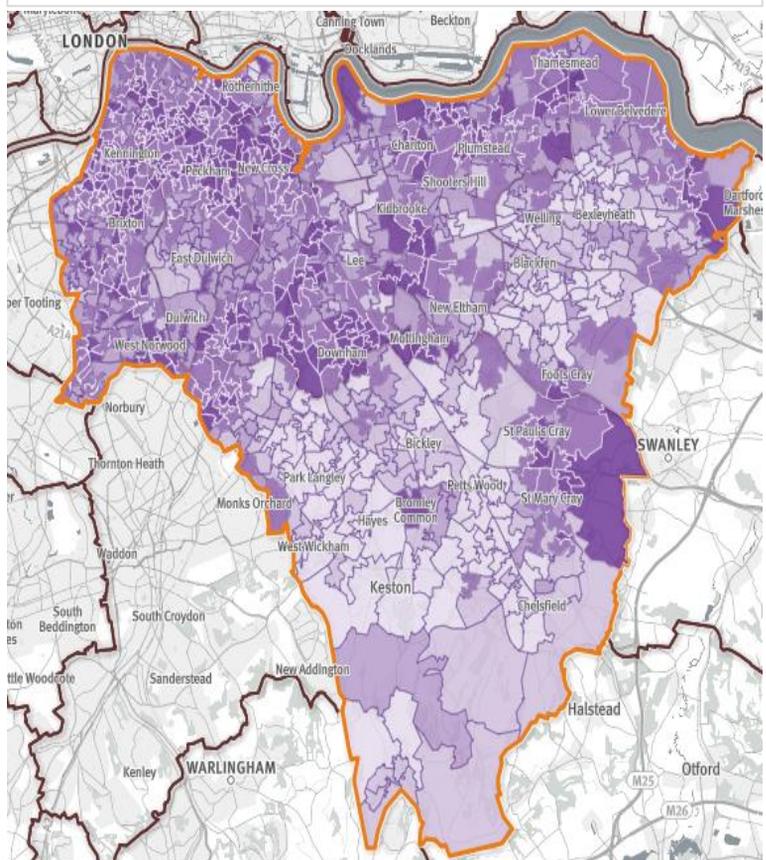
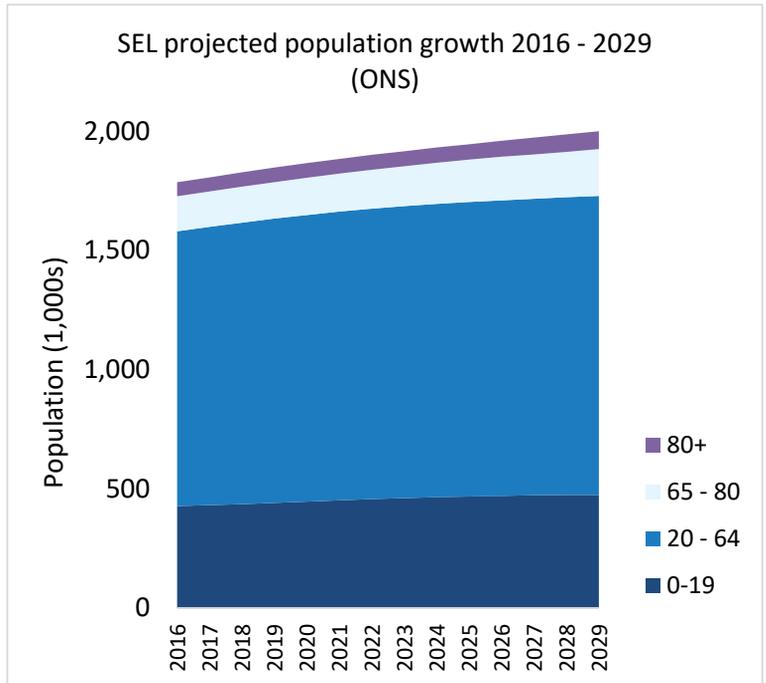
There is a large prison population of over 3,500 adult men and young adults across four prisons situated in Greenwich and Lambeth.

Significant levels of deprivation

One in five children live in low income homes. Four of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) rank amongst the 15% most deprived local authority areas in the country. The other two boroughs (Bexley and Bromley) are significantly less deprived, but have pockets of deprivation.

Highly mobile

In Southwark and Lambeth, roughly 9% and 10% respectively of the current population moved in and out over 12 month period. In Bexley the equivalent figure was around 5%, compared with approximately 3% in London as a whole.



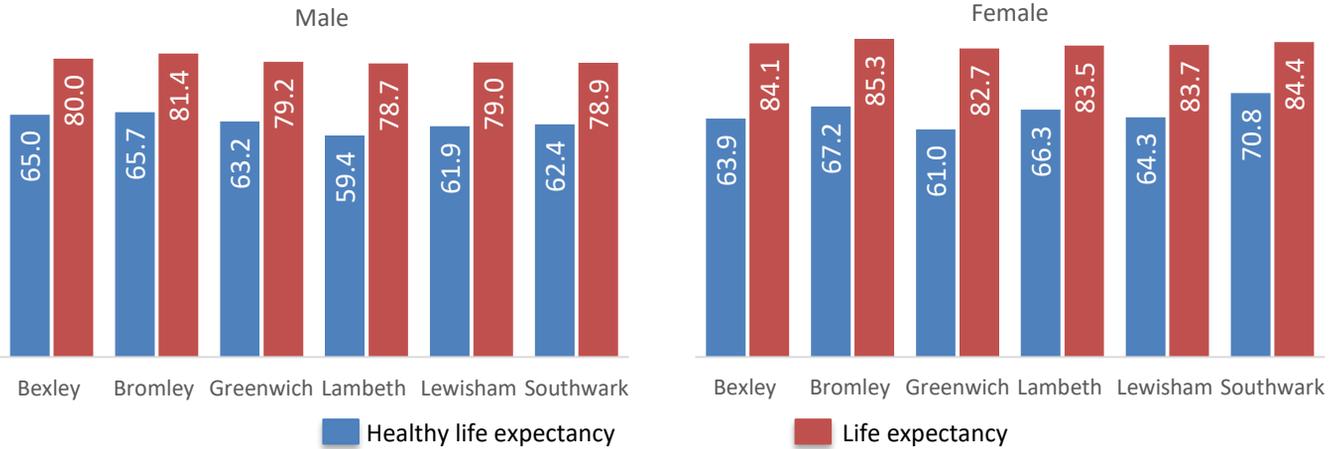
Source of map: © Crown copyright and database rights 201 Ordnance Survey 100016969 (dark purple is more deprived) Source: SHAPE <https://shapeatlas.net/place/>

Variation in life expectancy and healthy life expectancy

Life expectancy and healthy life expectancy at birth remain below the national and London averages for many of our boroughs, especially for males. In recent years the inequality in life expectancy has been increasing (*Public Health (England) Outcomes Framework, 2018*). This may be attributed to SEL having some of the highest levels of deprivation and inequalities in health in the United Kingdom.

Between our boroughs, life expectancy is similar, but *healthy* life expectancy does vary significantly. Males in one borough of SEL can expect to live on average almost 6 years longer in health than males in a neighbouring borough; for females, the difference is almost 10 years.

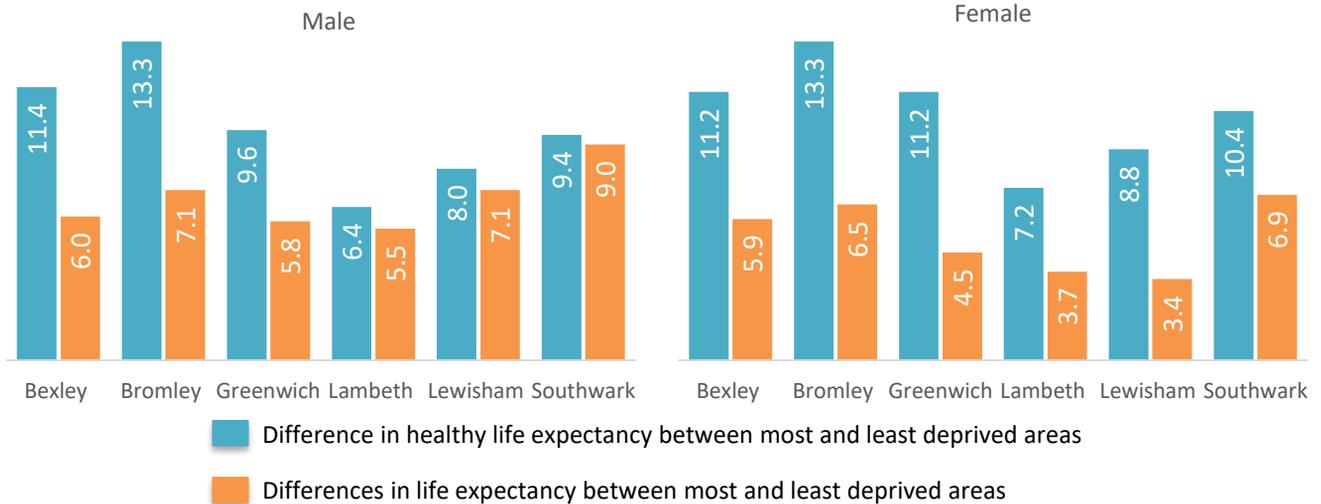
Average life expectancy and healthy life expectancy at birth, 2015-17



Source: Borough profiles for south east London extracted from Public Health Outcomes Framework accessed at <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/>

Whilst we have differences between our boroughs, differences in life expectancy and healthy life expectancy are significantly greater between the most and least deprived areas within each individual borough. For instance, in Southwark males living in the least deprived areas can expect to live 9.0 years longer than males in the most deprived areas. In Bromley, both males and females living in the least deprived areas can expect 13.3 more years of healthy life than those who in the most deprived areas.

Difference in life expectancy and healthy life expectancy at birth between most and least deprived areas within boroughs, 2015-17



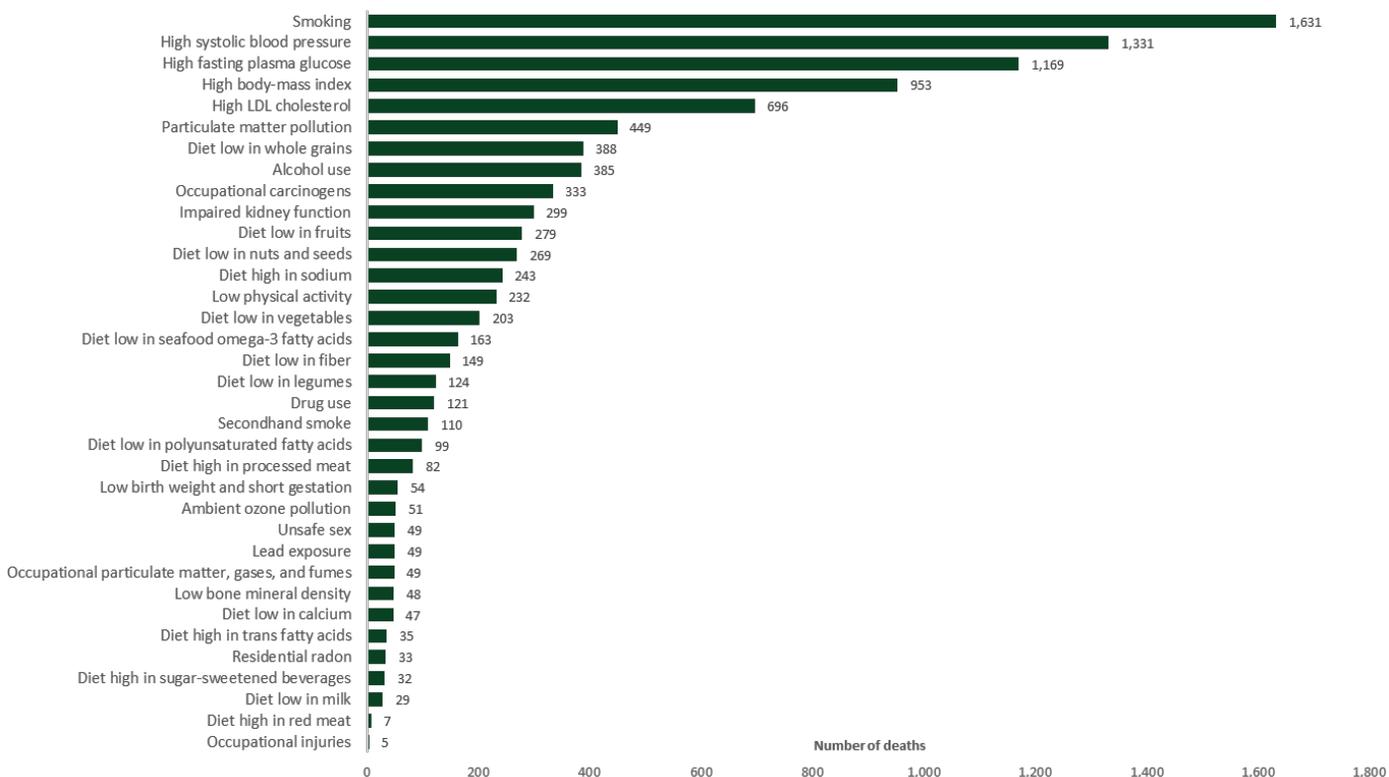
Source: Borough profiles for south east London extracted from Public Health Outcomes Framework accessed at <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/>

In addition to the variation seen in life expectancy, there is also variation between boroughs in infant mortality. Against a national average of 3.9 infant deaths under the age of 1 per 1,000 live births (London average, 3.3) two of our boroughs are significant outliers: Lambeth (4.7) and Greenwich (5.0). All other SEL boroughs are below the national average.

Several risk factors drive mortality and long term conditions across SEL

Locally, **cancer and cardiovascular disease** are the highest causes of under-75 mortality. In some of our boroughs, preventable mortality rates for cancer and cardiovascular disease are higher than both the London average and the national average. Analysing the burden of disease in south east London shows us the risk factors that contribute to overall mortality in our boroughs.

Number of deaths by attributable risk factor, boroughs in south east London, both sexes, all ages, 2017



Source: Calculated from borough-level data downloaded from *Institute for Health Metrics and Evaluation Global Burden of Disease*: <https://vizhub.healthdata.org/gbd-compare/>

Increasingly people are living with more long term conditions

As previously described in [chapter 1](#), increasingly more people are living with three or more long term conditions, reducing the number of years lived with good health for a significant proportion of the population. The most common of these are **depression, diabetes, chronic kidney disease, coronary heart disease and chronic pain**.

Working with King's Health Partners we have identified the five risk factors that significantly affect both long term conditions and premature deaths. These “Vital 5” factors are: **smoking, alcohol, blood pressure, mental ill health, and obesity**.

All five of the Vital 5 have a socioeconomic gradient and addressing them could significantly reduce the health inequalities in our boroughs. We know that within south east London we have high obesity rates in 4 out of 6 boroughs. Smoking cessation rates are low in half of our boroughs and alcohol related admissions are high in 2 of our boroughs.

As a system we recognise our need to increase our focus on addressing these factors, to enable us to reduce health inequality across the whole population and prevent ill health.

Each of our boroughs has a unique population with its own demographic makeup and subsequent challenges. The below provides an overview of each borough's population, and more detail on how Local Care Partnerships are being used to address resulting specific population need and health inequalities can be found in [chapter 4](#).

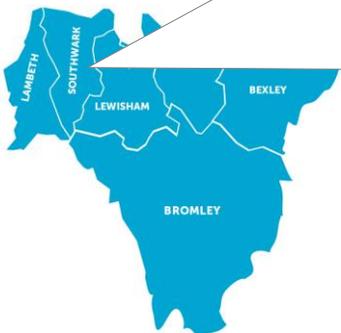
Lambeth

- A young and diverse population, 51% are between 20-44 and 42% of the population are from the black, Asian and minority ethnic (BAME) community.
- A third of the population live in the most deprived areas of the borough and there is widening relative inequality. 23% of children are from low income families and a third of older people are income deprived.
- Overall people are living longer, however people can live for between 15 and 20 years in poor health with a range of multiple long term conditions.
- 32% of deaths are from avoidable causes. Common causes are cancer, cardiovascular disease, respiratory, injury and drug misuse. There are significant differences between the most and least deprived areas.



Southwark

- A comparatively young and diverse borough with more than 120 languages spoken and 39% of residents born outside the UK.
- The 40th most deprived local authority in England and the 9th in London. Around 15,000 children under 16 live in low-income families.
- In 2017/18, Southwark had the 4th highest level of overweight and obese reception age children in London (25.4%) and 11th highest level for children in Year 6 (39.8%).
- Almost 50,000 adults experience a common mental health disorder and severe mental illnesses affect 1.2% of residents. The estimated prevalence of mental health disorders among children and young people is higher than the London average.
- About 1% of the population (3,500) has three or more chronic conditions. Hypertension (11%), depression (8%), and diabetes (6%) are the most common diagnoses.



Lewisham

- 25% of the population are 0-19 and around 10% are over 65. A very diverse borough – 46% of the population are from a BAME background.
- In 2015 Lewisham ranked as the 48th most deprived local authority in England and 10th in London. People living in the most deprived areas have poorer health outcomes and lower life expectancy compared to the England average.
- Cancer is the main cause of death (27%), followed by circulatory disease (25%) and respiratory disease (17%). Screening for bowel, breast and cervical cancer is significantly lower than the average for England.
- Demand for care is increasing as the population gets older; 14% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities.





Bexley

- Bexley's population is estimated to increase by 9% between 2019 and 2030.
- One in six people are over 65 and projections show that Bexley has a population that is ageing.
- Across Bexley the health profile of the population differs; Bexley has a relatively younger, ethnically diverse and deprived population towards the north.
- 22% of the population is black and minority ethnic (BME): this is expected to continue to rise.
- Obesity is the single biggest challenge for Bexley.

Bromley

- An ageing population, the proportion of people aged 65 and over is expected to increase gradually from 17% in 2017 to 18% by 2022 and 19% by 2027. The number of children aged 0-4 is projected to decrease over the same period.
- 19% of the population are from BAME backgrounds. Children and young people make up the highest proportion of the BAME population.
- For the period 2013 to 2015 there was a 7.4 year difference in life expectancy at birth between males living in the most and least deprived areas of Bromley, and 5.9 years for females.
- Although there is less difference in the level of life expectancy inequalities seen between males and females in Bromley, in the last eleven years there has been an increase in inequalities in life expectancy within gender for females but a reduction for males.
- The key causes of death in Bromley are cancer, circulatory disease and respiratory disease. There is significant variation in mortality rates for coronary heart disease and cancer between wards in Bromley.



Greenwich

- Greenwich has a young and very diverse population. Almost 25% are under 19 and around 10% are over 65.
- Greenwich has particular challenges including high levels of deprivation, inequalities and unemployment.
- About 20% of the population are from BAME backgrounds. The two biggest minority ethnic groups are Black Caribbean/African and South Asian/Chinese.
- Cancer, lung disease, dementia / Alzheimer's and digestive diseases (including alcohol related conditions) contribute to lower life expectancy in men. For women, factors include dementia / Alzheimer's, lung disease and infectious diseases.



Across the country there are differences in the way that services are planned, commissioned and delivered that are reflective of local need. Understanding the diversity of our population in south east London means that we take account of the range of local needs when shaping services across each of our boroughs.

However, some differences in the way care is delivered are not planned around the population's needs and can be due to differences in clinical practice or how services perform. This can lead to unwarranted variation in both patient outcomes and the cost of delivering care.

By comparing our services in SEL to others that serve similar populations, we can make an assessment of where there is variation in care and outcomes that is unwarranted. This helps the partners across the system focus effort to develop and deliver services that can better meet people's needs, meet clinical standards and make the best use of our resources.

NHS England & NHS Improvement support systems across the country in making this assessment through using the Bronze Diagnostic – a system wide tool that looks across NHS commissioners and providers. This report triangulates several data and benchmarking sources to identify, at a high level, the areas of care where improvements could be made in both outcomes and cost.

SEL Bronze Diagnostic – key system drivers and opportunities identified:

- 1. Emergency care with pressure from frailty** – High levels of A&E attendances and admissions, with pressure due to care home emergency admissions.
 - We will reduce the variation in emergency care across SEL through the delivery of the following core foundations of the LTP:
 - Transformed out-of-hospital care and fully integrated community based care.
 - Reducing pressure on emergency hospital services.
- 2. Prevention and detection** – High risk factors in the population and opportunities for increased detection.
 - We will reduce the variation and better meet people's needs across SEL through the delivery of the following core foundations and prioritised commitments of the Long Term Plan:
 - Improving cancer outcomes.
 - More NHS action on prevention.
 - Diabetes.
 - Services for children and young people.
 - Shorter waits for planned care.
 - Respiratory disease.
- 3. Mental health** – Despite high spend, mental health outcomes for adults are poorer than national average.
 - We will reduce the variation in mental health services across SEL through the delivery of the following core foundations of the LTP: improving mental health services.

We will continue to review the outputs of the Gold Diagnostic as it is finalised to further inform our understanding of opportunities across our system.

What do our residents say they want from the health and care system in SEL?

Our Healthier South East London (OHSEL) has talked to hundreds of people over the past three years about how to shape the future of local health and care services; this is complemented by even more engagement that is happening locally. As a result of these conversations we have made a number of changes, including seeking to improve services in hospitals, making it easier for people to see a GP, and bringing mental health services closer to where people live. However, we recognise there is always more to do.

To develop our response to the LTP, we commissioned support from Together Better and Kaleidoscope Health and Care to carry out a series of public engagement activities to gather the views and experiences of local people across our six boroughs. This involved:

- **12 face-to-face events** across the six boroughs, in which almost 290 people participated.
- **A series of conversations with 19 community groups** (involving 200 participants), whose voice is seldom heard in the NHS, reaching out to people in places where they meet, at times when they meet, and talking about the things they want to talk about. These discussions covered a range of issues relevant to the Long Term Plan, such as services working together and tackling social isolation.
- **An online survey**, which 76 people responded to.

To enable constructive discussions about plans, we focused conversations on six topics as set out below. The key messages from this discussion are summarised in the table below:

Topic	Key messages
Getting the best start in life	People want the NHS and schools to work together.
Young people's mental health	Young people need different kinds of support to feel understood.
Daytime hospital appointments	People would welcome telephone / video appointments, but not as a replacement to face-to-face appointments.
Access to services	People want clearer information about all of the services available (e.g. about which services are better than A&E).
Social isolation and charities	People want the NHS to work better with charities to tackle social isolation.
Services working together	People want joined-up, person-centred health and social care.

In addition, public and patient engagement was carried out across the six boroughs by Healthwatch. A two-pronged approach of surveys (completed by over 1000 residents) and focus groups was used to gather feedback on themes within the LTP. The key messages from this engagement very much aligned with what we set out in the table above. In addition, south east London residents identified the following four aspects as the most important in the delivery of their local services:

Topic	Most important aspect of delivery
Living a healthy life	Access to the help and treatment I need when I want.
Independence as they get older	I want my family to feel supported at the end of life.
Managing and choosing support	Communications are timely.
Interaction with local NHS	I have absolute confidence that my personal data is managed well and kept secure.

Feedback from our engagement is included throughout our Long Term Plan response. For more details please see the full engagement reports on the Our Healthier South East London website, available [here](#).

What are the priorities for our clinical leaders?

In ensuring our plans are clinically led we held a workshop with our Clinical Programme Board to identify our clinical leaders' views on which priorities should be progressed at pace in south east London. The four areas that were agreed as being the most important were:

1. **Addressing health inequalities** – we know a lot about health inequalities in SEL but we still need to do more research to develop a more detailed understanding of inequalities that exist between patient groups / conditions / communities. We need to tailor services to specific population need and make every contact count.
2. **Prevention** – there are a lot of examples of prevention initiatives but we need to agree a SEL-wide strategy to bring these examples together. Prevention needs to be a focus throughout the life course and should not be limited to people who are living without disease.
3. **Workforce** – there is a SEL workforce plan that is aligned to the Interim People Plan but data is dispersed and staff turnover, especially in nursing, is a key issue. We need to engage frontline staff and support them as new ways of working are tested.
4. **Digital** – the digital infrastructure in SEL and in London is continuing to evolve but there is still more to be done to increase interoperability, make better use of information and data, and to digitally enhance patient pathways.

These priorities map directly to key themes within the Long Term Plan. Whilst each of these topics is cross-cutting throughout our LTP response and are key enablers to transformation, our response also includes dedicated sections that set out our plans:

Clinical Programme Board priority	Dedicated section(s) of our response
Addressing health inequalities	<ul style="list-style-type: none"> • Understanding our population's needs. • Prevention and reducing health inequalities.
Prevention	<ul style="list-style-type: none"> • Prevention and reducing health inequalities.
Workforce	<ul style="list-style-type: none"> • Workforce – workforce plan to be further developed once the full People Plan is published.
Digital	<ul style="list-style-type: none"> • Digital First primary care. • Digital.

South east London is diverse, and the population's needs are complex – one size does not fit all. Like much of the country our population is both growing and ageing. We also have significant health inequality across our ICS. Life expectancy at birth can vary within a borough by up to 9 years between the most and least deprived areas. Healthy life expectancy can vary within a borough by up to 13 years.

There are also many wider determinants of health including deprivation, the local environment, housing, crime, education, employment and social isolation. People's individual lifestyle choices also directly impact their health.

As an integrated care system we know that we need to work in a systematic way with our partners to reduce health inequality in our boroughs. This means having a much more joined up approach between our partners and delivering care that meets people's needs at all levels of our system.

The information set out in this section of our LTP response clearly demonstrates that the challenges we outlined in our 2016 sustainability and transformation plan remain very relevant to us today:

- As our population continues to grow, particularly the ageing population and those with long term conditions (LTCs), **demand for health and care services will continue to increase.**
- **There is unacceptable variation in care, quality and outcomes** and without taking a more concerted and targeted approach to how we deliver our care, variations in care quality and outcomes could further impact health inequality.
- Through our engagement activities south east Londoners have told us that our **system is fragmented, resulting in duplication and confusion.**
- These factors combined contribute to the **increase in the cost of delivering health and care services.**

Our residents have told us what is important to them in implementing the Long Term Plan over the next ten years, and how we can work together as an integrated system to support them to stay well. The views of our residents will continue to be at the forefront of how we shape and deliver services at all levels of the system through our implementation of the LTP.

Our clinical leaders have identified priorities to progress at pace in south east London, further shaping how we deliver our plans.

Improving outcomes and addressing health inequalities is a golden thread through our plans and vision for the future. To support a systematic approach to this across our ICS, we are developing a population health management approach to personalise care and ensure a systematic and targeted approach to the delivery of evidence based interventions. The approach will cover: how as a system we can identify cohorts of need at neighbourhood, place, and system level; the evidence based interventions to be delivered; our approach to implementation and tracking of intermediate outputs; and longer term outcomes for population health. Our approach to population health management will help us to ensure that we identify and address unwarranted variation across all levels of the system, ensure that our System of Systems approach meets our population's needs in a coherent and responsive manner, and support working collaboratively across partners to help address the wider determinants of health.

To further support our ambition of reducing health inequalities we have carried out a high level equality impact assessment against our response to the Long Term Plan. This assessment focuses on how the implementation of our plans may directly impact patients, reflecting on what local people have told us as well as how we intend to consider equality and health inequality impacts. By giving focused consideration to equality impacts and working in an ongoing partnership with local communities and the voluntary sector, we believe our plans will be able to better tackle health inequalities and the challenges people can face when trying to access services. As we both continue to refine our overarching equality impact assessment and undertake further assessments throughout our the implementation of plans, we will continue to engage with partners and stakeholders, including patients.



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3) Service transformation priorities



3) Service transformation – actions and priorities

Introduction

This chapter sets out our service transformation priorities to the end of 2023/24 in response to the ambitions of the NHS Long Term Plan. In doing so we also highlight the transformation priorities for the SEL system, which focus on the objectives that are most important to meeting our population needs.

As described in [chapter 1](#), the priorities set out in the LTP align with our local transformation priorities and needs of our system. We are committed to delivering on these priorities to ensure we capitalise on opportunities in a way that best meets the needs of our local population. This will ensure that we deliver high quality services, and reduce the inequalities in access, service offer and health outcomes that prevail in our system.

For each section we have described our key challenges, vision for the future, objectives and priority actions to the end of 2023/24. We also summarise the impact we aim to achieve and enablers that will underpin our plans. For the foundational commitments of the LTP, we have provided more detail in the [appendices](#) on key milestones and how we will measure success.

Driving the progress in these areas is our ICS governance, comprising representation from across all partners, including patient and public voices. Importantly our governance structures include clinical leadership from executive teams and from frontline staff, who work to better support the practical delivery and implementation of our strategic objectives. Further supporting programme delivery is our network of Clinical Leads and Senior Responsible Officers, roles undertaken by subject matter experts from across south east London.

Contents

Service transformation priorities

1. Integrated community based care.¹
2. Urgent and emergency care.¹
3. Planned care.^{1,2}
4. Deliver better outcomes for major health conditions:
 - Cancer.¹
 - Adult mental health.¹
 - Preventing cardiovascular disease.
 - Respiratory disease.
 - Heart disease and stroke care.
 - Diabetes.
 - Learning disabilities and autism.
 - Children and young people’s (CYP) outcomes (including CYP mental health).
 - Maternity.
5. *Deliver financial savings and achieve financial sustainability – see [chapter 5](#).*

In parallel, we will develop our plans for 21st century care by:

- Going further on prevention and reducing health inequalities.
- Delivering personalised care.¹
- Delivering digital transformation in primary care.¹
- Leveraging research, innovation and genomics.

Note 1. These are the foundational elements of the NHS Long Term Plan, where additional detail, trajectories, and expectations of progress in the early years of implementation are expected.

Note 2. The planned care section covers both the foundational elements of digital transformation in outpatient care and shorter waits for planned care; these are combined because the former (digital transformation) will help us drive the latter (shorter waits).

Priority 1: Integrated community based care (CBC)

Deliver integrated community based care through the development of primary care networks at the core of our delivery model

Current challenges

- SEL has some of the highest levels of deprivation and inequalities in health in the UK. Four of the six boroughs rank amongst the 15% most deprived local authority areas in the country.
- Growing need among our increasingly ageing population for proactive community based care.
- Risk of inefficiencies and differences in health outcomes across SEL (despite the high quality of community services), because local planning has led to a range of different services and models.
- Inconsistent reporting for community services, variable quality of primary care data and a fragmented approach to shared care records.
- Lack of a consistent improvement method to quantify the impact of community based care on wider system sustainability (including how this will help us to manage acute demand).
- Recruitment and retention of workforce is a key challenge, particularly around community nursing and GPs. We require a system wide response to maximise the opportunity to develop, recruit and retain staff working in primary care networks as part of the national role reimbursement scheme.

Our vision for the future

Delivery of consistent and high-quality community based care for adults and older people with complex needs will keep people as healthy and independent as possible, in their homes.

Our objectives

We will develop and implement a core offer for integrated community based care across SEL. People with moderate to severe frailty, multiple conditions and dementia will receive timely and personalised care, coordinated or delivered by one of our community based multidisciplinary neighbourhood teams, integrated with our 35 PCNs. This will enable us to:

- Optimise quality of life for people with complex needs and reduce inequalities in health outcomes.
- Prevent unnecessary attendances at A&E and unplanned acute admissions.
- Eliminate delays in discharge from hospital.

To deliver these objectives, our priorities for community services will be to: (i) deliver crisis response within two hours, and reablement care within two days; (ii) provide 'anticipatory care' jointly with primary care; (iii) support primary care to develop Enhanced Health in Care Homes; (iv) build capacity and workforce to do these three things.

Health is created in neighbourhoods and communities, schools, places of worship, homes, and workplaces. – Kaleidoscope engagement report

We will deliver our vision and objectives through the following priority actions

1. Establish a systematic approach to addressing health inequalities within community services

- Define the 'core offer' to be delivered by community services at different geographical levels, with agreed access criteria. It will be developed by the community providers, in conjunction with primary and secondary care and local authorities. This is likely to include:

- **Neighbourhood:** processes to deliver anticipatory care; respective functions of community and practice nursing.
- **Place:** crisis and intermediate care pathways (includes reablement); a defined list of community-delivered LTC services; neuro-rehabilitation and stroke care; a defined list of community specialist condition services (e.g. wound care and continence).
- **Multi-place:** community specialist services (e.g. lower limb, lymphedema and services for vulnerable people).

- **System:** specialised community services (e.g. podiatric surgery).
- Provide a template for services to move to ‘best in class’; there are some notable examples of integrated community, mental health and learning disability services (e.g. Bexley Care) – we will spread good practice so these become the norm.
- Work with King's Health Partners and other stakeholders to develop PCN-based risk profiles of people requiring an urgent community response; roll out to other areas if useful (see also: [prevention and reducing health inequalities](#)).
- Support the four community providers to move towards a more formal partnership to share innovation, work on joint quality improvement initiatives (such as wound care) and benchmark services – this will support the delivery of consistent service outcomes across SEL.
- Establish effective links between community health services and mental health and learning disability services, to improve the care offered to service users.
- Roll out a standardised community services dashboard across SEL, to help us understand the impact of PCN-based anticipatory care services on acute unplanned activity within each borough.

2. Deliver a comprehensive PCN support and organisational development (OD) strategy across SEL and within our local borough based systems

- **Develop PCNs.** In SEL we have 35 PCNs, based on neighbouring GP practices that work together typically covering 30-50,000 people. PCN leadership has been established with a SEL network of 54 Clinical Directors. PCN leadership is represented within each of our local borough partnerships on the SEL CBC Board, and we have launched a SEL clinical director network to support the further engagement of a collective clinical voice across SEL. We have collectively agreed a set of principles for the organisational development of PCNs (see also: [appendices](#)). Next steps are to:
 - Support all PCNs to undertake a consistent self-assessment against the national maturity matrix.
 - Agree priorities for development and a SEL

framework for support, reflecting on the key principles for accessing support as agreed by our Community Based Care Board.

- Support PCNs to access support through local teams.
- To continue to support and develop a collective clinical voice for PCNs in the emergent ICS arrangements within local boroughs and the SEL system.
- **Develop a shared quality improvement (QI) method and approach.** Health and care representatives from across SEL have come together and agreed the importance of addressing health inequalities at the core of our approach to integrated care. We have agreed to the development of a common approach to monitoring key health risk factors (the Vital 5, described in: [understanding our population's needs](#)) and incentivisation of monitoring within SEL's wider commissioning intentions across acute, community and primary care services. Clinical leadership for the ICS has agreed that we require improvement methodology at system level to ensure best practice is adopted across care pathways, building on learning from current clinical effectiveness programmes. Next steps are to:
 - Agree a resourcing and delivery framework for SEL.
 - Agree hosting and evaluation support and recruit clinical leadership.
 - Develop and adapt current guidance, templates and approach within each local system, supported by SEL infrastructure and governance.
- **Agree core service improvements,** including consideration of the impact of phasing of the GP contract and management of the risk of not recruiting and developing roles within PCNs to deliver the new service specifications. Arrangements for the transfer of responsibility for extended hours services have been agreed. SEL was represented on national development groups for Enhanced Health in Care Homes (EHCH) and anticipatory care. Collation of relevant commissioning information from SEL is underway. Next steps are to:

specifications.

Our three-year plan to develop primary care is provided in the [appendices](#).

3. Deliver anticipatory pathways in conjunction with PCNs and local authorities

The SEL CBC Board is the strategic forum where the ICS, PCNs, local authorities and community providers work together to deliver integrated community care. We have already made progress with the CBC Board supporting each PCN to undertake a development programme with key partners; one of the outcomes will be the design of anticipatory care processes as per the current national guidelines (but in advance of the national specifications).

Furthermore, providers have configured many community services to align with PCN footprints and will develop a roadmap for a workable alignment of all services. A single point of access to community services is in place / in development in each borough. SEL GPs already are using the electronic frailty index. RightCare data indicates that around 52% of the expected frail population in SEL have been assessed. There are well established networks of voluntary sector services in each borough that could support the expansion of social prescribing (although it is currently not known if they are at a level to meet the increased demand from the new social prescribing workforce). Next steps are to:

- **Use current guidelines to design neighbourhood-based processes of care** that meet LTP requirements and NICE Guidelines (NG56) for the care of patients living with frailty / multi-morbidities (with agreement of LAs and PCNs). To include: risk segmentation tool; multi-agency care planning and joint plan; coordination of care, including social care; NHS 111 access to crisis plans for 'red' cohort patients; support to patients to self manage, use of personalised health budgets and signposting to support for carers – plus digital access to shared patient record.
- **Agree how the Better Care Fund (BCF) will support meeting the LTP targets with local authorities.**
- **Identify the wider network of place-based statutory and voluntary sector services** that will enable anticipatory care to be effective. Turn into a self assessment framework for place based boards to develop a prioritised development plan to implement (as resources allow).

- Understand current workforce relative to LTP requirements and agree an approach to deliver a future model that supports:
 - The sustainability and resilience of general practice.
 - An optimal approach to the recruitment and retention of new staff within PCNs and across the local system.
 - Develop commitment to collaboration across PCNs and with community providers to deliver the specifications within updated network schedules that best meet the needs of the local population in SEL.
 - **Optimise the benefit of the new workforce**
 - Review SEL and local General Practice Forward View (GPFV) workforce plans to support development of a once for SEL approach to workforce planning and support offers within SEL training hubs.
 - Develop a system wide approach to the recruitment and development of additional staff as part of PCNs via the national role reimbursement scheme and wider system approaches including:
 - Strategic development and oversight of clinical pharmacist development from clinical pharmacist leadership group.
 - Support for the recruitment and development of social prescribing link workers to optimise their delivery within local PCNs and across the local system; a competency framework for care navigators and social prescribing (link workers) has already been agreed.
- Most participants at events regarded social prescribing as helpful insofar as it connected people with services that could help them. However, there were mixed feelings about the approach and the term itself. While some people felt it was an overly medical model of tackling a social issue, others said that the prescription aspect was helpful for the credibility of VCSE organisations supporting socially isolated people, and for raising their profile.*
- Kaleidoscope engagement report.
 - Consideration of other roles to be recruited as part of the national role reimbursement scheme following confirmation of the national service

- Support PCNs to **establish a QI approach** that supports evidence based, data driven decision making and enables them to assess the impact of their care.
- Maximise the new resource by supporting PCNs to review the most efficient way of delivering the new **workforce and clinical governance** requirements, including consideration of partnering with other larger organisations.
- **Establish data and information sharing arrangements** between primary, community and social care partners and ensure community providers' patient records have full interoperability with GP systems.

4. Improve the responsiveness of community health response services: provision of 2 hour crisis / 2 day reablement response

Planning and review of crisis and reablement services currently takes place in well-established local forums, but there is no system-wide planning. This leads to a range of service models across SEL, with the risk of different service outcomes.

Each borough has a crisis service that provides assessment and plan within the patient's home. All are available at least 12 hours/day, 7 days/week. All offer admission avoidance and accelerated discharge. However, levels of integration with acute and primary care is variable, as is the level of provision.

Each borough has a reablement service offered for up to six weeks. Whilst the target patient cohort is similar, there is variation in the level of integration with LA services and the model of delivery.

Our priority actions include:

- Conduct a demand and capacity review of crisis and reablement services, leading to a costed plan to meet targets.
- Model delivery of crisis / reablement within place-based integrated pathways:
 1. Urgent community response: meet 2-hour crisis response target; access via 24/7 Integrated Urgent Care service, accessible via NHS 111 (see also: [urgent and emergency care](#)); 'same day' intervention by community nursing; multi-agency protocols for end of life care and care of people with dementia.
 2. Integrated intermediate care to meet NICE Guidelines (NG74): crossover with two-hour crisis response; home-based rehabilitation; bed-based rehabilitation; 'hospital@home'

service; two-day access to reablement.

- Review provision and model of bed-based intermediate care in line with Carter recommendations.
- Establish same / next day reporting of admissions to relevant PCN (to support a proactive 'pull' of patients back into the community via accelerated discharge).
- Support the introduction of a shared care plan across all agencies, including social care, to underpin integrated pathways and urgent community response.
- Develop and submit a bid to be a national accelerator site for urgent community response:

Further information on our application to be a national accelerator site for urgent community response

In Autumn 2019, the national Ageing Well team asked for expressions of interest for sites to implement the urgent community response pathway at a quicker pace than the rest of the country, in order that the learning from these 'accelerator' sites could inform the national programme.

The urgent community response pathway will deliver the LTP requirements of delivering a crisis assessment within a person's home within 2 hours of referral and reablement response within 2 days of referral.

The SE London integrated care system submitted an expression of interest on 18 November 2019 and was successful in becoming one of seven accelerator sites nationally. The bid covers the six boroughs within the ICS.

The accelerator proposal was developed out of the work already undertaken for the LTP response and the ICS-wide adult community services plan. Like that plan, the accelerator bid was produced in collaboration with community providers, local authorities, primary care and commissioners.

We have agreed with NHSE&I that each borough will seek to meet the 2 hour crisis assessment standard and the 2 day reablement standard by October 2021.

In addition to delivering the urgent community response standards, local areas also will continue to support the development of anticipatory care and deliver the Enhanced Health in Care Homes initiative over the next four years.

5. System wide and local priorities to deliver

Enhanced Health in Care Homes

There are over 100 elderly care homes (residential and nursing) across SEL. The distribution of these care homes is uneven both within and across boroughs (e.g. Bromley has 25 elderly care homes and Southwark has 8).

Each borough has made good progress in starting to implement a form of proactive enhanced primary care service for its care home residents by providing a consistent, named GP who is linked to a wider primary care team. This will be fundamental to improve care quality and reduce demand for unscheduled care from our care homes, as SEL has more A&E attendances and emergency admissions per care home resident than the national average (see also: [urgent and emergency care](#)).

Given the uneven distribution of care homes in SEL, these enhanced primary care models have largely been developed at the scale of borough level services to provide a team of dedicated healthcare professionals delivering the highest quality care for our residents. An EHCH network is well established in SEL, convening regularly since late 2017 to:

- Increase consistency across boroughs when applying EHCH framework principles.
- Undertake regular self-assessment benchmarking against the framework interventions and share peer-learning for continuous improvement among SEL care home leads.
- Support coordination of resources and programmes across SEL (e.g. resources from Healthy London Partnership).

As SEL care home residents experience longer lengths of stay in hospital than the national average, we are working to establish more efficient and secure ways to exchange information for healthcare professionals working in care homes, to expediate timely hospital transfers. SEL actively engages with the London regional EHCH programme and is supporting the design of the national PCN EHCH service specification.

Going forward, our priority actions include:

- Review how the national EHCH PCN service specification (when published) can be delivered in SEL in a way that builds on our progress to date, supporting development of the enhanced primary care service models that have been established at place based level.
- Continue to progress EHCH framework implementation through the SEL EHCH network. A

focus will be on consistency of our enhanced primary care services, seeking to reduce variation in these models across SEL and support continuous improvement reducing unwarranted variations in resident outcomes.

- Establish a multidisciplinary team (MDT) approach with community services in the delivery of EHCH framework interventions in addition to the development of existing primary care models. This will include training for care home staff and agreement on additional nursing and therapy support to ensure that nursing homes receive the same support available to people in their own homes.
- Explore opportunities to support out of hours access to clinical advice through piloting telemedicine services in SEL care homes and increasing 111*6 lines usage by care home staff (see also: [urgent and emergency care](#)).
- Expand existing digital programme of work to enable all SEL care homes with an efficient and secure way to exchange information between healthcare professionals. This will include full compliance across our care homes with the information governance requirements needed to use the NHS mail system.

The impact is expected to be:

- **Provision of a wider range of services to meet the needs of patients, closer to home.** Suggested measures include: a decrease in the proportion of patients indicating they have a difficulty in getting an appointment; increased patient and carer satisfaction.
- **More resilient and sustainable and integrated community based services,** providing evidence based support and continuity of care for south east Londoners. Suggested measures include: workforce capacity; increase in proportion of patients reporting they feel in control of their health; increase in proportion of people (65+) who are still at home 91 days after discharge from hospital).
- **Management in demand of acute services.** Suggested measures include: a reduction in ambulatory care sensitive conditions for key patient cohorts; reduced unplanned hospital admissions for people diagnosed with a LTC; reduction in delays in discharge from hospital.
- **Full delivery of the national service specifications** for primary and community care.

To undertake our priority actions, we will require the following key enablers to be in place:

- An agreed financial strategy for investment in primary medical and community health services over the next five years to meet the funding guarantee and maximise further investment into primary and community care wherever possible, including consideration of additional LTP allocations, investment and impact funding.
- Appropriate flexibility within the national Directed Enhanced Services specifications to enable service to be delivered collaboratively and at the right scale.
- Appropriate resourcing and leadership including programme and project management, analytic and clinical input and leadership for key interventions and enhanced partnership working with academic research centres and networks.
- Digital enablement to minimise the burden of data collection, bring together the data necessary for quality improvement, and create a single source of truth for decision making, and enable modelling and forecasting to enhance health and care planning.
- Development of a dashboard to track progress in implementation and impact. The ICS will develop a dashboard for use by place-based forums to measure the impact of the new developments on the target population cohort (65+ / frailty / multi-morbidities), and their use of:
 - Acute services (emergency department presentations and unplanned admissions).
 - Social care (care packages and care home admissions).
 - Community services (crises and reablement).
 - Primary care (crisis GP appointments, home visits).

The CBC Board will use an aggregated version of the dashboard to oversee the impact of the new developments and use of the new monies.

The dashboard is likely to include data on: patient reported measures; 2 hour / 2 day target via the revised community services dataset; emergency department presentations and emergency admissions of people with admissions for ambulatory care sensitive conditions; emergency admissions of people living with defined LTCs; zero day admissions; length of hospital stay; discharge destination; delayed transfers of care; reduction in readmission within 30 / 90 days; use of care

packages; number who receive reablement services where no further request was made for ongoing support; the number of people receiving intermediate care / rehabilitation on discharge and who were still living at home 91 days later; and residential and nursing home admissions.

- Investment in community care recruitment and retention. The community provider partnership will work collaboratively to address the challenges of recruitment and retention. The work programme is to be defined, but is likely to include:
 - Short term measures: joint advertising campaign; sharing non-appointed suitable applicants; joint interview fairs.
 - Medium term measures: rotational posts; split posts including GPs (e.g. working in a practice and intermediate care unit) and across PCNs; employment of GPs by community providers where this aids recruitment; create senior, more specialist clinical roles across boroughs / providers, where this aids recruitment to a service and enhance the overall quality of care; joint approach to nursing associate programme for community nursing shared 'passport', enabling easier movement of clinical staff across providers, and developing a single system set of competencies for new roles such as care coordinators; shared approach to apprenticeships.
- Investment in primary care recruitment and retention (GPs, nurses, physician associates); for more information on our plans, see: [workforce](#).

We have a good understanding of population need, the service offer our population wants to see and the current variation across our services (see also: [understanding our population's needs](#)). We are also clear about our objectives and the key deliverables. These are both ambitious and wide ranging and we have more work to do to translate our ambition and commitments into robust and realistic delivery plans, so that we are clear about the 'what' but also the 'how', including what needs to be in place to secure and give assurance around delivery – governance, resourcing (finance, programme management, transformation and OD support) and infrastructure.

See the [appendices](#) for more information on our key milestones and how we will measure success.

Case examples

One Bromley alliance

Integrated working locally and across the whole of south east London is already having an impact and we will build on this as an ICS.

In Bromley, health and social care organisations are working together in the One Bromley alliance:

- GPs, community matrons, geriatricians, mental health services, social care and the voluntary and community sector have worked together to identify patients who may need extra support.
- The quality of care has improved for over 3,400 people with complex and long-term health conditions in Bromley.
- Analysis suggests that the outcome of this model of integrated working is a 34% reduction in the use of emergency departments and admissions in this patient cohort.

Social prescribing link workers in Lewisham

Establishing the new social prescribing link worker roles in Lewisham is now well underway. Five primary care networks have established a partnership with Lewisham and Southwark Age UK and One Health Lewisham to deliver social prescribing. One other PCN has also engaged their first link worker and is building strong relationships with the local voluntary and community sector. This is a positive approach and provides harmonisation with the existing local social prescribing system.

The new partners are linked into the local social prescribing agenda through the recently created Social Prescribing Network. The Network has been established to provide local strategic oversight of social prescribing in Lewisham and includes social prescribers, voluntary and community organisations, Adult Learning Lewisham, library services and sports and leisure providers. Having been established by the council, future leadership and coordination of the meetings will come from Lewisham and Southwark Age UK working in partnership with all our stakeholders.

Financial assumptions, return on investment and downstream impact

We will invest in community based care services in line with national planning assumptions over the next five years, to secure the Long Term Plan and local objectives and outcomes. We are not yet at the stage of having a costed plan and will be focusing on this over the next couple of months, with a specific focus on years 2 and 3. Our objectives are as follows:

- To ensure that our planned investment is driven by implementation and delivery plans to secure our agreed objectives.
- To ensure that we establish a benefits realisation plan to demonstrate return on investment, including monitoring and evaluation mechanisms. We recognise that in some areas our community based care investment will reduce pressure on hospitals and may reduce cost, though the overall system cost base may not reduce.
- To ensure that we are also able to demonstrate annual improvements in productivity and efficiency within our community based care offer.

Priority 2: Urgent and emergency care (UEC)

Reduce pressure on urgent and emergency care services

Current challenges

- A mismatch between demand and capacity in both physical and staffing resource.
- Increases in acuity leading to increased rates of admission.
- Continuing pressure from patients presenting in emergency departments (EDs) with serious mental health issues.
- Challenges with patient flow, within the EDs, from EDs to ward areas, and in timely discharge from hospital.
- The variability in SEL of appropriate alternative pathways (e.g. to support streaming at the front door / admission avoidance).
- SEL has some of the most challenged sites in the country; performance against the current emergency care national standard on A&E waiting times is below target across SEL and has deteriorated over the past year.

Our vision for the future

To redesign our urgent and emergency care pathways to ensure patients get timely access to the right level of care for their needs, relieving pressure on A&E departments.

Our objectives

- To provide high quality and consistent UEC services to our population.
- To ensure that urgent and emergency patients are seen in the least intensive setting for their needs and that they have timely access to care.
- To deliver an integrated network of community and hospital-based care and seamless pathways across the UEC system.
- To improve performance against the A&E waiting time standard.

We will deliver our vision and objectives through the following priority actions

1. Deliver an integrated and consistent community based UEC offer across SEL

There was general agreement across those we engaged with that it is increasingly difficult to get GP appointments, and this was having an impact on increased attendance at A&E and other urgent services. – Kaleidoscope engagement report

- Develop and implement our population health management approach to identify at risk patients and offer proactive support (see also: [prevention and reducing health inequalities](#)).
- Continue to develop our model for proactive community based care, with PCNs at the centre of our integrated model (see also: [integrated community based care](#)).
- Implement rapid response services which meet the 2 hour response target (see also: [integrated community based care](#)).
- Continue implementation of the Enhanced

Health in Care Homes framework across SEL (see also: [integrated community based care](#)).

- Implement additional services to support people in mental health crisis and avoid the need for A&E attendance where appropriate (see also: [adult mental health](#)).
- Continue to deliver enhanced primary care support in care homes, to better support our care home population and reduce unnecessary conveyances and hospital admissions (see also: [integrated community based care](#)).
- Continue to build on our 24/7 Integrated Urgent Care (IUC) service, which is currently available accessible via NHS 111 or online. Clinical triage is provided by a single multidisciplinary clinical assessment service within integrated NHS 111, ambulance dispatch and GP out of hours services. The SEL 111 IUC service will continue to develop:

- Direct booking from the IUC service into 210+ SEL GP practices in line with the General Medical Services contract. This requires that GP practices make available one appointment per 3,000 registered patients per day for direct booking by the 111 IUC service.
- Referral pathways into relevant SEL services to take direct referrals from the 111 IUC service, London Ambulance Service (LAS) 999 crews and LAS 999 clinical hub.
- Access to mental health crisis plans for the 111 IUC service.
- Access to a broader range of patient records via Connect Care and Local Care Record (see also: [digital](#)).
- A digital strategy with the 111 IUC service provider for the next five years.
- Further develop the ‘star line’ single point of access services for healthcare staff; this enables our care staff (ambulance, nursing and care home, community nursing and community pharmacy) to gain both rapid access to a clinician within the clinical assessment service and onward referral to services (including community services).
- Review the consistency the offer provided by urgent treatment centres across SEL; potentially re-procure services based on commissioning requirements and outcomes of the review.
- Increase the number of patients being treated via same day emergency care services. All sites are to:
 - Improve access via primary care (NHS 111 and General Practice) into SDEC.
 - Improve hours of operation (7 day a week, 12 hours a day service).
 - Increase timeliness of clinical assessments.
 - Develop surgical assessment pathways that will be supported through SDEC.
 - Further develop and standardise SDEC and acute frailty provision (for frail, older people).
- Review all front-door services and streaming models operating across SEL with a view to standardising the approach and maximising opportunity.
- Implement services to support people in a mental health crisis (e.g. core 24 psychiatric liaison; consideration of peer support workers in A&E; see also: [adult mental health](#)).
- Continue to embed therapy and social work teams in ED (some sites already have this); review hospital site requirements to support this.

2. Hospital front-door services and streaming models to direct people to the least intensive setting for their UEC needs

Specific patient pathways for patients at A&E with stroke, heart attack, major trauma, severe asthma attack or sepsis to reduce risk of disability / death are already in place and will continued to be developed in line with clinical standards once they are confirmed.

All acute sites currently provide front door streaming to allow for patients to be directed to the right place of care. GSTT, KCH and LGT are able to stream patients internally to other services (e.g. early pregnancy units; same day emergency care units). Sites are also able to redirect to community services (pharmacies, GP practices and GP extended access hubs).

All SEL ED sites have operational same day emergency care (SDEC) services:

- Medical models in place for all relevant sites.
- Surgical models in place at some sites.
- Frailty pathways in place at some sites.

Our priorities over the next five years are to:

3. Improve in-hospital processes and enhance community offer to minimise the time patients spend in hospital

All SEL trusts have implemented long length of stay reviews and improvement programmes are in place to support optimising discharge.

The SAFER patient flow bundle has been introduced across wards in our hospitals, covering senior review before midday, recording patients’ expected date of discharge and clinical criteria for discharge, flow, early discharge and systematic MDT reviews of patients with extended length of stay.

We have established MDT ward / board rounds at each site. Some sites have therapy and social care teams in ED. A SEL ‘Trusted Assessor’ network has been established to support CCGs / boroughs to develop assessment and discharge services. Criteria led discharge is place on some wards.

Our priorities over the next five years are to:

- Continue to implement SAFER flow bundle, complemented by Red2Green.
 - Build on existing criteria-led discharge processes and roll out across additional areas.
 - Deliver against the High Impact Change Model (managing transfers of care between hospital and home), including:
 - Flow, MDT discharge teams and discharge to assess; embed MDT reviews on all wards every morning.
 - Continue to implement Trusted Assessor model with all boroughs for care home admissions.
 - Enhance community services to facilitate quicker discharge (e.g. implement reablement services which meet the two-day referral target – see also: [integrated community based care](#)).
 - Implement reablement services which meet the 2 day referral target (see also: [integrated community based care](#)).
- Digital IT costs associated with 111 development.
 - Appropriately trained and sufficient workforce for new models of care.
 - Organisational development and change management support to deliver changes in ways of working.
 - Consideration of additional transformation resource to undertake service reviews and support the system to implement new models of care.

See the [appendices](#) for more detail on key milestones and how we will measure success.

Case example

GP pop-up hub

SEL has implemented a new model to use GP skills at the front door of A&E. A GP pop up hub operates at GSTT which involves a GP working in a primary care setting within A&E. This has delivered a number of benefits including ensuring patients are seen by the most appropriate clinician and as quickly as possible, and has been particularly helpful in addressing capacity issues caused by surges at A&E during the evenings.

The impact is expected to be:

- A consistent model of community based UEC across SEL that ensures people only need to attend a hospital when they have an acute care need.
- At the hospital front door, patients are streamed to the most appropriate setting / service for their needs.
- More efficient delivery of inpatient care, which minimises time spent in hospital:
 - More timely discharge from hospital on SDEC pathways; our target is for a third of patients to be discharged on day of attendance.
 - Increased number of discharges before midday and number of weekend discharges.
- Improvement in patient experience and outcomes for those with UEC needs.
- Reduction in rate of growth in non-elective attendances and admissions for ambulatory care sensitive conditions.
- More people in a mental health crisis, and more people in care homes, will feel proactively supported in the community, through early identification, assessment, intervention and rapid access to specialist care when needed.
- Improved performance against constitutional targets (e.g. reduced waiting times in emergency departments; reduced length of stay).

To undertake our priority actions, we will require the following key enablers to be in place:

Financial assumptions, return on investment and downstream impact

In overall terms our planned actions to reduce pressure on UEC services should result in overall system productivity and efficiency improvements, noting that:

- Our community based care investment to support UEC pathway improvements and specifically our ability to support and manage patients in the community will come from the investment envelopes that we have set to comply with national planning assumptions.
- Our community based care plans and investment will support reduced pressure on hospital services through A&E diversion, admission avoidance and supported discharge services plus our disease / condition specific work in areas such as LTC management (e.g. stroke, cardiovascular disease, respiratory disease and diabetes). These plans will result in reduced acute activity, noting that where these reductions support an ability to take out material cost / capacity, e.g. through closing a ward, this will support genuine system cost out.
- Our in hospital pathway redesign plans are focused on improved productivity and efficiency (e.g. through streaming, same day emergency care and reduced length of stay); where these plans result in a shift along the care pathway and support an ability to take out material cost / capacity this will further support genuine system cost out.
- We will be undertaking further work over the coming months to confirm the detail of our planning assumptions with regards the financial impact of our UEC system transformation plan.

Priority 3: Planned care

Improve planned care outcomes and performance

Current challenges

- Our providers are not currently meeting planned care performance targets: GSTT at 86%, KCH at 77% and LGT at 85% in May 2019 (c.34,000 patients waiting over 18 weeks).
- We have significant capacity constraints in acute-based planned care under the current delivery model, which will be further stretched as demand grows.
- Our current model of outpatients is very traditional with the majority of appointments being delivered face-to-face, and the demand is rising due to the number of patients needing long term follow-up care.
- We want to improve outcomes by reducing waiting times and providing more personalised treatment.

Our vision for the future

Re-designing planned care to ensure that residents in SEL have timely and consistent access to services, and that these services deliver value for the patient, the clinician and the system, contributing to an effective and sustainable integrated care system.

Our objectives

- Improve performance, quality and ensure sustainability.
- Improve patient access, outcomes and experience (a priority is cutting long waits).
- Transform the outpatient model to reduce face-to-face appointments by a third – equating to a reduction of over 600,000 appointments in SEL.
- Ensure capacity is better aligned to demand for planned care.
- Expand volume of planned surgery year-on-year.

We will deliver our vision and objectives through the following priority actions

1. Implement access to telephone and video services alongside face-to-face appointments

Nationally, the Royal College of Physicians reported that 28% of doctors say 10-20% of consultations could be delivered using alternatives to face-to-face. In SEL 2018/19, excluding outpatient procedures, 6% of appointments at GSTT, 1% of appointments at LGT and 2% of appointments at KCH were delivered principally by telephone.

In our public and patient engagement activities, the residents involved generally welcomed accessing alternatives to traditional face-to-face appointments, including telephone and video consultations.

However, there is a clear need for more information about these services and when it is appropriate to access them. People also felt strongly that they should not be complete replacements for face-to-face appointments at the appropriate time, in particular as initial diagnostic appointments before then having digital follow-up appointments.

I think a lot of precious time is wasted by giving patients outpatients appointments when much of the time a phone call would be adequate. – Survey respondent

It is also important to ensure that people with additional needs are considered to ensure that appointments remain in the most accessible format. – Kaleidoscope engagement report

To implement access to telephone and video services, our three providers are testing different approaches to support SEL wide learning and roll out:

- LGT will set up telephone and video clinics as part of the referral assessment service (RAS) roll-out at the trust.
- KCH is working with outpatient specialties to explore pathway redesign, and telephone and video consultations are being reviewed as part of this work; services prioritised are rheumatology, cardiology, general paediatrics, renal, ophthalmology, dermatology, haematology and urology.

- GSTT will implement ‘Attend Anywhere’ video consultations.

Comparisons will be made between the three providers at a specialty level to understand variation in practice and encourage uptake of telephone and video clinics.

Longer term, taking blood remotely will be an enabler for increased uptake of video and telephone appointments, as well as remote monitoring of patients using Patient Reported Outcome Measures (PROMs). GSTT will trial an approach in rheumatology to taking blood remotely (as part of a wider project around remote monitoring using PROMS, described under priority 2 below); venous collection of blood will take place locally to enable blood monitoring remotely. If successful, we will roll this out across other specialties.

2. Implement access to virtual services

In addition to telephone and video clinics, other types of virtual clinics are being developed, including review of information provided by patients and GP records.

The monitoring of patients using digital PROMs has the potential to reduce the number of appointments, as patients do not need to be seen when their disease scores are low. This increases capacity for new patients to be seen more quickly or for follow up patients who need more intensive outpatient care. GSTT began a trial in rheumatology in 2019 to ascertain whether patients are willing to provide PROMs remotely for long term conditions.

In diabetes, patients download their blood glucose results at home, which are then reviewed by a clinician online. GSTT is working to implement the GDm-Health app (gestational diabetes management app) to manage routine patients remotely.

Building on this progress, our priority actions are to:

- **Trial remote monitoring of patients using PROMs within rheumatology.** GSTT will test whether ease of access to a prescription will increase adherence to the provision of electronic PROMs. If successful, we will look to procure a product which can deliver remote monitoring and roll this out across a number of specialties. This should free up capacity which will be used to help trusts reduce waiting times.
- **Deliver virtual clinics for patients with chronic kidney disease at both KCH and GSTT.** Depending on severity and rate of progression of their disease, patients will have their review

virtually on electronic patient records at GSTT by consultants. To implement the clinics, we will resolve contractual issues with EMIS and run GP engagement sessions.

- **Explore the feasibility of machine learning / artificial intelligence.** Longer term, machine learning will be used to improve planned care, helping to identify and stratify patients needing care. For example, should the remote monitoring trial prove patients are willing to provide PROMs, it is hoped algorithms can be embedded to highlight which patients need review and how, rather than relying on clinicians reviewing individual patient records.

3. Offer better support to primary care

Support to primary care is currently provided in four key ways. Firstly, **advice and guidance** is available to all GPs in SEL via the e-Referral Service (e-RS) and Consultant Connect (a telephone advice and guidance service). The Consultant Connect app has additional functionality via PhotoSAF which allows GPs to take photos (in a way that is compliant with information governance regulations) and to share these with secondary care consultants where this functionality has been set up.

Secondly, **RASs** enable referrals to be clinically triaged and ensure that people are cared for in the most appropriate setting. Where patients can be managed in primary care, the referral is returned with advice and a management plan for the patient. Four RASs have already been introduced in ophthalmology (KCH and GSTT patients), dermatology (KCH and GSTT patients), cardiology (KCH and LGT patients) and general paediatrics (GSTT patients).

Thirdly, web-based **decision support tools** (e.g. VisualDx) are enhancing diagnostic accuracy, aiding therapeutic decisions and improving patient safety. The service has been rolled out to all GP practices in SEL.

Furthermore, **Capacity Alerts** are in place for some specialities (orthopaedics, bariatrics, gastro-intestinal and Liver) at KCH.

To build on this progress, our priority actions are:

- Wider roll out of Consultant Connect: looking at opportunities to increase the number of specialties available to GPs, improving answer rates and reducing variation in utilisation.

- Wider roll out of PhotoSAF on Consultant Connect for advice and guidance to other visual specialties, such as gynaecology and allergy.
- Roll out of PhotoSAF across SEL so all GP dermatology referrals have a photo attached with the referral.
- Improve quality and responsiveness of e-RS advice and guidance.
- Introduce RASs and clinical triage across a wide number of specialties at GSTT, KCH and LGT to ensure patients are seen in the most appropriate setting.
- Explore opportunities to introduce capacity alerts across a wider range of specialties at GSTT, KCH and LGT.
- Support work to diversify the workforce within primary care with the introduction of MSK first contact practitioners (FCPs) across SEL.

4. Provide appointments closer to home through community services

There are a number of community services in place in SEL covering a range of specialties (e.g. dermatology, cardiology, gynaecology, respiratory, ophthalmology). Some of these community services have been commissioned on a 'once for all' across the six CCGs, whereas others are commissioned for individual CCGs and services vary by borough.

Moving forward, all boroughs in south east London will align their approaches and will seek to introduce services based on SEL service specifications. The specialties where it has been agreed there may be benefit to introducing community services (using a SEL service specification) are: respiratory, dermatology, cardiovascular, and gynaecology.

These have been selected on the basis that they would utilise a broader workforce, are amenable to delivery in a community setting without significant infrastructure needing to be created, and address capacity challenges in secondary care.

Building on this progress, our priorities are to:

- Assign responsibility for different specialty areas to Planned Care Leads across SEL.
- Scope the potential opportunity and impact of introducing community services.
- Work closely with trusts to develop service specifications to ensure optimised pathways and appropriate staffing and delivery models.

- Make the best use of the diverse range of clinical expertise available in our system, including GPs with extended roles, first contact practitioners and optometrists to support a richer skill mix.
- Implement community services.
- Monitor impact.

In response to the LTP ambitions, we will also continue to roll out **MSK FCPs** across SEL. To date FCPs have been piloted in Lambeth and Southwark.

We will:

- Work closely with primary care networks (see also: [integrated community based care](#)) to ensure FCPs are introduced across SEL and integrated with the wider MSK pathway.
- Review opportunities to expand such a model to other disciplines in the coming years where appropriate.

5. Cut long waits and reduce waiting lists by introducing clinical triage across a wide range of specialties

Recent audits across a number of specialties showed around 25% of referrals could have been managed in primary care were advice and guidance offered; of those patients requiring hospital treatment, between 15%-38% were booked into the wrong clinic or could have benefitted from diagnostics prior to their appointment. This has a major impact on wait times for patients and referral to treatment (RTT) compliance.

To address this and ensure patients are seen in the right place, first time, our Planned Care Boards are overseeing the implementation of referral assessment services across all key specialties.

RASs act as a single point of referral, but ensure that appointments are not booked until referrals have been clinically triaged by consultants. Based on the outcome of the triage, the patient will be booked into the appropriate secondary care clinic or diagnostic test, a community service, or returned to the GP practice with advice and a suggested management plan.

We expect to increase the proportion of patients managed back with primary care or in community settings, and reduce the number of secondary care appointments (thereby cutting long waits). We expect this will reduce the overall quantum of new appointments, whilst reducing the number of follow-up appointments per pathway.

This capacity will be used to support incremental annual backlog reduction, noting that the pace of recovery will be linked to funding availability as well as available capacity.

As previously described RASs in four specialties have been established already. Building on this progress, our priorities are to:

- Continue to roll out RASs at each provider.
- Ensure that consultants have time to triage included within job plans, and tariffs agreed as part of their contracts.
- Improve access through reducing waiting times, offering non face to face / digital and community based alternatives.
- Have support mechanisms in place for primary care to support continuous quality improvement.
- Full review of guidelines, referral forms and access criteria for all specialties on a pan SE London basis.
- Review of clinics for all key specialties to ensure maximum utilisation of non-face to face clinics including telephone, video and virtual review.
- Develop online patient portal to provide two-way messaging with consultants, support uptake of PROMs recording and monitoring, and offer self-management advice and support.
- Increasing volumes of surgery undertaken by improving productivity and efficiency, shifting from inpatient to day case, and increasing capacity.
- Ensure compliance with emerging national policy on patient choice at 26 weeks.

6. Cut long waits and reduce waiting lists by developing clinical networks in some specialty areas to ensure safe and sustainable services and by taking action to make the best collaborative use of available capacity to treat patients

Work is progressing with the three providers to develop a more collaborative approach to the management and development of services. This has focused on the development of networks where services are particularly challenged due to increasing workload and capacity constraints and / or where the recruitment and retention of medical and other clinical staff is particularly difficult. The areas of initial focus are orthopaedics, dermatology, bariatrics and urology.

Orthopaedics and bariatrics are key drivers of the SEL 52 week wait position, and as such networked

approaches in these specialties will help address long waits through a whole pathway approach and ensuring providers are working together to make best use of available capacity. Through our Planned Care Board, we will also look to align approaches around insourcing, outsourcing and waiting list initiatives.

A key component of the networks and of system improvement more broadly will be implementing the Getting It Right First Time (GIRFT) recommendations, and exploration of productivity gains as identified through Model Hospital, RightCare and peer review. The SE London Planned Care Board will systematically review these opportunities and develop pan-provider / commissioner action plans. It is recognised that productivity improvements alone are unlikely to be sufficient to close demand and capacity gaps. Work has recently commenced to undertake capacity reviews in a number of key specialties and this will continue over the coming months and years, to review opportunities to better utilise capacity at our acute sites, in the community and at cold sites such as Queen Mary's Sidcup and Orpington Hospital.

Our priorities are to:

- Ensure networks have strong clinical leadership support in order to drive agreed changes forward across SEL.
- Develop and maximise out of hospital pathways and community services, where appropriate, in order to reduce referrals to secondary care.
- Develop speciality specific workforce strategies that strengthen resilience through expanding the roles of non-medical clinical staff and by joint appointments between specialist centres and local services improve recruitment and retention.
- Agree clear service standards based on best practice and standardisation of pathways, where appropriate, throughout the networks.
- Develop a collaborative approaches to managing demand and capacity on a SEL wide basis.
- Work closely with providers identify and prioritise other services that are fragile or challenged and would benefit from a network approach to development.
- Increase volumes of surgery undertaken by improving productivity and efficiency, shifting from inpatient to day case, and increasing capacity.

- Ensure specific action to support incremental annual backlog reduction, noting that the pace of recovery will be linked to funding availability as well as available capacity.

The impact is expected to be:

- To meet the LTP objective with regards outpatient transformation and to secure over time a return to RTT compliance in SEL.
- Virtual appointments: improve patient experience, improve 'Did Not Attend' rates, reduce carbon emissions, maximise the use of hospital estate, offer greater opportunity for clinicians to work flexibly, improved resilience in the face of severe weather / transport strikes / demonstrations in central London.
- Patient initiated follow-up: reduce unnecessary attendances for patients who do not need follow-up appointments and a reduction in waiting times as follow-ups are given on the basis of clinical need, not arbitrary timeframes.
- Ensure patients are seen in the right place, first time, with advice and guidance enabling more patients to be managed within primary care; it is anticipated that clinical triage will result in 25% of referrals being returned to primary care with advice and guidance, and patients who need to be seen in secondary care are booked into the most appropriate clinic.
- Increased resilience of services as part of a network, reduced waiting times and ensuring equity of access across south east London.
- Review capacity across the system reflecting new ways of working and increased productivity to ensure any remaining gaps are closed.
- Incrementally reduce the number of long waits year on year.

7. Explore networked approaches to diagnostics to ensure we have sufficient demand and capacity in place at SEL level

SEL's performance does not currently meet the national diagnostics standard. The expectation is that at month end no more than 1% of patients should be waiting more than 6 weeks, in aggregate across a range of diagnostic modalities. In August 2019, SEL's performance was at 6.9% against the 1% target.

Endoscopy is a key area of challenge in SEL, and one of the main drivers of the performance position. A SEL endoscopy task and finish group has been established which has completed some detailed demand and capacity modelling at site and SEL level.

This work has forecast demand for the next 10 years, and modelled this against current endoscopy capacity, and a number of possible future scenarios.

Building on this detailed analytical work our priorities are to:

- Explore ways to improve endoscopy services through collaborative working across GSTT, KCH and LGT, and what a "network" for endoscopy could look like.
- Complete workforce modelling to understand the additional workforce that would be required to move towards the different capacity scenarios that have been modelled. Current collaborative initiatives being explored include:
 - Clinical Fellows who can provide additional flexible endoscopy capacity across our sites, alongside their research work commitments.
 - A collaborative approach to training and retaining nurse endoscopists, working together to provide sufficient training opportunities and offering exciting rotational work across units to retain staff.
 - Development of a pool of service fellows who can work across SEL, gaining training and experience in specialist work alongside providing additional capacity in units across SEL.

Alongside endoscopy, we are also exploring networked approaches in other diagnostic areas. In March 2018, the South East London Cancer Alliance (SELCA) commissioned a short review of imaging provision in SEL, due to the pressures timely access to imaging was having on cancer performance (see also: [cancer](#)). The SEL Imaging Collaborative was established in February 2019 and has been progressing work under three main strategic areas identified in the review: workforce, networked reporting and imaging equipment. Key examples of progress made to date include:

- A number of joint medical appointments between LGT and GSTT / KCH to support medical vacancy issues at LGT.
- Agreed SEL prioritisation of Health Education England (HEE) funding in support of radiographer reporting to extend the scope of practice for radiographers and enhance retention and recruitment.
- SEL wide GP access project reviewing imaging demand and access issues.

- Networked reporting proposal to enable the technological development required to integrate reporting technology across trusts.

Building on this progress, our priorities are to:

- Complete some demand and capacity analysis for wider imaging modalities, starting with MRI.
- Develop collaborative and network solutions across GSTT, KCH and LGT to address the challenges faced.
- Drive work forwards in the context of the National Imaging Strategy.

To undertake our priority actions, we will require the following key enablers to be in place:

- Payment and incentives: ensure incentives are aligned to encourage providers to deliver services virtually.
- IT and digital: resolve IT challenges and ensure providers across primary, community and secondary care have appropriate equipment / software to deliver services virtually.
- Workforce: ensure primary care have the skills and capacity to manage patients where the referral has been returned with advice and guidance.

See the [appendices](#) for more information on our key milestones and how we will measure success.

Case examples

Referral assessment services

Following a series of audits with a number of specialties, it was identified that around 25% of referrals could have been managed in primary care if support and guidance was offered. Furthermore, a third of patients requiring hospital treatment would have benefitted from being seen in a different clinic, or having a diagnostic before their first appointment.

To address this, LGT are rolling out a series of referral assessment services. These allow a single point of referral by specialty, where referrals are clinically triaged by consultants to ensure that patients are seen in the right place, first time. The cardiology RAS went live in August 2019, with eight other specialties having moved on to RAS in December 2019.

Community services

MSK first contact practitioners: FCPs have been piloted in Lambeth and Southwark. Two different models have been piloted:

- 1) In Lambeth, the FCP has been based in GP practices and only patients registered at those practices have been able to refer patients to the FCP.
- 2) In Southwark, the FCP has been based at an extended primary care service and practices in that locality have been able refer patients to the FCP.

Clinical networks

Within dermatology GSTT are working with LGT to provide clinical and operational leadership, including oversight of the provision of service, including developing some specialist services locally and establishing RASs and community provision.

As a wider network, we are looking to review pathways, treatment protocols and workforce development across the system. We are looking to expand this approach with other specialties over the course of the next few years to reduce variation and support sustainability and quality and performance improvement.

Financial assumptions, return on investment and downstream impact

Our actions to improve planned care outcomes, including outpatient transformation and improved in-hospital elective pathway management should result in overall system productivity and efficiency improvements, noting that:

- Our outpatient transformation will both reduce outpatient activity through the management of more patients in community settings and change activity type through a shift from face to face outpatients.
- Our in-hospital pathway improvements, including GIRFT and Model Hospital initiatives, will support better use of internal capacity, a reduced reliance on prohibitive outsourcing and improved productivity and efficiency.
- Recurrent productivity and efficiency and pathway transformation financial benefits will be partially offset by additional investment to support waiting list reductions and the achievement of shorter waits for patients.
- We will be undertaking further work over the coming months to confirm the detail of our planning assumptions with regards the financial impact of our planned care system transformation.

Priority 4: Deliver better outcomes for major health conditions

Introduction to this section

This section sets out our priorities to the end of 2023/24 to deliver better outcomes for major health conditions, focusing on those prioritised in the Long Term Plan. Our overarching objective is to step up our focus to ensure systematic action to address the disease burden, from **prevention through to early detection and intervention, combined with best practice treatment** once patients have developed disease, or are ill, over the next five years.

These include:

- Cancer.¹
- Adult mental health.¹
- Preventing cardiovascular disease.
- Respiratory disease.
- Heart disease and stroke care.
- Diabetes.
- Learning disabilities and autism.
- Children and young people's outcomes (including CYP mental health).
- Maternity.

We recognise that for some of these areas there is more work to do to translate our commitments into more detailed and tangible plans. For example, whilst we have long standing plans for cancer, mental health and maternity which have been refreshed where necessary in response to the Long Term Plan, we are still in the early stage of developing our plans for cardiovascular disease prevention, heart disease, and respiratory disease. For other areas such as children and young people and learning disabilities and autism there is a need to clarify which elements the different parts of our System of Systems will progress and to bring a focus to the key deliverables we are seeking to achieve. In many of these areas, diabetes for example, we have some significant areas of good practice in SEL; the next stage of our planning needs to ensure we establish a more consistent approach, 'levelling up' our practice across SEL.

It is clear that the breadth and scale of the LTP requirements will mean an ongoing focus and refinement of our plans. This will include ensuring that we have put into place the resourcing required to support immediate delivery, whilst also supporting effective planning for future years. As with all of our plans, this will need to be in the context of the constraints that we have (including those around workforce, finance, digital and estates, together with the overall leadership capacity in SEL). We also need to ensure that partners are engaged and able to support delivery in these specific areas as well as more broadly. To develop plans further we will deliver a number of engagement activities with all of our ICS partners and stakeholders, including patients.

Note 1. These are foundational elements of the NHS Long Term Plan, where additional detail, trajectories, and expectations of progress in the early years of implementation are expected.

Current challenges

- The rate of early diagnosis of cancer (stage 1 and 2) in SEL is low (51% in 2017), compared with the national ambition of 75% by 2028; further rates varied by 12% between our CCGs. Too many patients (18% in 2018) are first diagnosed with cancer through emergency presentation.
- SEL are below England in terms of coverage and uptake of bowel, breast and cervical screening.
- SEL performance on the 62-day wait target (for first treatment following an urgent GP referral for all cancers) is below both the national standard and average national performance against the standard. Our current challenges are driven by rising demand, issues with workforce and diagnostic capacity (see also: [planned care](#)), and the high volume of shared pathways between providers.
- Inequalities in patient experience and outcomes: 1-year adult survival rates are higher than England in three of our boroughs, but lower in the other three.

Our vision for the future

A collaborative model to deliver high quality cancer services across community, primary, and secondary care in south east London. To ensure that our patients receive timely diagnosis, high quality treatment, excellent experience and improved clinical and quality of life outcomes.

Our objectives

- Support the national ambitions to improve survival rates and early stage (stage 1 and 2) diagnosis in SEL.
- Reduce variation and inequality in access to cancer services and treatment and waiting times within SEL, through collaborative working in the sector to improve and standardise cancer pathways and close working with other referring regions and pan-London.
- Improve patient experience of cancer services and quality of life outcomes, through supporting initiatives for personalised care.

We will deliver our vision and objectives through the following priority actions

1. Work with national and regional teams to improve uptake and coverage of bowel, breast and cervical screening in London

Education about the body such as what prostate or bowel is would be helpful in understanding what the screening was for. – Healthwatch recommendation

- **Implement local screening improvement activities** working with local stakeholders including Public Health / local authorities, PCNs and the ICS:
 - Establish a SEL screening improvement virtual group to inform local priorities using screening data and results of pilots to develop evidence base and targeted interventions.
 - Implement recommendations around evidence based interventions from SEL 2019/20 screening improvement pilots.
 - Use national screening data to understand need and inform priorities.

• Increase population and healthcare professional awareness of screening

- Work with Cancer Research UK to deliver education and training to primary care.
- Targeted work and education (e.g. outreach language and addressing cultural barriers) to support public understanding of screening programmes.
- Develop digital solution for pre-screening reminders for non-responders (including link to access information on screening information) – we are currently working with Cancer Research UK to send texts to non-responders.

• Work with SEL screening centres and GP practices to ensure oversight of quality and capacity

- Training and retention in primary care and secondary care workforce.
- Improve access: offer weekend and evening services and deliver cervical screening in a wider number of settings.

- **Continue engagement with pan-London partnership to establish NHS regional screening improvement activities and delivery of NHSE&I led interventions:**

- Share learning and improve consistent evaluation across the region.
- Reduce current variation and inequalities in delivery and health outcomes.
- Increase delivery of evidence based interventions and generate new evidence.
- Implement HPV (human papillomavirus infection) primary screening by 2020. Implementation of HPV testing in the cervical screening programme is led by NHSE&I through the HPV Primary Screening Transformation Clinical Advisory Group, of which SEL is a member.

2. Implement early diagnosis intervention bundles

- **Reduce “patient interval” (length of time from symptom onset to first consultation)**

- Continue to implement targeted awareness and education campaigns for harder to reach groups.
- Improve communication and awareness, including targeted work to address cultural language barriers and use of community and mental health teams to engage with hard to reach population.
- Start scoping implementation of lung health checks in Lewisham and Greenwich, pending national roll out of checks expected from 2023/24.

- **Reduce “primary care interval” (time from first consultation to specialist referral)**

- Establish GP recognition and optimal referral practice, including adherence to NICE Guidance (NG12) with implementation of decision support tools.
- Improve access to urgent direct access diagnostics and optimise the use of symptomatic FIT (faecal immunochemical test) and consider lowering the threshold in primary care.
- Strengthen communication between primary and secondary care – GP as the patient advocate; implement process for joint significant event analysis.
- Continue to work with PCNs (see also: [integrated community based care](#)) to

support work to deliver their national service specifications (supporting early cancer diagnosis) and deliver education and training programmes (informed by National Cancer Diagnosis Audit findings).

- **Reduce “secondary care interval” (time from referral to diagnosis / treatment)**

- Extend use of fast track cancer pathways as appropriate and implement new diagnostic models (we have developed fast track cancer diagnostic pathways for testis, muscle invasive bladder cancer and anal).
- Develop interventions to support vulnerable patients, including navigator roles and psychiatric Clinical Nurse Specialist (CNS) roles.

- **Early detection research and innovation**

- Engage with King’s Health Partners (KHP) academics to understand early detection research findings and how to support translational work and rapid uptake (see also: [research, innovation and genomics](#)).

- **Collaboration to implement best practice / evidence based interventions**

- Work with London regional and cancer alliance colleagues to develop London strategy for population symptom awareness and sharing of evidence based recommendations.

3. Deliver the national specification on rapid diagnostic centres in south east London

South east London has been allocated funding over 2020/21 to 2023/24 to deliver the national specification on rapid diagnostic centres.

GSTT established a ‘vague symptoms’ clinic in 2015 for patients with serious but non-specific symptoms which could indicate cancer, as a pilot supported by south east London commissioners. Since then the service has developed into a nationally recognised and celebrated model, which provides an innovative and holistic service to patients with and without cancer. The model has influenced national policy on establishing ‘rapid diagnostic centres’.

All CCGs in SEL are able to refer into the existing clinic and the team has built up pathways for cancer and non-cancer patients to be referred onwards to the appropriate services within and outside trusts.

Following finalisation of the national service specification for rapid diagnostic centres, we are

developing plans to enable expansion of the model and principles in SEL over years 2-5, to support national aims that 1) patients receive only one urgent cancer referral in order to be diagnosed with cancer; and 2) once on an appropriate pathway, care and diagnostics are organised around the needs of the patient, and a diagnosis pursued whether cancer or otherwise.

Our priorities are to:

- Support the current team to recruit to clinical, non-clinical and programme roles to support expansion in 2019/20 and beyond using cancer transformation funding. Non-clinical roles will support the clinical team to provide a good patient experience.
- Implement plans to introduce patient cohorts with tumour site-specific symptoms, starting with colorectal.
- Promote the service to primary care across SEL.
- Improve onward referral to appropriate services (e.g. mental health services).
- Develop strategy and plans for further expansion in SEL from 2020/21 to 2023/24 in line with likely demand, ease of access for patients in SEL and coordination with diagnostic services.

4. Implement a comprehensive SEL clinical programme across all tumour sites supported by cross-cutting groups to drive improvements in cancer performance, outcomes and experience and deliver the cancer five year plan

Ten SEL tumour groups are leading the work across the system to agree standardised clinical models of care including diagnostic pathway, developing best practice guidance and quality standards and will be vehicles for sharing good practice and innovation, and reducing variation in access, waiting times and quality of cancer pathways.

The remit of the programme is across the entire cancer pathway from prevention to personalised care and end of life care. All groups have a clinical Chair, primary and secondary care representation and have support from one of the SELCA cancer improvement managers. Building on this progress, our priorities are to:

- **Deliver the faster diagnosis standard (FDS)**
 - Develop, implement and monitor a comprehensive evidence based timed pathway across the SEL Cancer Alliance to support delivery of the national cancer access standards (more information is provided under

priority 5).

- **Improve 1 and 5 year survival**

- Ensure the appropriate level of engagement with patients, primary care and other key stakeholders to optimise referral pathways and reduce fragmentation of cancer pathway.
- Build on partnership working to support interventions in community and primary care to support early diagnosis of cancer.
- Deliver a comprehensive clinical programme to embed best practice and early implementation of innovation and research.

- **Improve quality and reducing unwarranted variation**

- SEL expert clinical body will lead coordination and consistency across the network on service models, clinical guidelines, audit, research and service improvement to support delivery of cancer elements of Long Term Plan.
- Improve cancer patients' experience and outcomes through delivering excellence in clinical care, research, innovation, and education.
- Use of national and local data to identify inequalities and variation in clinical outcomes and patient experience and inform clinical work programme priorities.
- Strengthen patient engagement and co-working (see priority 11).

5. Reduce “secondary care interval” (time from first consultation to specialist referral)

Much progress has been made to improve the timeliness of diagnosis for patients. All three SEL providers have purchased the Somerset Cancer Register which enables the capture of the new 28 day standard. We have agreed SEL-wide standards for when patients can be removed from cancer pathways following ruling out a cancer diagnosis, and have developed a SEL dashboard for providers using NHS digital data to support local analysis of performance.

We have started an education programme for our sector tumour groups on the 28 day standard with a focused approach on upper gastrointestinal, to support implementing the new national timed pathway. We have revised SEL timed pathways to have a greater focus on the 28 day diagnosis standard. SEL Cancer Alliance has recruited a Faster Diagnosis Lead to coordinate the trust and primary

care approach to implementing and improving performance on this new standard, and sector operational roles to support embedding best practice cancer management.

To build on this progress, we will:

- Develop SEL guidance for clinical and operational staff on how to implement this pathway.
- Educate clinical and admin staff on revised SEL pathways.
- Develop new reporting tools for SEL, benchmarking trusts which supports local and tumour group analysis and discussion.
- Develop quality assurance processes and improve cancer data team processes to improve data quality and completeness for pathways. Support providers to improve data completeness for screening pathways.
- Implement / embed the national timed pathways for colorectal, prostate, lung, and upper gastrointestinal cancer.
- Engage with primary care on the entry pathway for patients into secondary care.
- Develop a system wide analysis of the challenges / barriers to improving performance at trust site and tumour level with corresponding trust action plans.
- Recruitment to remaining posts for new operational staff into the sector.
- Develop diagnostic pathways with clinical congruity on diagnostic algorithms.
- Improve compliance against our agreed timed pathways with a focus on increasing the volumes of patients entering one stop clinics or same day diagnostics.
- Invest in equipment and staff and capacity to enable faster access to diagnostics (radiology, endoscopy and biopsies).
- Improve communication processes with patients to support faster diagnosis from GP referral – support primary care to provide newly developed leaflets co-designed with patients to diagnosis in line with the SEL guidance on FDS communication.
- Improve our multidisciplinary meeting (MDM) processes through a focused approach to leadership development and teamwork in key MDMs. Evaluate potential to roll out approach.
- Review our workforce strategy for cancer and

develop our understanding to focus on key staff groups that will increase our resilience against growing demand for diagnostic pathways.

6. Implement a range of high quality treatment interventions across the Alliance. This will ensure patients receive the most effective, precise and safe treatments, with fewer side effects, shorter treatment times and reduce variation in access and outcomes

- Further develop the Alliance Clinical Programme with consistent approach to the most effective, precise and safe treatments.
- All MDTs to have implemented multidisciplinary meetings attributed improvement outcomes, including:
 - Implementation of SEL MDT quality standards.
 - Implementation of standards of care in accordance with tumour appropriateness.
- Support the new SEL and Kent Radiotherapy Network and ensure delivery of three year workplan. This will ensure consistent use of best practice pathways and new radiotherapy dataset across a 3m+ population.
- NHSE&I specialised commissioning is undertaking a consultation on the service specification for children and young adults. This will determine to organisation of services in London. Under current arrangements there is no principal treatment centre in SEL but both KCH and LGT have paediatric oncology shared care units. GSTT is a centre for teenagers and young adults (see below).
- Teenagers and young adults (TYA):
 - Open a new purpose built TYA centre on the GSTT site in Q2 2020/21.
 - Expand role of research team in TYA to increase percentage in trials to 50%.
 - Work closely with the three acute trusts to support implementation of new and innovative treatments (evidence based) (e.g. GSTT's robotic initiative to support thoracic and head and neck programme).
- Continue strong engagement with genomic hub to support delivery of genomics testing (see also: [research, innovation and genomics](#)).
- Oncology workforce – establish a revised workforce model for SEL, based on mapping work.

- SACT (Systemic Anti-Cancer Therapy Dataset) – ensure adequate local provision for SACT within agreed travel times and complete work on clinical protocols at GSTT; GSTT’s Cancer Academy has developed a SACT passport for workforce.

7. Work with NHSE&I and our London South Genomic Laboratory Hub partners to increase genetic and genomic testing coverage and ensure equitable access to all tests covered by the National Genomic Test Directory

For information on our plans to deliver this priority see: [research, innovation and genomics](#).

8. Ensure that all patients diagnosed with cancer have access to high quality personalised care

By 2021 everyone diagnosed with cancer will have access to personalised care, including a holistic needs assessment, a care plan and health and wellbeing information and support.

We have already made some progress towards delivery of this vision. The SEL Cancer Alliance has recruited a sector Personalised Cancer Care Team to support providers with delivery of personalised care plans. We have undertaken pan London projects (e.g. on cancer rehabilitation and motivational interview training for workforce). At ICS level we have also delivered or commissioned workforce training and education, including: eHNA (holistic needs assessment) training, advanced communications training (in secondary and primary care) and level two psychology training.

We have set up an Alliance wide HNA working group to standardise patient experience and have supported roll out of HNAs and health and wellbeing events (HWBEs).

Building on this progress, we will:

- Roll out Somerset Cancer Register for Personalised Care priorities; all three SEL providers have purchased Somerset Cancer registry which enables the capture of the new 28 day standard. We will ensure data collected on Cancer Outcomes and Services Dataset to align with national recording of data.
- Work towards the new Living With and Beyond Cancer metrics (both London and national metrics).
- Complete HNA data sharing agreement across the Alliance, to improve patient experience.
- Hold regular Personalised Cancer Care Alliance meetings to allow stakeholder discussions (including primary care and charity partners) and

drive the personalised care agenda.

- Develop core standards for treatment summaries (documents produced by secondary cancer care professionals at the end of treatment which informs primary care professionals of any actions they need take and who to contact with any questions).
 - Continue training and education of workforce.
 - Continue support of London-wide personalised care projects.
 - Deliver lung and colorectal “prehabilitation” projects (personalised support to patients from diagnosis to enable better outcomes from treatment).
 - Use findings of pan London Cancer Rehabilitation mapping and TCST (London’s Transforming Cancer Services Team) Commissioning Guidance for Cancer Rehabilitation to highlight areas of need.
 - Utilise TCST Commissioning Guidance for Psychological Support to implement psychology referral pathways.
- 9. Implement stratified follow up pathways at end of treatment for the agreed cohort of breast, colorectal and prostate cancer patients and other tumour specific pathways as appropriate**
- Implement digital solution to support remote monitoring of all cancer patients on a self-management pathway.
 - Agree and implement process for SEL Cancer Alliance oversight and assurance of self-managed pathways.
 - Develop processes for routine collection and review of data on number of patients entering pathways and outcomes.
 - Improve number of breast cancer patients entering a supported self-management pathway.
 - Review end of treatment clinics provision for breast cancer patients to ensure access to standardised high quality provision at all trusts.
 - Finalise standardised SEL clinical protocols for colorectal and prostate cancer.
 - Roll out work to develop primary care register of prostate cancer patients at all SEL GP practices.

- Implement stratified follow up pathways and supported self-management as appropriate for colorectal and prostate cancer patients.
- Establish end of treatment clinics for prostate and colorectal cancer patients.
- Develop core principles for stratified follow up that can be applied to other tumour specific cancer follow up pathways (e.g. stage 1a endometrial cancer).

10. Enable development, resilience and productivity of the cancer workforce in south east London

In 2019/20 and beyond

- Continue to support Phase 1 Cancer Workforce Plan implementation with HEE.
- Develop our understanding of the current workforce and identify SEL priorities for next phase of workforce plans (in line with national/regional cancer workforce planning and through SEL tumour groups and system urology and dermatology networks).
- Complete work on sector oncology modelling to support identifying capacity required.
- Scope urology CNS workforce across the sector and potential for sector roles.
- Establish a programme to improve processes for MDT clinical decision-making in key tumour groups in the sector (urology, colorectal, lung).
- Support cancer clinical leaders in primary and secondary care through courses and development opportunities.
- Work with primary care networks and charities on developing effective social prescribing strategies and on identifying, promoting and developing cancer education tools and events.
- Continue to embed new sector operational roles focusing on cancer and review impact at 6 and 12 month stage.
- Develop plans in response to pan London work on cancer rehabilitation mapping.
- Respond to national guidance relevant to cancer workforce and work with HEE on actions to improve recruitment and retention of clinical nurse specialists.
- Continue to deliver courses and events to respond to learning needs analyses, working jointly with Guy's Cancer Academy and the SEL Cancer Alliance, including for non-clinical and

administrative staff.

- Identify and promote training opportunities provided by charities and other sectors.

2020/21 – 2023/24

- Review and refresh SEL cancer workforce approach, aligning with other trust or system strategies, to support workforce resilience.
- Identify and implement opportunities for joint / sector roles and role redesign in key areas to address recruitment and retention issues in SEL.
- Explore better use of artificial intelligence and other automated technology to support role redesign and address workforce gaps.

11. Involve patients and carers in our patient experience and service transformation work

We have made much progress in involving patients and carers in our service transformation work. We have introduced a more structured approach to addressing common sector issues raised in the National Cancer Patient Experience Survey, including a patient experience working group (led by Lead Cancer Nurses from each acute trusts, patient representatives and the Alliance team), and an overarching SEL action plan covering common sector issues, particularly around patient communication and information.

We have provided Public and Patient Involvement training for all SEL Cancer Alliance cancer improvement managers so that we can involve and co-design patients in our service transformation projects.

Furthermore, we actively participate in national networks for patient involvement and experience (NHSE&I led) and have undertaken a co-design (patients and staff involved) project in gynae-oncology around reducing inequalities and patient experience. Building on this progress, we will:

- Improve engagement with a more diverse group of people that better represents our local population and community.
- Improve and standardise patient information at different stages of cancer, from pre- to post-treatment. Working closely with Guy's Academy as well as primary care on specific interventions.
- Identify patient experience leads across the system and share learning.
- Ensure patient involvement / engagement is incorporated in all key projects.

- Introduce patient involvement pools across the Alliance, ensuring easy and safe access to tumour specific patients who can provide input or co-design projects.
- Continue to promote the concept of co-working between patients, carers and staff.
- Strive to evolve and work towards best possible patient involvement.
- Ensure effective communication with stakeholders (including patients) about initiatives, impact and results.
- Ensure evaluation tools are incorporated in the patient experience and involvement work.

SEL is not one of the pilot sites for the national cancer metric on quality of life, but KCH is leading the SEL Patient Experience Collaborative to improve access and use of the Local Care Record in cancer pathways.

The impact is expected to be:

- Better collaborative working across the sector and coordination of care.
- Earlier and faster diagnosis – improving 1 and 5 year survival, stage 1 and 2 diagnosis and 28 day diagnosis from current levels.
- Reduced variation in SEL in the quality of cancer care and improved clinical and quality outcomes.
- Improved patient experience and engagement with people on cancer pathways in SEL (as reported in the National Cancer Patient Experience Survey).
- Improved performance on national cancer standards, particularly the Faster (28 Day) Diagnosis Standard.
- Improved clinical workforce productivity, e.g. optimising non-clinical roles in cancer, implementing stratified follow up pathways (reducing outpatient appointments), training, shared roles.
- Improved productivity through pathway change (e.g. procedures under local anaesthetic rather than general).

To undertake our priority actions, we will require the following key enablers to be in place:

- New strategic investment in capital projects relating to delivering cancer objectives.
- Cancer transformation funding to support sector programme team, sector tumour groups and key

interventions (including pilots), and early notification of LTP additional allocations from 2020/21 onwards.

- A clinical and non-clinical cancer workforce which is resilient and can adapt to new pathways and cross-sector working.
- Investment in equipment to enable faster access to diagnostics (radiology, endoscopy and biopsies)
- Collaborative working with input from providers, commissioners and arms length bodies.

See the [appendices](#) for more detail on key milestones and how we will measure success.

Case examples

Collaborative working across SEL

KCH and GSTT have agreed a system wide approach to the recent consultation on teenager and young adults' cancer services and the future of children's cancer services. A new purpose built TYA centre will open on the GSTT site in Q2 2020/21.

Sector operational role – senior operations manager

Rationale – Providers have multiple priorities to manage which often rely on the same individuals, demanding their time and that of their teams. Within cancer, organisations have agreed a key set of commitments that if implemented should have direct impact on the quality of care experienced by our patients. Maintaining a focus on delivering these commitments along with the demands of continually tracking and monitoring thousands of patients is challenging.

New role – Dedicated operational resource to focus on cancer that allows other operational leaders to balance their time appropriately across competing demands. With a background skill set in delivering operational services at a senior level, these roles will also have the time to understand the underlying challenges and develop a portfolio of improvement for key tumour groups where it is challenging to deliver high levels of performance and patient experience.

Support – These roles have the support of Alliance and Provider Director level roles alongside a small dedicated team of service managers and patient navigators. We are developing skills through an internal course in quality improvement that will underpin their approach.

Case examples

Rapid diagnostic centres

The rapid diagnostic centre / clinic in SEL is hosted by GSTT and currently sees patients with non-specific symptoms which could indicate cancer.

We are developing plans to expand the GSTT model in line with the national specification for rapid diagnostic centres for years 2-5, including: improving capacity to manage increased referral demand; introducing tumour site specific pathways; and planning for future roll out of the model and principles to other sites in SEL, to support improving access for patients across SEL.

Financial assumptions, return on investment and downstream impact

- We will invest in cancer services in line with the additional allocations set out in the Long Term Plan, with investment focused on supporting the delivery of agreed cancer priorities and outcomes.
- We are working on costed plans for use of cancer transformation funding with sector business planning sessions in progress during Q4 to support detailed planning for year 2 (2020/21) and to set the direction for years 3-5. We are not currently assuming a return on investment impact, as our expectation is that this will be offset by increased screening and 2 week wait referral uptake, noting that over time early diagnosis should result in overall downstream benefit.

Adult mental health

- Nationally, mental illness continues to be under-diagnosed and under-treated. In London, only a quarter of those experiencing difficulties are receiving treatment.
- Often, the physical health of people with mental illness is also poor and life expectancy of those under 75 years with serious mental illness (SMI) is shortened by 10-20 years; this 'mortality gap' is higher than the London average in all SEL boroughs except Southwark.
- In addition, the number of people developing psychosis also varies across SEL with early onset cases in Lambeth, Lewisham and Southwark totalling twice that of the remaining boroughs.
- Nearly 90% of those with mental ill health across England reported stigma and discrimination having a negative impact on their lives.
- Demand for mental health services is varied across SEL, but as a population we are experiencing:
 - High numbers of known patients presenting in A&E in crisis and increasing new presentations of mental health issues.
 - Many mental health assessments leading to admission as well as some inpatient wards consistently running at near 100% capacity.
 - Increases in the acuity of these patients thus requiring more costly specialist interventions, amidst increasing financial pressures.
 - High demand for beds and length of stay at almost twice the national average.

Our vision for the future

All communities will be able to access locally based care for their mental and physical health and wellbeing needs, which empowers each individual's choice of intervention at every point of expressed need, for all ages and stages throughout their life, including support for social factors of good health (e.g. housing, employment and meaningful activity and maintenance of social networks).

Our objectives

- Reduce hospital bed based care and length of stay, by providing more support for crisis away from hospital settings.
- Increasing access to therapeutic support within community services to recover and stay well.
- Reduce inequality in access and experience of mental health and physical health care for people with severe, moderate and mild mental illness across SEL.
- As a result, in the longer term, reduce the mortality gap for people with SMI.

Prompt access to mental health services was also stressed as vital. – Healthwatch recommendation

We will deliver our vision and objectives through the following priority actions

1. Implement new integrated community mental health models of care wrapped around primary care networks

The six boroughs have focused in 2019/20 on development of mental health alliance structures which will underpin partnership working – between MH and acute trusts, CCGs, local authorities, the voluntary, community and social enterprise (VCSE) sector, patients, carers and public – to ensure that services are co-produced and that local resource is valued as central to the transformation of community MH care.

The alliances are at different stages in their development and maturity but are well placed to work with the primary care networks as these structures evolve (see also: [integrated community based care](#)). Our priorities to 2023/24 include:

- Continue to implement new models for a core integrated community mental health offer, focusing on a whole person approach. Integration with primary care will be supported by MH alliance structures at borough level. Community support will be delivered via local hubs (centres) which:
 - Bring together existing services for psychosis, mood, anxiety and personality disorders.
 - Incorporate voluntary sector and local authority professionals to provide support with housing, benefits and employment.

- Place a greater emphasis on prevention of mental ill health by working with Public Health (local authorities) to deliver strategies which address mental and physical health determinants.
- As a first step in 2019/20, Oxleas will test the new model in a single PCN in Bromley, extending to Bexley from 2020/21.
- SLaM will continue to build capacity in the community in Lambeth, Lewisham and Southwark by implementing elements of the new model in 2019/20.
- We will review pathways associated with co-existing personality disorder traits, community rehabilitation, older adult (e.g. frailty) and eating disorder (provided by SLaM) to provide more tailored support for these cohorts from within core integrated community teams.
- Provide access for all six boroughs to community eating disorder clinics.
- Increase the number of MH staff working in the new community model (clinical and non-clinical) who are trained in dialectical behavioural therapy; this is known to provide a better quality of care for people with co-existing personality disorder traits.
- Build on the initial plans with the South London Partnership to support rehabilitation closer to home for people with complex needs.
- Map both workforce capacity and estates within PCNs and potential for digital enablers by 2020/21 to ensure full integration of the following services into the new community mental health service:
 - Improving access to psychological therapies (IAPT).
 - Early intervention in psychosis (EIP).
 - Individual placement and support – employment services (IPS).
- Develop a system workforce plan with increased workforce from the voluntary sector focusing on roles which provide psycho-social support to care for complex needs working alongside social workers, occupational therapists, nurses and other MH practitioners.
- Improve data systems to support improved accuracy and volume of data collected regarding MH activity in SEL, and establish commitment to a learning approach and robust evaluation using data to agree where investment is needed to

address health inequalities.

- Develop community transformation steering groups which will oversee all elements of the community provision and link into the crisis redesign programmes, 0-25 transition and PCN development programmes.
 - Develop a sustainable workforce moving away from increasing traditional community mental health team roles and instead developing new roles working across organisational boundaries with both primary care and the third sector.
- 2. Implement increased capacity to support more people in IAPT services including people with physical health long term conditions**

Quick access to low level support services such as IAPT would help patients recover quicker. More thorough assessments at these services would assist in ensuring the right support and treatment is given to help recovery. – Healthwatch recommendation

By 2023/24, the national ambition sets an expectation that almost 70,950 patients across SEL will be starting IAPT treatment. In addition, the ambition is to provide a service for people with long term conditions (with a proportional increase aimed at 65+ ages), and that all services are integrated with primary care.

The ICS achieved both the access and recovery standards for 2018/19. There is a clinically led ICS IAPT group which meets bi-monthly to review performance, support improvements and address challenges via sharing of best practice and collective problem solving. Of ongoing concern is the challenge to recruit therapists due to competition for these roles in London.

We have invested heavily over the years to expand availability of IAPT services for people with long term physical health conditions, however there remains variability in provision of this service across SEL. We are also working to provide more access to IAPT interventions via online platforms, to meet the changing needs of our population.

In addition, progress has been made for services to be integrated in primary care, but this is also challenged by limited physical space available in GP practices.

To deliver the national ambitions and address these concerns, our priorities to 2023/24 are:

- Address high staff turnover (especially psychology wellbeing practitioners) and training by working in collaboration with the London IAPT programme team to develop strategies, learn and share good practice.
- Promote IAPT digital and online therapeutic interventions and group IAPT (helping people to understand the benefits of alternatives to face-to-face and one-to-one options).
- Pursue a single procurement for digital platform and contract across SEL; this will reduce the overall cost of the digital contract and eliminate variation of digital platform services available.
- Agree the “second appointment wait time” as a measure of quality for service provision and undertake actions to maintain this at the national average; the ICS IAPT group has already agreed recovery plans to reduce waits across SEL for second appointments, for which three SEL boroughs are outliers with waits ranging from 2 to 3 times longer than the national average.
- Each borough service will make better use of data to:
 - Understand the disparity and inequity of access, outcomes and experience across SEL.
 - Provide targeted awareness-raising and identification of the gap in provision for people with protected characteristics under the Equality Act 2010; we will focus on BAME communities and older adults over age 65.
 - Develop action plans to address the gap in services for people where there is evidence of unmet need.
- Build on relationships with secondary care long term condition specialists to explore what push and pull levers are needed to further encourage a culture of proactive reach from secondary care into IAPT services, and to develop integrated pathways.
- As PCN structures develop (see also: [integrated community based care](#)), the ICS IAPT group will engage with the community based care workstream to develop a plan to ensure primary care integration (including ensuring appropriate estate space is identified).
- The ICS will continue to work closely with London

STP colleagues and Health Education England to develop actions to address the limited number of psychology wellbeing practitioners in the system across London and the affordability challenge of filling vacant posts.

3. Embed annual physical health checks, EIP and IPS services for people with SMI within core community mental health service offer

SMI – physical health checks (PHCs):

South east London reported in quarter one 2019/20 an achievement of 18-45% of people with SMI having received their annual physical health check – far short of the national standard of 60%. Challenges in SEL primarily centre around variation in methodologies to identify patients, how primary and secondary care work jointly to deliver and capture relevant data, and a current unclear ICS position on how to embed the PHC as a lever to establish parity and address health inequalities. Our priorities are to:

- Host workshops bringing together patients, professionals and carers in the care of patients with SMI to understand what the gaps are with undertaking the PHC, and how this can be improved across the ICS.
- Resolve technical data issues, through shared learning and technical support from NHSE&I intensive support team to ensure data accuracy in line with requirements of the mental health services data set.
- Develop plans that will support joint work via the new community model to stratify population with SMI by comorbidity and substance misuse, to better target services to optimise a needs focused approach through delivery of social prescribing and personal health budgets to improve outcomes (see also: [personalised care](#)).

Early intervention in psychosis:

There is variation in provision of prevention and early detection for psychosis across SEL; early detection / at risk of mental state (ARMS) services (which provide outreach into the community to identify those who are at risk developing symptoms of psychosis or prodromal) is not provided across Bexley, Bromley and Greenwich boroughs. Our priorities are to:

- Build on the transition pilot in Bromley, Bexley and Greenwich (which provides clinical care as well as supports young adults to transition into adult EIP or other pathways such as primary care or IAPT), to develop 0-25 transition model.
- Influence processes and practice to better meet the needs of patients reducing unwarranted variation in outcomes (supported by increased use of DIALOG and HONOS, paired outcomes reporting).
- Map the gap in ARMS provision across Bexley, Bromley and Greenwich boroughs to understand need and based on findings look to develop a SEL wide solution.

Individual placement support:

In line with LTP ambitions, SEL IPS services have set a plan to increase the number of people accessing IPS services by over 4,230 people, having successfully delivered access targets for wave 1 and being on track for wave 2 funded increases. Our priorities are to:

- Review current wave 1 Bromley and Greenwich services trajectories for 2019/20 and 2020/21 and update where overperformance is anticipated based on trend data.
- Identify the access gap to 2023/24 and agree workforce requirements to reach the goal. This will be monitored via CCG contract monitoring arrangements.
- Launch the SEL IPS network group which will be a vehicle to coordinate support for SEL IPS services; we will share fidelity guidance and learn from the Bromley centre of excellence for IPS and IPS Grow, which is the national network supporting IPS good practice.

4. Implement a consistent core offer of specialist community perinatal services across SEL with links to maternity community clinics (see also: maternity)

The implementation of specialist community perinatal mental health (CPMH) services in SEL has enabled increased access for women seeking support with their mental health during the perinatal period. The demand for this service is estimated at nationally at 4.5% of birth population.

CPMH teams cover all six boroughs in SEL and deliver pre-conception, antenatal and postnatal perinatal mental services. Referrals are sourced from a wide range of professionals such as maternity, health visiting, GP practices and other mental and

physical health services. Teams are multidisciplinary and integrated with primary and secondary care. Our priorities are to:

- Undertake a review to establish greater understanding of local population need and enable more women to access the service and have improved outcomes.
- Develop a perinatal workforce which delivers a needs led approach to therapeutic support in the community by working with voluntary sector and local authority partners to increase peer support and lived experience roles embedded in CPMH teams.
- As we further embed services within maternity services, safeguarding and children services, and IAPT, we will build on current research to identify women from BAME communities and those who are seldom heard whose access to CPMH services is underrepresented.
- Provide training to upskill staff to provide a wider range of therapeutic care and increase the capacity to support women whose needs are more complex including those with a personality disorder diagnosis.
- Both providers will collaborate to provide clinical leadership supervision for perinatal mental health MDT teams and IAPT therapists to ensure sustainable quality improvements across all six boroughs in both secondary and primary care. Work has already begun with a series of workshops scheduled to develop plans to strengthen integration of pathways between the voluntary sector, secondary care and primary care.
- Implement support for dads / partners / significant others following the pilot of DadPad, which is a digital tool providing information and signposting for support with their mental health such as IAPT services.

5. Implement alternative crisis support working jointly with police, LAS and the voluntary sector, and improve the quality of psychiatric liaison services

Environments should be appropriate for people going through a mental health crisis. – Healthwatch recommendation

To deliver the expansion of crisis alternative models, the national community crisis funding being allocated will enable us to:

- Work as a system to establish a stepped approach to crisis care, ensuring that our population has timely access to a consistent range of interventions that support delivery of care in the least restrictive environment.
 - Review the effectiveness of existing crisis café / sanctuary models of alternative crisis support, with a view to expanding the offer to provide full geographical coverage of complementary and alternative crisis care across SEL.
 - Implement a step down housing offer to enable earlier discharge from hospital, alongside our proposal to increase crisis safe spaces.
 - Implement new models of crisis support delivered by peer support workers and lived experience practitioners working in EDs, community and primary care, to support the holistic approach to mental health care at every access point for crisis support.
 - Develop a comprehensive training programme to ensure staff have the competencies to meet the requirements of the new roles and develop staff with the confidence to undertake their duties which will improve staff wellbeing and aid in the retention of staff.
 - Increase capacity of crisis resolution home treatment provision working in line with best practice to provide effective lower intensity community based support away from A&E where clinically appropriate.
 - The ICS will implement new workforce models which move away from the traditional clinical practitioner models for crisis support to one which has a focus on interventions being holistically applied in the least restrictive setting (where peer / lived experience is a valued part of delivering the quality improvements in crisis care provision).
 - Increase the mental health liaison support delivered in all five ED sites (see also: [urgent and emergency care](#)):
 - Queen Elizabeth Hospital and Princess Royal University Hospital will deliver a core 24 Psychiatric Liaison service (which is already provided at our other three ED sites). The liaison team will operate on-site as a distinct service on a 24/7 basis, providing care within recommended response times following referral (1 hour for emergency department referrals; 24 hours for urgent ward referrals), and resourced in line with (or close to) recommended staff skill mix.
 - GSTT, LGT and KCH will go further and operate an enhanced core 24 liaison function to support increased ED referrals (for patients where MH is the primary disorder and are awaiting an inpatient bed, as well as supporting in-reach into wards).
 - Increase access to psychiatric liaison for older adult mental health, and children and young people, via redesigned liaison pathways for all age psychiatric liaison services; we will bring in the appropriate clinical expertise to deliver this as part of the core liaison offer.
 - Allocate additional funding for liaison (core 24 and enhanced) to increase nursing and clinical leadership to provide a robust oversight of the growing service. Due to prior difficulties in recruiting to a clinical fellow post, we may alternatively invest in more consultant psychiatry time (having also found this approach to be more sustainable for the service).
- 6. Implement pathways with specific focus for people diagnosed with personality disorder, older adults and eating disorders**
- Personality disorder**
- We will:
- Provide increased therapeutic support for inpatients.
 - Streamline discharge planning processes using learning from multidisciplinary assessment and discharge events to enable a hospital length of stay that is closer to the national average of 32 days.
 - Ensure that community mental health teams have been supported to enhance their capacity to provide evidence interventions for individuals with personality disorder diagnosis.
 - Further support the development and expansion of service user led mutual aid for appropriate individuals with personality disorders.
 - Provide training in dialectical behavioural therapy for more staff in community and primary care, therefore providing improved quality of contacts and interventions for people with a diagnosis of personality disorder who can benefit from this approach.
 - Build on the personalisation agenda and social prescribing as a vehicle to deliver a holistic whole person approach (see also: [personalised care](#)).

Older adults

We will:

- Review different models to reduce waiting times for memory services.
- Develop trajectory and action plans to reduce waiting times.
- Review if an external evaluation is required to assess what type of residential and nursing home beds are required across SEL for service users with dementia and SMI.
- Work closely together with ICS IAPT group to develop a plan and a trajectory to be developed to increase access of older adults to IAPT.

Eating disorder

We will:

- In SLaM's adult community transformation service, identify gaps in knowledge and provide consultation and support, supervision and training to primary care staff.
- Implement a self referral process to services which we anticipate will increase access by approximately 40%.

7. Implement increased provision for suicide bereavement, problem gambling and rough sleeping

Suicide bereavement

We will:

- Map availability of postvention¹ (bereavement) support across SEL to understand any gaps in access and address variation in availability and unequal access, looking to best available guidance and working with the Thrive London suicide prevention team.
- Improve the quality of communication between mental health and acute NHS organisations, and multi-agency collaborations through borough and inpatient planned prevention work.
- Pilot a bereavement (postvention) support group in SLaM for staff and any member of the community to access.

Rough sleeping

We will:

- Set up the Lambeth Homelessness and Mental Health Collaborative, which will develop a clinical and peer support model that comprises:
 - Assertive clinical in- and outreach delivering

trusted assessment and brief intervention.

- Integrated mental health and substance misuse treatment through our homeless outreach team.
- Intensive support provided by trauma and psychology, informed by voluntary sector workers.
- Support through lived experience workers.
- Responsive holistic (including physical health) care that supports easy access to primary care through the King's Health Partners Pathway Team and Health Inclusion Team.

Problem gambling

We will:

- Work with Public Health partners to develop a clear collective plan to reduce associated gambling harm in line with national strategy and regional expectations, including clearer referral and treatment pathways and raised awareness in primary and social care.
- Undertake a collaborative approach including business organisation to raise awareness of problem gambling and associated health harm through local campaigns, providing access to national helplines and digital / online support.

The overarching impact is expected to be:

- Patients and carers will be able to seek a range of differing support for their mental and physical health needs at any point at which they feel support is needed; we will deliver the LTP ambition to implement new integrated models to enable increased access for adults and older adults and for those with more complex needs.
- In doing so, support will be made available locally in primary care settings coordinated through the integrated community services, eliminating the reliance on referrals and discharge to access the right care for individual needs. This will result in:
 - A reduction in the number of people with SMI presenting in crisis (and in the longer term, reduce the mortality gap).
 - A reduction in hospital bed-based care and length of stay by providing more support for crisis away from hospital settings and increasing access to community services to recover and stay well.

Note. 1. An intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals).

- A reduction in suicides in line with national ambition to reduce suicide by 10% and London ambition to be a zero-suicide city.

To undertake our priority actions, we will require the following key enablers to be in place:

- Development of a workforce working flexibly across organisations and age ranges.
- Strong leadership to coordinate what happens at place and system levels to ensure the right capacity across the system and reduce unwarranted variation.
- Transformation funding to be clearly identified, ringfenced and allocated in a timely manner.
- Improved data and evidence, so that our mental health services can better understand and respond to the needs of the population.
- London outcomes framework to measure population outcomes and benchmark performance.

See the [appendices](#) for more information on our key milestones and how we will measure success.

Case examples

Lambeth Living Well Network Alliance

Lambeth Living Well Network Alliance has implemented local living well hubs which provides a single point of access for population health needs. The hubs aims to reduce stigma around seeking help, offer support and advice, and provide signposting and referrals to community mental health teams. The resulting impact will be a reduction in referrals to secondary care as introductions to the living well network increase.

“You have a cluster of different professionals; you’ve got social workers, you’ve got [occupational therapists], you’ve got nurses, you’ve got support workers who have all been on the job with different backgrounds and loads of experience. So you have a pool of ideas, a pool of resources, a pool of skills. You just need to speak to somebody or send an email around and you will see people responding and it makes it much easier. And who benefits? It’s the client because you are able to meet their needs. You are not just alone.” – Community Psychiatric Nurse, Living Well Network Hub

Upskilling of primary care mental health professionals

Funded by Health Education England and sponsored by OHSEL, mental health staff working in primary care will receive evidence based training delivered locally by King’s Health Partners and SLaM.

Participants from Southwark, Lewisham and Bexley (GP Federations and voluntary and community sector organisations) who work in mental health services are being trained to be skilled in supporting people with physical health needs in parity with their mental health.

As we continue to deliver integrated mental and physical health and wellbeing support with a range of offers in primary and community settings, this programme provides us with a growing workforce to support new models of integrated mental health care.

Financial assumptions, return on investment and downstream impact

We will invest in (adult) mental health services in line with national planning assumptions over the next five years, to secure the Long Term Plan and local objectives and outcomes. A workforce data collection was undertaken by mental health trusts in November 2019. A second, more detailed, collection which will include the non-NHS provider workforce is due to take place by the end of 2019/20. The data from both of these collections will inform our planned expansion timetable and development of new workforce models.

Our objectives are as follows:

- To ensure that our planned investment is driven by agreed implementation and delivery plans to secure our agreed objectives.
- To ensure that we identify and agree a benefits realisation plan to demonstrate return on investment, productivity and efficiency including agreed monitoring and evaluation mechanisms.
- We recognise that in some areas, investment will reduce pressure on inpatient MH services in acute hospitals, but in overall system terms, will not in all cases reduce the overall cost base.

Our vision will require workforce models which provide flexibility to support a greater number of people based on their individual needs. In addition to our provider recruitment and retention plans to reduce vacancies in clinical and allied health posts, we have developed an ICS workforce group with the following priorities:

- Work with our voluntary sector partners to increase capacity of lower level therapeutic interventions, psycho-social and enhanced recovery support within our integrated community multidisciplinary teams and primary care networks.
- Continue to invest in the upskilling of primary care staff to be able to work confidently in both a physical and mental health needs based capacity with access to professional supervision and advice from secondary care.
- Develop a programme to explore how we can create a sustainable workforce primarily recruited from within our local communities.
- Scope how we deliver therapies through other professionals and how we embed these new roles with traditional and new models of care where appropriate.

Preventing cardiovascular disease (CVD)

Current challenges

- CVD is the largest cause of premature mortality but is largely preventable through detecting and treating key risk factors.
- Greenwich and Lambeth have two of the highest rates of under 75 mortality from CVD in London (source: PHE One London June 19).
- Meeting the London Vision ambitions: for atrial fibrillation, protect 973 more known people, find and treat 6,575 undetected people. For hypertension, protect 45,600 more known people, find and treat 97,536 more undetected people.
- Estimated shortfall of ~5000+ cases of familial hypercholesterolaemia who require diagnosis, treatment and remain at risk of developing coronary heart disease and other complications.

We will deliver our vision and objectives through the following priority actions

We have already made significant progress with SEL's CVD prevention agenda and we have an ICS clinical lead. To design and oversee the transformation programme, we have established a SEL CVD Prevention Steering Group which includes both clinical and CCG representation.

We have mapped and reviewed existing services, strategies and gaps across the six SEL CCGs / boroughs. Based on this we have agreed high-level milestones for delivery of the London Vision. We have reviewed best practice / evidence based interventions and models of care (CVD Prevention Resource Pack). Furthermore, we have developed draft CVD prevention commissioning intentions for SEL.

This emerging transformation programme incorporates the following priority actions:

1. Deliver enhanced support for prevention

- We are committed to expanding the current offer related to smoking cessation, with a particular focus on the evidence based Ottawa model – but we need to work as a system to secure an affordable delivery model to support roll out (see also: [prevention and reducing health inequalities](#)).

Our vision for the future

- Delivery of the London Vision for CVD prevention by 2023.
- People are empowered and supported to take control of their circulatory health and to take action on risk factors.
- Whole system working to detect and provide optimal treatment for south east Londoners with atrial fibrillation (AF), hypertension (HTN) and familial hypercholesterolaemia (FH).

Our objectives

- Protect known, untreated individuals with a high-risk of AF and HTN, and perfect diagnosis to treatment pathways.
- Detect unknown individuals with AF, HTN, FH.
- Enhance primary prevention through education, tobacco dependency treatment, healthy lifestyle promotion and enabling self-management through digital platforms and peer support.

- Use social prescribing to help embed and promote existing healthy lifestyle and education programmes aimed at risk factor reduction (see also: [personalised care](#)).
- Facilitate opportunities to offer and improve digital platforms, and patient support / peer groups, to support patients to self-manage their care / condition.

2. Intensify effort for case finding and early intervention

- Work with general practice and PCNs to consider how to systematically review all untreated, high-risk patients with AF and consider for anticoagulation.
- Undertake pulse and blood pressure checks in all NHS health checks, including for people with learning difficulties and serious mental illness, and within community clinics (i.e. diabetic foot care; vaccinations).
- Roll out community anti-coagulation services across SEL, building upon existing good practice. This forms part of our wider planned care strategy, which includes ensuring consistent community access in at least four specialties by the end of 2020/21.

3. Reduce variation in care quality and inequalities in health outcomes throughout SEL

- Build on best practice in SEL and examples supplied by the London CVD Prevention Partnership.
- Develop, adopt and adhere to SEL standardised protocols and guidelines for the detection, diagnosis and management / treatment of AF, HTN and FH.
- Reduce health inequalities through considering additional / targeted support for SEL priority wards and GP practices with the highest levels of deprivation, as well as hard to reach groups.

The impact is expected to be:

- Save lives by reducing heart attacks and strokes (400 lives/year across London).
- AF: protect 973 more untreated people; find and treat 6,575 more undetected people.
- HTN: protect 45,600 more people; find and treat 97,536 more undetected people.
- FH: find and treat 25% of the expected population.

London Vision for CVD Prevention	ICS position (2017/18)	London ambition by 2023
Atrial fibrillation detect	66%	85%
Atrial fibrillation protect	82%	87%
Hypertension detect	56%	80%
Hypertension protect	55%	80%

To undertake our priority actions, we will require the following key enablers to be in place:

- Integrated and standardised services for CVD prevention across SEL, at borough level under the guidance of the SEL CVD Prevention Steering Group and working in partnership with PCNs (see also: [integrated community based care](#)).
- Strong clinical engagement and buy-in at primary care, PCN and community level.
- Alignment of commissioning arrangements to ensure a consistent approach across SEL.
- Support to help embed new and existing SEL protocols into everyday practice.
- Data collection, sharing and evaluation to monitor impact / track progress, including in relation to improving health inequalities.

- The national roll out in 2020 of the CVDPREVENT audit.
- Implement a system-wide population health management programme, to identify population needs and develop targeted population health management interventions to meet those needs (see also: [prevention and reducing health inequalities](#)).

Case examples

‘Be sure of your blood pressure’ in Greenwich

A collaboration between the Royal Borough of Greenwich and Charlton Athletic Community Trust (CACT) – funded by the British Heart Foundation – hit its target of delivering 10,000 outreach blood pressure checks in August 2019. CACT’s Health Improvement Team has been visiting workplaces, town centres, community events and local pharmacies since October 2017.

Community anticoagulation service in Bexley

The Bexley Community Anticoagulation service is provided by Cotter – Laubis, who are the GP Partners at Bellegrave Surgery in Welling.

The service began in 2013, incorporating all apart from the most unstable patients, including those with heart valves coagulopathies. The anticoagulation clinics are held at 7 GP Practices within Bexley and also provide home visits for the housebound, thereby providing easy access for patients wherever they live in the borough.

Patients are referred from haematology to the community anticoagulation service when their international normalised ratio is in a stable range. The community service also receives referrals directly from cardiology and primary care. The service will initiate direct oral anticoagulants for appropriate patients or warfarin.

All patients are seen within 1-2 weeks of referral. The service has approximately 2,000 patients on their caseload and in 2018/19 88% of patients had a time in range greater than 60%. Patients are mostly seen by anticoagulation trained nurses (following initiation by anticoagulation nurse practitioner or GP), who work under the supervision of anticoagulation trained GPs in each practice, who in turn have access to a consultant haematologist on a daily basis.

Current challenges

- There is higher incidence of some lung diseases such as Chronic Obstructive Pulmonary Disease (COPD) in parts of SEL (e.g. Southwark) than the national average.
- Smoking rates are higher than the national average in parts of SEL; smoking cessation rates are lower in most of SEL than RightCare peers.
- The accuracy of existing COPD diagnoses is low in some CCGs / boroughs and unknown in others.
- COPD detection rates are lower than RightCare peers and the national average in all CCGs / boroughs.

We will deliver our vision and objectives through the following priority actions

We have already made significant progress in delivering our respiratory programme and we have an ICS clinical lead, who represents SEL at the London Respiratory Partnership Board. To design and oversee the transformation programme, we have established a SEL Respiratory Steering Group with both clinical and CCG representation.

We have mapped and reviewed existing services and gaps across six SEL CCGs / boroughs (summary of RightCare baseline assessment). We have considered best practice interventions and models of care and their feasibility for SEL.

Our plans build on best practice in SEL and incorporates the following priority actions:

1. Ensure accurate diagnosis of COPD and increase case finding

- Establish a baseline at borough level of accuracy of existing COPD diagnoses by establishing the percentage of patients who have a post bronchodilator spirometry showing FEV1/FVC <0.7.
- Work with general practice and PCNs to consider how to review all patients on GP practice COPD disease registers who do not have a post bronchodilator spirometry showing FEV1/FVC <0.7.

Our vision for the future

- People are empowered and supported to take control of their respiratory health and to take action on risk factors.
- Whole system working to detect, accurately diagnose and provide optimal treatment for south east Londoners with COPD and other respiratory diseases.

Our objectives

- Improve and ensure accurate diagnosis of COPD and other respiratory diseases, and increase case finding and early detection.
- Optimise the use of medicines and improve inhaler technique for asthma and COPD.
- Increase referrals to pulmonary rehabilitation and improve outcomes.

- Develop and adopt a SEL guideline for accurate diagnosis of COPD and other respiratory disease, including quality assured and Association for Respiratory and Technology and Physiology certified spirometry.
- Roll out virtual clinics and diagnostic/respiratory hubs at community/PCN level, building upon existing good practice in SEL. This forms part of our wider planned care strategy, which includes ensuring consistent community access in at least four specialties by the end of 2020/21.
- Increase COPD detection rates in line with the national average (65% reported to estimated prevalence) by 2023.

2. Medicines optimisation for inhaler use in asthma and COPD

- Primary/community/pharmacy annual medication reviews to include inhaler technique.
- Adoption and roll-out of existing SEL guidelines for management of asthma and COPD.

3. Improve access to pulmonary rehabilitation services

- By 2023/24, ensure 60% of people appropriately referred start, and 75% complete, a pulmonary rehabilitation programme.

- Increase referral rates into pulmonary rehabilitation through development and adoption of SEL standardised resource to educate and train on the benefits and who should be referred.

4. Deliver enhanced support for prevention

- We are committed to expanding the current offer related to smoking cessation, with a particular focus on the evidence based Ottawa model – but we need to work as a system to secure an affordable delivery model to support roll out (see also: [prevention and reducing health inequalities](#)).
- Facilitate opportunities to offer and improve digital platforms, and facilitate patient support / peer groups to support patients to self-manage their care / condition.

The impact is expected to be:

- Detection of c.14,000 more people with COPD.
- Reduced exacerbations of asthma / COPD and associated psychological impact.
- Improved health outcomes and quality of life for people with respiratory disease.
- Better control of disease as more people receive correct treatment and medication.
- Reduced risk of admission and length of stay if admitted.

To undertake our priority actions, we will require the following key enablers to be in place:

- Integrated and standardised services for prevention across SEL, at borough level under the guidance of the SEL Respiratory Steering Group and working in partnership with PCNs (see also: [integrated community based care](#)).
- Strong clinical engagement and buy-in across the whole respiratory pathway.
- Alignment of commissioning arrangements to ensure a consistent approach across SEL.
- Support to help embed new and existing SEL protocols into everyday practice.
- Data collection, sharing and evaluation to monitor impact / track progress, including in relation to improving health inequalities.

Case example

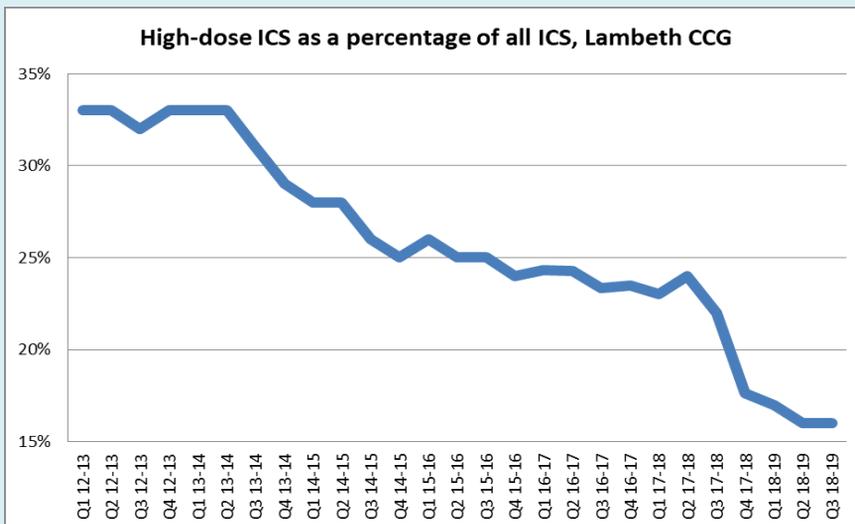
Virtual clinics and respiratory diagnostic hubs in Lambeth and Southwark

A study published in 2013¹ revealed that locally, there was overtreatment of COPD with inhaled corticosteroids. Findings included:

- Spirometry findings were inconsistent with COPD diagnosis in 35% of patients.
- Inhaled corticosteroids were prescribed outside of guidelines in 38% of patients.
- There was a lack of focus on high-value interventions (treating tobacco addiction; pulmonary rehabilitation).
- Overtreatment with inhaled corticosteroids could account for 12 additional cases of pneumonia and waste of >£500,000 per year.

In response, Lambeth and Southwark CCGs put in place specialist support to generalists in the primary care setting – in the form of **virtual clinics** – to provide skills and knowledge transfer focused on case reviews and education. This model offers system leadership to drive change, provided by an integrated respiratory team, consultant pharmacist and GP clinical leadership. The focus on specific objectives aligned to desired system outcomes has led to:

- Increase in high-value pulmonary rehabilitation interventions.
- Reduction in inappropriate inhaled corticosteroid prescribing.
- Admissions stable / reducing.
- Increase in asthma action plans.
- Increase in annual reviews.
- Increase in medicines adherence.
- Reduction in overuse of rescue therapy in asthma.



Lambeth and Southwark CCGs also commission a **respiratory diagnostic hub model**. This redesigned pathway offers embedded, community based, quality-assured diagnostic respiratory hubs to improve the quality and consistency of diagnosis of COPD and other respiratory disease. The hub model is complemented by the virtual clinics, which provide education on the need for quality-assured spirometry and correct interpretation.

1. White et al. Overtreatment of COPD with Inhaled Corticosteroids – Implications for Safety and Costs: Cross-Sectional Observational Study. PLoS One, 2013.

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0075221>

Heart disease and stroke care

Current challenges

- There are an estimated 9,446 people with undiagnosed heart failure in SEL.
- Average rate of cardiac rehabilitation uptake is 51% against the LTP's ambition of 85% by 2028.
- Out of hospital cardiac arrest survival rates following cardiopulmonary resuscitation vary across south east London.
- Access to thrombolysis for eligible patients is below target and below the national average in 3/6 boroughs; timeliness is below target in all boroughs.
- Nursing and rehabilitation support worker capacity within community stroke teams is lower than the national average.
- Recommended waiting times for community assessment for eligible patients following a stroke are met in two of our six boroughs.

Our vision for the future

- Higher detection rates for heart failure and valve disease through appropriate access to echocardiography in the community, and increased diagnosis in primary care.
- Improved quality of life and outcomes for people with heart disease through better access to and higher standards for cardiac rehabilitation.
- Improved survival rates for people experiencing cardiac arrest with a cardiac cause in community settings.
- Improved quality of life and outcomes for stroke survivors through the appropriate level and range of support being available seven days a week.

Our objectives

- Improve the detection and treatment of people with heart failure and valve disease.
- Improve stroke care, rehabilitation and outcomes.
- Build upon the work of existing networks and expertise in south east London.

We will deliver our vision and objectives through the following priority actions

1. Improve detection and treatment of people with heart failure and valve disease

- Consider how to promote adoption of the pan London heart failure diagnostic pathway to support increased and earlier detection of heart failure and valve disease outside of the hospital setting.
- Ensure consistent access to the recommended test for heart failure (NT-proBNP) across SEL.
- Participate in and consider recommendations of the forthcoming London Cardiac Clinical Network audit of echocardiography, which will look at appropriate access and usage in clinical settings including in the community.
- Review current workforce numbers and consider how to improve access to heart failure specialist nurses to allow patients to receive specialist care and advice in the community and following hospital admission.
- Increase the uptake of cardiac rehabilitation for

eligible people in line with the LTP ambition of 85% by 2028. Current SEL uptake is at 51% and completion rates at 70%.

- Encourage all cardiac rehabilitation services to input into The National Audit of Cardiac Rehabilitation and to participate in the London Cardiac Clinical Network service mapping process, to identify service improvement opportunities.
- Review commissioning arrangements for cardiac rehabilitation in SEL to ensure services are sustainable and meet population need based on LTP ambition of 85% uptake.
- Explore and address reasons for variation in the standard of cardiac rehabilitation services in SEL in line with the national standards set by the national Certification Programme for Cardiac Rehabilitation.

- Improve survival for cardiac arrest in community settings by working with partners to educate the public on cardiopulmonary resuscitation (CPR) and promoting use of public access defibrillators. Bystander CPR on witnessed cardiac arrests varies between 54% to 66% across the SEL boroughs (versus London average of 70% in 2016/17), and survival to discharge rates vary from 7% to 13% (versus London average of 9.5% in 2016/17).

2. Improve stroke care, rehabilitation and outcomes for stroke patients

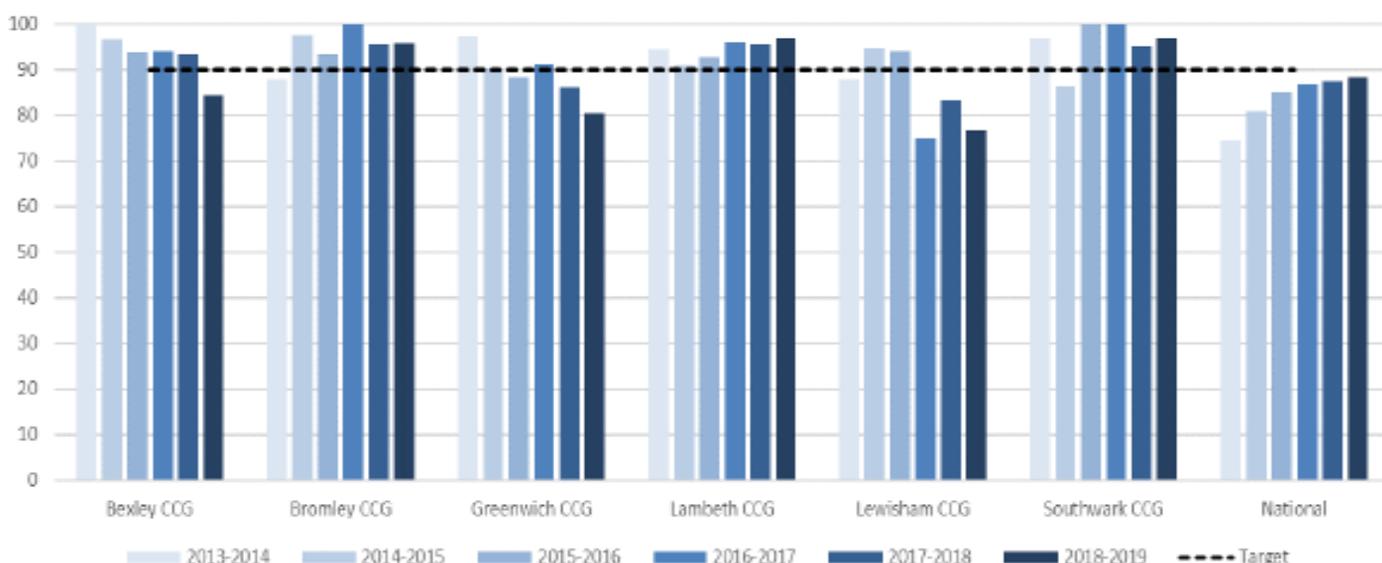
- Mechanical thrombectomy and clot-busting treatment (thrombolysis) can significantly reduce the severity of disability caused by stroke. The London Stroke Clinical Network is monitoring the performance of mechanical thrombectomy units and we will consider their recommendations to improve services.
- Develop plans for local services to improve access to thrombolysis in the three boroughs who in 2018/19 did not meet the 90% target (pan London stroke model) for the percentage of eligible patients given thrombolysis.
- The number of eligible people who received thrombolysis within 1 hour of having a stroke (pan London stroke model) deteriorated in 4/6 boroughs in 2018/19 and was below the national average of 62.3% in all boroughs. We will investigate this drop in performance

and develop corresponding improvement plans.

- Strengthen stroke rehabilitation by reviewing the staffing and commissioning of community stroke and early supported discharge teams. We know that the number of nurses and rehabilitation support workers available in SEL are lower than the national average. Additionally, some SEL services are set up to support stroke patients who only need one person to assist their rehabilitation, but not if they need more than one person, which is increasingly the case.
- Review current operating model for moving towards integrated community stroke rehabilitation services to ensure a consistent offer to stroke patients across SEL. This includes the referral to assessment target for people eligible for early supported discharge to receive a community assessment within 24 hours of leaving the inpatient unit, and access to vocational rehabilitation.
- Investigate accuracy of data provided to the Sentinel Stroke National Audit Programme (SSNAP) on stroke 6-month reviews in order to understand and address variation in performance across SEL.
- Collaborate with the pan London approach to Integrated Stroke Delivery Networks.

Percentage of eligible patients given thrombolysis

Data source: SSNAP



3. Build upon the work of existing networks and expertise in SEL

To help deliver the improvements needed in SEL in response to the LTP we will work more closely with our key partners as follows:

- South London Cardiac Operational Delivery Network.
- King's Health Partners Cardiovascular.
- South East London Vascular Network.
- South East London Stroke Operational Network.
- London Cardiac and Stroke Clinical Networks.
- London Ambulance Service.
- Third sector.

The impact is expected to be:

- Earlier and improved detection of heart failure and valve disease.
- Improved exercise capacity and quality of life for people with heart failure (following cardiac rehabilitation) and reduced hospital admissions.
- Improved survival rates for cardiac arrest with a cardiac cause in community settings.
- Reduced severity of disability and complications caused by stroke.
- Improved outcomes for stroke survivors, including more people returning to work or gainful occupation, and reduced hospital readmissions.

To undertake our priority actions, we will require the following key enablers to be in place:

- We have started to work with key partners to identify which of these challenges and priority actions are already in hand, and those that will need additional transformation support. We plan to build and maintain more effective partnership working with our key stakeholders, including patients, and agree a high-level milestone plan for delivery against the LTP.

Current challenges

- High and increasing prevalence of diabetes in SEL. The estimated prevalence of diabetes (undiagnosed and diagnosed) is 8.9% in SEL, compared to 8.5% nationally. Within SEL, Lewisham has the highest (9.8%), while Bexley has the lowest (8.2%) (Source: Public Health England, 2017).
- Longstanding unmet health need and growing obesity, creating significant numbers of those at risk; obesity rates are higher than the national average in four of our six CCGs.
- Inconsistent and disparate services across SEL, including prevention and care for diabetes.
- Significant variation in health outcomes for people with diabetes across SEL.

Our vision for the future

- Improved health outcomes with a reduction in health inequalities across SEL.
- People with diabetes to experience fewer complications through high quality, integrated care across each step in their care pathway.
- SEL to continue to lead innovation and service developments for diabetes.

Our objectives

- Ensure consistent and joined up prevention and service provision across SEL.
- Target the current health inequalities and reduce variation.
- Establish a whole system response to the Vital 5 and achieve a reduction in Type 2 diabetes.

We will deliver our vision and objectives through the following priority actions

1. Expand our Type 2 diabetes prevention (see also: **prevention and reducing health inequalities**)

- Expand the capacity of the NHS Diabetes Prevention Programme, Healthier You, across SEL in order to double the number of people attending the NHS Diabetes Prevention Programme.
- Each borough to implement local diabetes prevention pathways, e.g. Southwark, Greenwich and Lambeth community developed interventions (including Walking Away from Diabetes; sports club focused groups targeting working age men and women).
- Deliver a targeted approach to reach those patients who have not previously been accessing the 12 month course with primary care, identifying specific population groups who would benefit from referral to the Healthier You prevention programme.
- Expand the referral routes beyond primary care in line with the ambition of NHSE&I to open up referral routes for diabetes prevention to employers and secondary care.
- Deliver a diabetes prevention programme for those post gestational diabetes.
- The patient voice data collected across London will guide the diabetes strategy with patients

highlighting self-management support and the need to generate confidence and trust in the care provided.

- Patients tell us that they want to take more control of their diabetes whilst in hospital and that we need to provide better food and portions at better times; this will form an essential component of our inpatient strategy work.
- GSTT are already working to improve the meals and meal delivery times for diabetes inpatients; we plan to build on this directly as a result of patient feedback.
- South east London has developed a test environment for very low calorie diets for obese people with Type 2 diabetes, based on the success of recent randomised control trials, DiRECT and DROPLET, which showed encouraging results in weight loss and a reduction of HbA1c. The intervention consists of total diet replacement products with a support package to encourage weight stabilisation and maintenance of weight loss.

The impact is expected to be:

- Numbers of people developing Type 2 diabetes to become static or decrease.
- Reduction in the number of women with gestational diabetes developing Type 2 diabetes.

2. Innovative technology projects and structured education to support patients in making their own decisions on managing their health

- Introduce and promote HeLP, the digital education tool and management tool for people with diabetes.
- Launch self-referrals, eye screening referrals and Type 1 pathway for Diabetes Book & Learn, and electronic bookings for Type 1.
- Pilot and evaluate Think Diabetes phase 2 with local authorities, London Ambulance Service and Transport for London (TfL).
- Deliver HEAL-D, a self management programme for the Black African and Caribbean population which is informed by the culture and diet of this population. The aim is to increase the number of Black African and Caribbean people who are self-managing their diabetes.
- We know that patients with diabetes with black and Asian ethnicity have a higher risk of being diagnosed with diabetes, experience the condition earlier and complications develop at a younger age. With targeted self-management programmes we can address this inequality.
- The diabetes Book & Learn services enables working across a large geography and sharing resources so we can provide targeted services to a diverse population. Our aim to reduce this inequality begins by educating our BAME population in self management and prevention of diabetes (see also: [personalised care](#)).
- The HEAL-D programme starts in March 2020 in a phased approach, beginning in three of the SEL boroughs, Lambeth, Southwark and Lewisham, to understand how the initiative works in a real world situation following the pilot. Once the programme has been established it will be available in the remaining boroughs from late 2020 / early 2021.
- Feedback from our patients who have attended our local prevention programmes has been positive with further education and practical sessions being requested.
- Our current offer will be enhanced and available across all of SEL with more information and education on food choices, exercise and managing diabetes via workshops and group based initiatives.

- More people who are at risk and or diagnosed (particularly for hard to reach groups) educated to understand how to reduce the risk of getting diabetes or in managing their condition.
- Improvements in equality of access and personalised care by increasing menu of diabetes education options; particularly targeting higher risk groups like the working age and BAME groups, people with learning disabilities and people with serious mental illness.
- Improved diabetes outcomes for pregnant women with Type 1.

3. Integrated, efficient services that provide a standard, high level of treatment and care

- The use of data and particularly outcomes data highlighting variation will be used across all ICSs / STPs to understand and reduce variation. This is much more possible now; with national audits there is a commitment to driving participation in all national diabetes audits. LHCRE will add even more to this (see also: [digital](#)).
- Information available across primary and acute care via the National Diabetes Audit for Primary Care and the National Diabetes Inpatient Audit allows variation to be identified and understood. Learning from the work undertaken to improve diabetes treatment targets will be spread to practices where there is identified need.
- Working across London via the diabetes clinical networks, including the London Diabetes Inpatient Network Steering Group, supports the sharing of learning and allows projects and developments for improvement to be adopted quickly and efficiently. The learning from South West London and North Central London's work on employing and training diabetes inpatient specialist nurses (DISNs) will be used to strengthen and widen the skill base of staff in SEL.
- Understanding the impact of the initiatives in other STPs on length of stay and readmissions will support the development of the SEL workforce, directing focus on the most effective areas for attention.
- Develop the DISN network with training and peer support to develop our staff and encourage retention within SEL. We already have full coverage of DISNs across the trusts; we are eligible for wave 2 of NHSE&I transformation funding in this area and will use this to upskill our current staff and future proof our workforce.

The impact is expected to be:

- Identify gaps and variations in service delivery across SEL.
- Establish a clinical network to share good practice and learning from GIRFT.
- Baseline mapping of availability and adoption of medical technologies with a plan for spread and embedding to reduce inequity.
- Improve patients' eight care processes and three treatment targets:
 - Roll out the Clinical Effectiveness & Standardisation of Treatment Programme to other boroughs across SEL, building on the work undertaken in Southwark to provide guidance on treatment, care and referral pathways for diabetes.
 - Expand the Year of Care training currently available via the You & Type 2 digital pilot programme in 13 practices across three boroughs.
 - Respond to Vital 5 priority areas for management, adopting a population approach to health management to reduce the health impact of diabetes (see also: [prevention and reducing health inequalities](#)).
- Implement universal access to a multidisciplinary foot care team across SEL within 24 hours of referral, six days per week.
- Recruit navigator posts across SEL foot network with one referral pathway.
- Support primary care services to develop dedicated care plans that are underpinned by social prescribing (see also: [integrated community based care](#) and [personalised care](#)).
- Expand "You & Type 2" initiative in primary care.
- Provide access to emotional and mental health support to those who need it and ensure that those with serious mental illness have access to specialist diabetes treatment, support and care.
- Improved health outcomes for those with diabetes including reduced length of stay, reduced amputations, reduced readmissions and improvements in patients' treatments targets.
- Integrate pathways of care, ensuring patients are seen by the right specialist, avoiding duplication.
- Maximise community assets to improve outcomes for people with diabetes.

- Reduced variation in service delivery and outcomes across SEL.

To undertake our priority actions, we will require the following key enablers to be in place:

- A programme of work that covers the end to end service delivery across all partners in south east London.
- A culture of joint working.
- Agreement from clinical leaders to prioritise change in this area.

Case examples

Diabetes prevention

The NHS Diabetes Prevention Programme continues to have high referral rates with a total of 1,057 referrals made to the programme so far in 2019/20, with a forecast year end referral total of 3,171 like for like. With identification initiatives being planned to target ethnic groups, south east London is planning to increase the referral rate of 4,420 from 2018/19. Conversion rates this year have increased, with 45% of referrals being converted to attendances.

Education support package for at risk groups

- A range of introduction courses and education sessions for patients at risk of diabetes are available across SEL. These are short courses that often encourage people to attend structured education. The courses can be locally developed or can be national initiatives such as Walking Away from Diabetes as a precursor to DESMOND (a training course for people with Type 2 diabetes that helps people to identify their own health risks and to set their own goals).
- SEL has established a digital and call-centre booking service, Book & Learn, which allows patients a choice of education provider and location across 12 boroughs. Up to date health information is shared digitally with course provider and collected 12 months post completion to aid analysis. See also: [personalised care](#).

Case examples

Support patients to self manage: You & Type 2

SEL has established the You & Type 2 pilot programme, enabling patients to hold their care plan that incorporates information added by the patient themselves. 13 practices across Lambeth, Lewisham and Southwark have been trained in the 'Year of Care' care planning principle that gives patients the capability of designing their care plan. Software has been developed to capture the care plans, enabling patients to hold these themselves. Personalised videos encouraging and informing patients have been developed. Referrals to virtual patient education has begun. A digital app will be available where patients can access their diabetes health data and links to support networks and groups putting the patient at the centre of their care. The initiative is expected to increase patients' involvement in their care to ultimately improve their treatment targets and reduce the impact of diabetes in the long term.

Financial assumptions, return on investment and downstream impact

CVD, heart disease, stroke, respiratory disease, diabetes

- Our assumption is that our planned actions across these major conditions will result in a return in investment and downstream impact – through the early identification of risk, targeted intervention and reduced acute utilisation and the stabilisation of disease / disease progression.
- We continue to undertake further work to assess the expected impact of our actions, noting that community based care investment will be covered from the application of national planning assumptions and that benefits will form part of the overall UEC and planned care benefits realised.
- In overall terms, whilst acute cost may reduce, our expectation is that effective population health management with regards these major conditions will result in increased overall cost through the establishment of proactive risk stratification and early intervention and care coordination and case management.

Learning disabilities and autism

Current challenges

- **Healthy lives:** nationally life expectancy for people with learning disabilities can be 14-18 years lower than the general population. In addition, up to 40% of people with a learning disability in England report difficulties in using health services, versus just 18% of the general population.
- **Supporting independence:** delivery of more consistent and high-quality community based care is needed to keep people with learning disabilities and / or autism as healthy and independent as possible, in their homes. In January 2019, there were 55 SEL adults per million and 20 SEL children per million receiving care in hospital, compared with the LTP ambitions of 30 and 15 per million respectively by March 2024. Housing presents a further challenge due to differing strategies across boroughs.
- **Sustainable care organisations:** analysis of 2017/18 SEL adult data shows that the average package of care costs 66% more (£50k) in a specialist hospital than in the community. By commissioning innovative services more collaboratively, we can ensure that more people are cared for in the community, and the cost of the average package of care is reduced.

Our vision for the future

For people with learning disabilities and / or autism to achieve equality of life chances, live as independently as possible and to have the right support from mainstream health and care services.

Our objectives

There are approximately 8,000 people with learning disabilities and 17,000 people with autism in SEL. Our objectives for people with learning disabilities and / or autism are to:

- Reduce long term inpatient care, through improved admission prevention interventions and enhanced discharge pathway planning; we will work towards meeting the LTP ambition for inpatient care.
- Improve quality of life and / or care, through improved care facilities and care delivery, focus on repatriation to home borough (where appropriate) and increase involvement in care and treatment decisions.
- Ensure the right support is in place to enable and enhance community living experience through community services and support, while recognising the importance of community resources, employment and opportunities to promote independence.

We will deliver our vision and objectives through the following priority actions

1. Early intervention and admission prevention

- Implement more effective diagnostics for children and young people and families.
- Embed standard operational procedures (e.g. standardised templates) to increase use of dynamic support registers; dynamic support registers are used to support people of all ages in the community and to raise concerns around the safety of a person, so that actions can be taken to reduce the risk of hospital admission by effectively utilising the Care (Education) and Treatment Review (C(E)TR) process.
- Improve the numbers of annual health checks for people with learning disabilities (and autism in due course) and ensure physical health checks are given to at least 75% of people aged 14+; current

performance is variable and challenging across SEL with some boroughs nearer to the 75% than others.

- Ensure appropriate medication and treatment, through the Stopping Over Medication of People With a Learning Disability Programme / Supporting Treatment and Appropriate Medication in Paediatrics Programme.

The impact is expected to be:

- More people with learning disabilities and / or autism will feel proactively supported in the community, through early identification, assessment and intervention (from a range of clinical and non-clinical options).
- Reduced A&E attendances and admissions to mental health and specialist hospital for people with learning disabilities and / or autism.

2. Deliver coordinated care for people with learning disabilities and / or autism

- Develop and strengthen links within the wider ICS and regionally, for example with lead provider collaboratives and programme boards.
- Continue to deliver case management via two case managers; their role often involves:
 - Co-ordinating care by bringing together all those responsible for Care, (Education) and Treatment Reviews.
 - Co-ordinating discharge of CCG inpatients to the community.
 - Liaising with and reviewing provider services.
- Develop local pathways for people with special educational needs and disability.
- Continue to enhance data management to inform decision-making, e.g. detailed reviews (deep dives) on a specific groups of patients, with a view to establishing realistic discharge dates.
- Make reasonable adjustments and use ‘digital flags’ in response to particular needs of individuals.
- Explore how to pilot new “keyworker” roles for CYP with the most complex needs and their families.
- Deliver Learning Disabilities Mortality Reviews, learn from the findings and implement good practice.

The impact is expected to be:

- Improved experience of care for people with learning disabilities and / or autism, as care will be coordinated across health and care providers, schools and police.
- Improved C(E)TR performance.
- Increased involvement of people with learning disabilities and / or autism in decisions around their care.
- Reduced A&E attendances and admissions to specialist hospitals for people with learning disabilities and / or autism.

3. Commissioning to improve community capacity

- Roll out community autism service: continue to conduct two pilot specialist autism support services for people in south east London (hosted by Oxleas and SLAM); assuming pilots are successful, commission providers to embed the new model.

- Expand intensive, specialist community based services for adults with a learning disability and / or autism.
- Continue to work with local authorities across South London and via the South London Partnership to provide targeted support for people with complex care needs, using a pooled budget (e.g. for housing solutions).
- Continue to work with South London Partnership Community Forensic Services; SEL worked in partnership with NHSE&I to develop the South London Partnership Community Forensic Services model which is now mobilised.
- During 2020/21, employ a CYP Lead (0-25) to support patient care and admission prevention; specifically, case management and benchmarking.

The impact is expected to be:

- Improved community capacity, which will reduce reliance on inpatient provision.

To undertake our priority actions, we will require the following key enablers to be in place:

- Workforce transformation – collaboration with workforce specialists to ensure south east London learning disability / autism spectrum disorder health and care providers have access to the correct workforce capability and capacity to provide quality care services.
- Communications and engagement – proactively engage with south east London service users, their families, commissioners and providers to raise awareness of the learning disabilities and autism programme, increase participation in the programme and shape future activities.
- Continuing to work in partnership with local authorities and provider collaboratives.
- A named Senior Responsible Officer to oversee local implementation of LTP ambitions.
- Management and analysis of data for assurance and development of commissioning intentions.
- Case management functions to ensure quality patient care and prevent avoidable admissions to hospital.
- Commissioning resource and arrangements across the six boroughs and place-based partnerships.

- Learning disability and autism lead roles across SEL to support patient care and local and place-based service delivery.

Financial planning assumptions

Funding to support our learning disabilities and autism objectives will be secured through our overall allocation uplifts, as required. We will also support the release of funding for reinvestment in local learning disability services as we redesign our service offer to provide support and placements closer to home.

Children and young people's outcomes

Current challenges

- Increasing numbers of CYP in vulnerable groups, with greater risk of health and wellbeing needs (e.g. 'looked after' children, young carers, those in poverty, those with long term conditions).
- High rates of hospital admissions for CYP with mental ill-health and some long term conditions (asthma; epilepsy).
- Variation across SEL in access to key services, such as community CYP health teams.
- Recruitment, retention and upskilling of community nursing, mental health and learning disability workforce.
- Child obesity and excess weight is a significant issue (SEL is above the national average).
- A number of fragmented and duplicated specialised services.

Our vision for the future

To give every child the best start in life. A healthy, happy and well supported start in life will help to ensure that children go on to be healthy, happy adults. Our aim is to improve outcomes and reduce health inequalities for all those aged 0-25 through system change and leadership that impacts on:

- Better physical and emotional support for families.
- More joined-up and consistently excellent health and care services.
- Easy access to the right services first time.

Our objectives

- Deliver effective mental health and wellbeing services with improved access to support in schools, crisis provision and 0-25 service.
- Develop networked services to support children with LTCs (epilepsy, diabetes and asthma) and integrate multidisciplinary community health services around these children.
- Improve access to assessment and support for CYP with learning disabilities and autism.
- Ensure access to consistently high quality specialised services.
- Stronger focus on prevention and early intervention to improve outcomes and reduce health inequalities.

We will deliver our vision and objectives through the following priority actions

1. Expand children and young people's mental health services

Concerns were also raised about the difficulty of accessing child and adolescent mental health services (CAMHS) and the need for better integration and communication between schools and NHS services to address this. – Kaleidoscope engagement report

- Pilot models of care for a comprehensive mental health offer for 0-25 year olds that reaches across mental health services for CYP and adults. This will be done via an incremental plan, co-produced with young people and professionals, rooted in the communities they serve and implemented jointly across different types of providers.
- Widen access to CAMHS to ensure at least 35% of CYP with a diagnosable mental health condition

receive treatment from NHS-funded community mental health services, including improved access to support in schools. Mental health support teams in schools are currently being developed in three boroughs (Bromley, Greenwich and Lewisham) and all boroughs are taking preparative work to expand and embed this programme.

- Deliver initiatives to reduce CAMHS waiting lists; we have dedicated funding to enable this. This includes trialling a 4-week waiting time pilot and co-designing new approaches with CYP and families to reduce missed appointments and provide early interventions.
- Widen the mental health workforce; we are on course to deliver an increasing workforce trajectory that will be in excess of the anticipated posts needed by 2021 (anticipated by Health Education England). In particular we will focus on

increasing workforce capacity and capability to enable us to:

- Expand access to CYP IAPT.
- Extend our current service models to create a comprehensive offer for 0 to 25 year olds.
- Continue to achieve and maintain the CYP eating disorder standard and build capacity to improve self-harm and crisis services.
- Continue to review and develop the digital support offer such as the online mental health support service which is currently available to all CYP 10 years+ across SEL.
- Regularly refresh our CAMHS transformation plans to ensure partners are aligned and committed to a whole system approach to improving CYP mental health and reducing health inequalities.
- The South London Partnership (a provider collaborative) has successfully developed a new model of care for CYP presenting in crisis or needing help to manage or prevent further crisis presentations. Many more children now receive inpatient care close to home with a minimal length of stay. Work will continue to develop 24/7 crisis support and intensive home treatment to reduce inpatient stays further and provide personalised care.
- Align CYP mental health work programme with plans for CYP with learning disability, autism, special educational needs and disability, children and young people's services, and health and justice.
- Promote good mental health and intervening early when problems first arise. Provide choice about where CYP can get advice and support such as in schools and colleges, digital interventions and alongside physical health services.

The impact is expected to be:

- More CYP will be able to access mental health support where and when they need it, regardless of their age or diagnostic profile.
- Young people will feel supported in the transition from CAMHS to adult services.
- Reduce avoidable A&E and emergency admissions for CYP in crisis, inappropriate out of area placements and length of inpatient stay.

2. Developing networked services to support children with LTCs (epilepsy, diabetes and asthma) and provide integrated multidisciplinary

community health services

- Test and further develop our models of care that provide person centred and age appropriate healthcare for CYP up to 25 years. This includes the provision of integrated community teams of mental and physical health professionals covering a range of services to support children and their families closer to home. Continue building evidence base for models (such as the Evelina London Children & Young People's Health Partnership which works in partnership with primary care) to give families additional support in managing long term conditions in CYP.
- Develop clinical networks for long term conditions. We recently established a SEL asthma network which will work closely with the pan-London network. The networks will share best clinical practice, supporting the integration of paediatric skills across services and bespoke quality improvement projects.
- We recently set up a south east London CYP Transformation Board to provide system wide leadership for the delivery of the CYP programme with a view to achieving the delivery of high quality, evidence based, clinically effective and cost-efficient services.

The impact is expected to be:

- Reduced avoidable A&E attendances and emergency admissions.
- Reduced inpatient admissions and bed days.
- Improved experience for professionals and families.
- Prevention of future health problems.

3. Meet the needs of children and young people with learning disabilities and autism

Our plans to deliver this priority are set out in our section on [learning disabilities and autism](#).

4. Meet the needs of children and young people for specialised services

- Improve access to high-quality treatment services, including roll out of radiotherapy networks, strengthening of CYP cancer networks, and reform of MDT meetings. See also: [cancer](#).
- Strengthen networks for CYP specialist services, including cancer, specialist surgery, critical care and congenital heart disease.

- Ensure that specialist services meet national standards for co-location and care.

5. Work with Public Health to improve prevention (see also: **prevention and reducing health inequalities**)

- Deliver improvements in childhood immunisation rates to reduce health inequalities.
- Support vaccination of all boys aged 12 and 13 against HPV-related diseases, such as oral, throat and anal cancer.
- Review the support offer for treating obese children and severe obesity related health complications, and develop plans to increase capacity and access to weight management services by 2021-2023. CYP weight management services are not currently available in all boroughs.
- Youth violence including knife crime is a rising urgent problem. We will work collaboratively with partners to develop and implement effective ways of reducing violence.

To undertake our priority actions, we will require the following key enablers to be in place:

- Secure continued increasing investment into CYP mental health and emotional wellbeing services and support.
- Joined up commissioning and innovative use of budgets across partners where appropriate.
- Engagement and co-production with local communities.
- System leadership.
- A workforce with a wider and flexible skillset.
- Alignment of the South Thames Paediatric Network and other specialised service networks for CYP.
- Support for the development of specialised services, including cardio-respiratory services, at an expanded Evelina London Children’s Hospital.
- Support in evidencing impact and evaluating services.

Case example

The Well Centre, Lambeth

The Well Centre provides an open access service that provides a holistic approach to young people’s mental and physical health issues. The service is delivered by a partnership between statutory and voluntary sectors (primary care, youth health charity and CAMHS). A panel of young people actively input into service design, decoration and use of space, registration design and proto-typing of journey through the service.

The centre has developed an assessment to proactively identify mental health concerns in young people. It is open for “drop-in” three afternoons a week (3:30pm-7pm), staffed by a GP (adolescent health experienced), two youth workers and Band 7 CAMHS nurses. Young people can drop in or book an appointment.

There are youth work outreach activities at other times – including regular counselling sessions in schools, school assemblies and young people’s activities (e.g. Girls’ Group).

There is multiagency working between schools and colleges, parents, youth participation ambassadors, local authorities, voluntary sector, primary care, adult mental health education and training and hospital trusts.

Results

For the year 2017/18:

- 705 young people seen by at least one professional (e.g. GP and youth worker and / or a mental health practitioner).
- 55% of new patients were peer to peer referral, or self-referral.
- 88-100% user satisfaction scores over the last 2.5 years.
- 46% reported improved self-esteem and emotional wellbeing in 2017/18.

Financial assumptions, return on investment and downstream impact

We will invest in children and young people's services in line with national planning assumptions over the next five years, utilising a combination of the designated allocations for primary care, community services and mental health, our acute budget allocations plus any appropriate additional LTP allocations. Funding will be allocated to secure the Long Term Plan and local objectives and outcomes. We are not yet at the stage of having a costed plan and will be focusing on this over the next couple of months, with a specific focus on years 2 and 3. Our objectives are as follows:

- To ensure that our planned investment is driven by implementation and delivery plans to secure our agreed objectives.
- To ensure that we establish a benefits realisation plan to demonstrate return on investment, including monitoring and evaluation mechanisms. We recognise that in some areas our community based care investment in children and young people's services will reduce pressure on hospitals and may reduce cost, though the overall system cost base may not reduce.
- To ensure that we are also able to demonstrate improvements in productivity and efficiency and pathway transformation within our children and young people's service offer.

Current challenges

- Rising rates of pregnant women within SEL with medical complexities including diabetes, obesity, smoking related risk factors, cardiac disease, assisted conception and mental health needs, pose significant challenges around clinical resource and outcomes. The 2018 MBRRACE report (2014-2016) showed the direct causes of maternal death as 1) thrombosis; 2) haemorrhage; 3) suicide and indirect causes of death through cardiac disease and cancer.
- Services not fully meeting the needs of our diverse community of mothers and babies and those of our most vulnerable families who may be facing significant challenges such as domestic violence, homelessness and immigration concerns. Black women are five times and Asian women twice as likely to die in pregnancy and childbirth compared to white women.
- Workforce challenges, including recruitment, retention and training. Local strategic maternity workforce planning is required in all areas of the workforce (midwives, obstetricians, support workers and pelvic health physiotherapists). The Local Maternity System is the lead for maternity workforce issues with the support of ICS workforce colleagues and HEE teams.

Our vision for the future

The Local Maternity System will continue to deliver the extensive SEL Better Births plan, ensuring that mothers, babies and their families in SEL experience joined up, high quality care during and after their pregnancy. They are supported to make choices that are right for them and be provided with safe care that supports a good outcome.

Our objectives

- Meet the Halve It ambition to reduce stillbirth, neonatal mortality, serious brain injury and maternal death by 20% by March 2020 and 50% by 2025, and preterm births from 8% to 6%.
- Meet continuity of carer targets of 35% by March 2020, 51% in 2021 and 75% in 2024 for BAME women and those most vulnerable.
- Implement public health strategies to improve contraception, pre-conception care, breastfeeding, and pelvic health.
- Continue our work on choice and personalisation; all women to have a personalised care plan (PCP) by March 2021. To finalise our SEL 'choice offer' and increase births in midwifery settings.

We will deliver our vision and objectives through the following priority actions

South east London maternity services

The maternity services in south east London provide care to over 25,000 women. The three NHS trusts providing maternity care are:

- Guy's and St. Thomas' NHS Foundation Trust.
- King's College Hospital NHS Foundation Trust.
- Lewisham and Greenwich NHS Trust.

South east London neonatal services

There is neonatal service provision at all five sites within the three SEL acute trusts:

- GSTT – Neonatal Intensive Care Unit.
- KCH – Neonatal Intensive Care Unit at Denmark Hill and Special Care Baby Unit at Princess Royal

University Hospital.

- LGT – Local Neonatal Unit at both University Hospital Lewisham and Queen Elizabeth Hospital.

Women and families from Bexley, Bromley, Greenwich, Lewisham, Southwark and Lambeth access care at the hospital trusts, with care also being provided to many women who live outside of the SEL boroughs.

South East London Local Maternity System (LMS)

Formed in 2017 the LMS has wide stakeholder membership, including clinicians, commissioners, service users and local authorities.

SEL has a diverse population of 1.9 million, which is predicted to increase by 9.5% over the next 10 years.

The number of people from BAME groups ranges from 19% in Bromley to 46% in Lewisham and four out of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) ranking amongst the 15% most deprived.

In response to the National Maternity Review and the subsequent Better Births report, the LMS created the SEL Better Births implementation plan and this was submitted to NHS England (as it then was) in January 2018. A refresh of the plan was submitted in September 2019.

To support implementation of the SEL plan several workstreams are in place focusing on the individual aspects of delivering the national and local Better Births plan. These are:

1. Continuity of carer.
2. Choice and personalisation.
3. Maternity Voice Partnerships.
4. Halve It and newborn.
5. Public health.
6. Sharing and learning.

Workforce and digital are oversight groups.

1. Continuity of Carer (CoCarer) – The LMS aims to provide guidance and support to trusts for the implementation of continuity of carer, to meet the national targets and improve outcomes for women, babies and families within SEL.

Continuity of carer is set out in Implementing Better Births: *Continuity of Carer as meaning each woman has consistency of midwife or a team of not more than 8 midwives throughout the antenatal, birth and postnatal period. She has a named midwife who takes responsibility for coordinating her care throughout all these three phrases and has a midwife she knows at the birth. The woman is enabled to develop an ongoing relationship of trust with her midwife* (Sandall 2018).

The journey so far has focused on how SEL can reach the national ambition using models of care that are workable and sustainable within the current financial climate. An emphasis has been put on all continuity models within SEL providing continuity throughout the maternity pathway.

With each of the five sites at various stages of the process it has been recognised that a whole service change is required.

CoCarer training has been provided to several staff groups within the trusts, which alongside staff surveys and system reviews has enabled the exploration and formation of feasible action and implementation plans.

In March 2019 9.4% of women within the LMS were booked on to a CoCarer pathway, with KCH Denmark Hill offering CoCarer above the national ambition at

25% and GSTT at 14%.

The expansion of provision of CoCarer across SEL through the introduction of additional midwifery continuity of carer teams started in September 2019 at KCH and LGT. Further teams are being established throughout 2020/21 including within our areas of highest deprivation.

Currently the LMS is working with the integrated care system, the trusts and public health to map lower-layer super output areas and ethnicity data to get a better understanding of where the highest levels of deprivation are, and which groups this affects, with a focus on the most vulnerable and women from a BAME background. We have geographical based caseloading teams that started at the end of 2019 with plans for a steady increase over the next 18 months to support better outcomes for these groups of women and their babies.

Initial estates planning has commenced to support the formation of further continuity teams. All trusts have implementation plans up to the 51% national ambition and a trajectory has been produced for the LMS accordingly. We have drawn on learning from the early adopter sites of NWL to plan the birth centre continuity models across our sector.

We have strong links with SEL Maternity Voice Partnerships (MVPs; see below) with representation on the LMS continuity of carer workstream. We plan to continue to work with our service users to assess, plan and evaluate out continuity models.

The impact is expected to be:

- 35% of women to be booked on to a continuity pathway by March 2020.
- 51% of women to be booked on to a continuity pathway by March 2021.
- 74% of BAME women and those most vulnerable to be booked on to a continuity pathway by March 2024.

2. Choice and personalisation – We are working in partnership with clinicians, commissioners, local authority and MVP representatives to widen and improve a woman’s choice (see also: personalised care).

SEL offers all 3 options of place of birth – birth centre, home and hospital based. 66% of women are now offered a personalised care plan at their booking, a significant increase from the previous 0% reported at the end of 2018, with the plan to have the same maternity PCP format across SEL.

Feedback from a PCP stakeholder event is providing the basis of the SEL choice offer in the form of a Directory of Service, which is currently in advanced planning stages with plans to launch by the end of 2019/20.

The LMS is working on enhancing the choice offer for women and families by translating our Directory of Service into the top five spoken languages within SEL and producing an animation of the offer, providing visual information for women and families where English is not their first language, where there are literacy difficulties and / or language difficulties.

Learning from NHSE&I pioneers highlights the importance of a quality choice conversation with women and the use of motivational interview training to enhance quality and understand the effects of personal bias, and the use of positive language to assist a meaningful choice conversation with the woman. The workstream has commissioned 3 Motivational Interview training days for midwifery and support staff.

Our trusts have committed to increasing midwifery led births across the LMS with birth centre continuity teams planned at all three trusts and a commitment from the Directors of Midwifery to increase midwifery led unit (MLU) births from our current 15% to 20% by March 2021.

The impact is expected to be:

- Provide integrated and personalised maternity care across the whole pathway.
- SEL written and animated choice offer to be available to all women.
- All women to have a personalised care plan by March 2021.
- All women to receive cohesive information about their maternity choices.
- MLU births to increase to 20% by March 2021, together with additional continuity teams facilitating an increase in SEL of women giving birth in midwifery settings.

3. Maternity Voice Partnerships – Each of the 6 boroughs within SEL has a Maternity Voice Partnership. The LMS has an MVP Chair workstream that is planning the implementation of LMS funded, MVP led projects to further enhance co-production across the sector and meet the Better Births and LTP ambitions. The valuable contribution of the MVP members is recognised by the SEL LMS with continued co-production a priority for all current and future work.

We have MVP Chair representation at LMS meetings and five workstreams of the Better Births plan have MVP representation. The MVPs have participated in a number of “Whose Shoes” events including those about Down Syndrome, diabetes and smoking cessation. More events are planned for 2020.

All MVPs are using their local development plans to share the knowledge and experiences of local women and to incorporate these experiences and feedback into developing MVP-led LMS projects. Current projects planned are a perinatal support project led by Bexley MVP, a postnatal buddy system project, and currently under discussion is how a project could support and enhance the experience of BAME women.

We are working with the MVP and our SEL trusts to gain further insight into trust CQC survey results, and we are using MVP social media pages to raise women’s awareness of the importance of their feedback in improving services and to signpost women to where and how to give their feedback.

The impact is expected to be:

- Continued co-production of maternity care within SEL.
- Continued feedback from women and families regarding maternity services in SEL.

4. Halve It and newborn – LMS partners including clinicians, user representatives, commissioners and service user voices are working together to deliver the Halve It ambition. We have a specific focus on preterm birth, stillbirth and asphyxia, newborn care and maternal mortality and morbidity.

Co-production with clinicians, commissioners and user representatives with LMS funding has supported the recruitment of a pre-term midwife champion for each of the five sites. They are working to continue to embed the successful PRECePT model of care, review current pathways, including pre-term clinics and implementation of the pan London in-utero transfer guideline, and to ensure that very premature babies (<27 weeks) are born within a hospital that has a neonatal intensive care unit. The London in utero transfer guideline is already ratified for use in one trust with the other two trusts currently working their way through the ratification process.

Implementation of Saving Babies’ Lives Care Bundle (SBLCB) Version 1 has taken place, with planning in progress for implementation of Version 2 through gap analysis and LMS wide workshop meetings, the first of which took place in December 2019.

There is variation in the practice of fetal monitoring and competency assessment for staff caring for women in labour across the LMS, and the LMS will welcome the launch of the clinical network fetal monitoring toolkit to provide guidance for the future.

LGT has the lowest benchmarking rates for hypoxic ischemic encephalopathy in the whole country. This success is due to the robust fetal monitoring pathway of care that they have in place, including fetal monitoring training with competency assessment and support within the clinical areas from fetal wellbeing midwives and the obstetric workforce.

Use of and interpretation of ECGs was recognised as an area that health professionals in SEL required further training in, therefore LMS funding has enabled the recruitment of an ECG champion at all five sites who will receive training and updating from an obstetric physician and cardiologist, which will enable them to train their colleagues within each hospital site.

All trusts have ATAIN action plans that have been signed off by the Neonatal Operational Delivery Network and all three trusts have been part of the MatNeo programme of work.

The subgroup is currently planning to review hypoglycaemia and jaundice pathways to establish if a standardised approach can be achieved across SEL.

SEL LMS has strong links with the Neonatal Operational Delivery Network and the ICS will work together with neonatal services, with targeted funding, to support the expansion and improvement of neonatal critical care services, data collection and sharing, further developing allied health professional support and support for families to become involved in the care of their baby whilst on the neonatal unit.

Less than 6% (national target) of term babies born are admitted to neonatal care in SEL.

The perinatal mortality review tool is in use at all three trusts, with plans to utilise the tool's data to acquire a more accurate picture of stillbirths within the LMS.

Recognition that labour ward culture has a big impact on the safety culture within a trust has prompted the plan to roll out five full day study sessions at all five sites around human factors, situational awareness and escalation. A number of staff within the trusts have already received a variety of training around this subject, but the plan is now for an LMS wide approach.

A SEL maternal medicine network working group was formed in July 2019, with the next step to express interest in SEL being an area for a maternal medicine centre. The impact expected is that women with complex medical needs will have timely and coordinated access to maternal medicine clinics, ensuring that they have the right care, at the right time in the right place.

LMS funding has been allocated to increase obstetric engagement with the implementation of the Better Births plan. We are currently working up feasible options for trainees outside of training, such as quality improvement fellows.

Trajectories for reducing stillbirths, neonatal death, serious brain injury and maternal death have been submitted.

The impact is expected to be:

- A reduction in avoidable stillbirths, neonatal death, serious brain injury and maternal death.
- A reduction in preterm birth from 8% to 6%, with improved care pathways for threatened and actual preterm births.

5. Public Health – Clinicians, user representatives, commissioners and local authority colleagues are developing plans on smoking cessation, breastfeeding, immunisation, obesity, contraception and more recently postnatal care (see also: prevention and reducing health inequalities).

Working with all stakeholders including primary care networks and service users the LMS is working to influence and implement public health strategies around pre-conception and preventative health pathways with the expected impact that women will begin their pregnancy in a healthier position.

SEL has some of the highest rates of smoking in pregnancy in London, with current data from NHS Digital showing 1,261 women smoked at delivery (2018/19). Bexley and Greenwich CCGs have committed to reduce smoking in pregnancy to 6% or less by 2022 as both boroughs did not meet the national target of less than 6%.

Through LMS funding the workstream has recruited a smoking cessation project lead with a remit to scope current smoking cessation service provision across the LMS, research best practice and what makes a difference and provide recommendations to the LMS and local authorities regarding future planning and provision.

The workstream also plans to create an infographic for pregnant smokers that can be shared across the LMS. Current scoping has shown that there is variation amongst cessation support services provided across the LMS. It was recognised that the three trusts did not have sufficient equipment to be able to perform carbon monoxide monitoring as recommended in the SBLCB Version 2, therefore each trust has been provided with funding to purchase the monitors.

GSTT and LGT are UNICEF Baby Friendly accredited. KCH will aim to seek accreditation in line with the postnatal guideline recommendations, to formally begin the process later in 2019/20 and reach full accreditation by 2023/24.

Breastfeeding initiation rates within SEL vary from borough to borough, but rates remain high compared to the national average. Feedback from women via the MVPs has shown that breastfeeding support could be improved in the trusts and in the community. To ensure that SEL has a good picture of the local services available, further work is planned in collaboration with the MVPs to establish current infant feeding service provision in both settings.

Our next steps will be to review the data that has been collected, providing insight as to where gaps may lie, and to carry out focus groups with women. Recommendations will be based on women's needs and will form the basis of the SEL breastfeeding strategy.

The public health workstream has representation from the NHSE&I immunisation lead who regularly feeds back any concerns around uptake of immunisation. All trusts have a programme of work to ensure that women are aware of the immunisations on offer. The public health project manager also attends the Immunisation Board meetings to ensure there is two way communication with the LMS.

Scoping of services available to women with a raised or high body mass index has taken place, with plans to focus on this requirement from April 2020.

Provision of contraception to women during the immediate postnatal period remains under-utilised in SEL. A pilot of SHRINE was carried out at St. Thomas' Hospital, which provided training to specialist safeguarding midwives to provide contraception (progesterone only pill, injections and implants) for vulnerable women. The LMS recognised the worth of this project and provided funding for a similar project to take place across the

three trusts within the LMS. It is currently in the planning stages to ensure that it will be practical and sustainable and opened up for all women rather than just the most vulnerable. The predicted impact will be the offer of appropriate contraception to women after having a baby, before they leave the hospital.

A postnatal gap analysis has already been performed as per request from the London maternity transformation team. This gap analysis will be mapped to the recently published NHSE&I postnatal guidelines. LMS funding has been set aside to support any work that is required to improve postnatal care with a focus on physiotherapy pathways, pelvic health services and infant feeding best practice.

A workshop meeting has taken place with all stakeholders, including health visiting services and physiotherapy, to review the mapping exercise and commence writing of the LMS postnatal action plan. It is recognised that postnatal care within SEL needs to be significantly strengthened, including co-production with primary care and health visiting services, with improved handover of care between all services.

The LMS is currently working with all four other London LMSs to produce information videos for women around pelvic health in pregnancy, for labour and the postnatal period.

The impact is expected to be:

- Women will start pregnancy in a healthier position.
- Improved uptake of immunisations.
- Reduced number of women smoking in pregnancy.
- Improved infant feeding support and clear breastfeeding strategy for SEL.
- Improved pathways of support for women with a raised body mass index.
- Clear action plan to improve postnatal care in SEL.

6. Sharing and learning – The LMS has established a workstream made up of clinicians and allied health professionals which provides oversight of incidents within the LMS. It provides a Sharing Board that enables trusts to learn from each other, prevent avoidable events occurring again and generally provide insight around any event or incident where learning has taken place.

This workstream has recently gone through an overhaul as it was originally set up as a multidisciplinary incident investigation team. With the introduction of the Health Safety Investigation Branch and the Perinatal Mortality Review Tool the workstream is now the LMS sharing and learning platform.

The group discusses incidents that can be shared to enhance knowledge and learning across the LMS. Supporting events include the Safety in Maternity Services meetings and SBLCB workshop.

The updated workstream meets quarterly with each trust presenting a case that can be shared; any learning will also be shared via a quarterly newsletter that is sent out to all of the trusts. The SEL LMS has also acquired a FutureNHS digital platform that will further enable sharing and learning for maternity staff across the LMS.

The group are planning on reviewing the Perinatal Mortality Review Tool in more detail to try and learn further about avoidable mortality within the LMS.

The impact is expected to be:

- Ensure there is a robust mechanism to share learning from the maternity services across the LMS in order to prevent and reduce harm and recurrence of harm.

7. Perinatal mental health

Links are being made with perinatal mental health services (SLaM and Oxleas) and ICS colleagues to align SEL perinatal mental health plans and future gap analysis to reach the LTP target and improve access and quality of care for mothers, partners and their children.

For our full plans for perinatal mental health see: [adult mental health](#).

The LMS will review healthcare professional training within the LMS ensuring services are able to identify and support women with mental health concerns.

The LMS will work with the MVPs to gain insight from local service users, including groups that are facing health inequalities.

An LMS funded project is about to commence planning, and will offer women at risk of or experiencing postnatal depression the opportunity to attend a singing group with their babies, in Bexley, Bromley and Greenwich. This will be delivered by the Breathe Organisation – Melodies for Mums. We have also acquired funding to offer the same service to women in Lambeth, Southwark

and Lewisham therefore providing a SEL wide service for affected women.

8. Digital

Project managers and trust digital midwives are working towards implementation of digital care records and personalised care plans for all women cared for within the LMS (see also: [personalised care](#)).

Due to the different IT systems in use at the trusts, wider discussion has taken place with ICS leads around future interoperability of digital records within the LMS.

Our SEL trusts are at varying stages with eRedbook implementation with go-live dates for mid-2020.

9. Workforce

The LMS recognises the need to build a resilient workforce across SEL through networking and partnership.

The LMS aims to implement recommendations from the CapitalMidwife Working Place culture subgroup, to develop systems to improve the leadership culture, to support maternity staff and improve the working environment.

A new workforce workstream started in December 2019 and will build on the work described above in conjunction with our ICS workforce leads, HEE and the Royal Colleges to address workforce gaps, recruitment and retention and address training and education needs.

To undertake our priority actions, we will require the following key enablers to be in place:

- Ongoing dedicated investment to continue to support the current extensive Better Births programme of work.
- Continued co-production and stakeholder engagement working with our established Maternity Voice Partnerships in SEL.
- Workforce planning and training.
- Continue to work with our digital colleagues at the LMS trusts and NHS Digital.
- Public Health strategies around prevention, including smoking cessation, obesity, immunisations, breastfeeding (accredited infant feeding programme) and contraception.
- Implementation of our current Better Births plan.

Case example

The Poppie Case Loading Midwifery Team

The Poppie case loading midwifery team at University Hospital Lewisham, caring for women at risk of or who have had a previous preterm birth, is an example of the enhanced benefits for women and babies of continuity of carer, safer and more personalised care. The full evaluation is yet to be published but preliminary results show improved outcomes in breastfeeding rates and women reporting high levels of satisfaction with care.

Financial planning assumptions

Funding to support the delivery of the Long Term Plan priorities will be secured through our annual acute budget uplifts plus appropriate targeted funds such as any ongoing non-recurrent Local Maternity System funding allocated to SEL. We have a costed plan for use of the LMS funds in 2019/20 but are not yet at the stage of having a costed plan for future years and will be focusing on this over the coming months, with a specific focus on years 2 and 3.

Further transform our health and care services to meet future demand

Prevention and reducing health inequalities

Current challenges

- Significant inequality in life expectancy across our ICS (both within and between boroughs).
- Deprivation varies across SEL which impacts health inequalities (Lambeth, Southwark, Lewisham and Greenwich are amongst the 15% most deprived LAs in England).
- Physical inactivity, obesity and smoking rates are higher than the national average in a number of our boroughs. There are particular challenges for some of our most vulnerable residents (e.g. smoking prevalence in adults with long term mental health conditions is at 31%).
- Rising demand for health services overall, as a result of both an ageing and growing population in SEL. In ten years there will be 15,000 more people over 80 in SEL (25% increase).
- We need a more systematic approach to prevention to help people stay healthy and also moderate demand on the NHS.

For more information see: [understanding our population's needs](#).

There should be a wider societal view of health rather than focus on medication, illness, and disease. People said that they would benefit from being referred (not signposted) to a holistic lifestyle service to support in successfully making life changes. – Healthwatch recommendation

We will deliver our vision and objectives through the following priority actions

- 1. Deliver a system-wide population health management (PHM) programme, which will inform our prevention activities (see also: [digital](#))**
 - Establish a leadership coalition (across the NHS, Public Health, clinical, academic, information and technology partners) to coordinate prevention priorities across SEL between local government and the NHS, aligning with clinical programmes to ensure that priorities reflect local needs.
 - Resource and deliver a system-wide PHM programme to identify population needs and

Our vision for the future

- To reduce health inequalities seen within boroughs and across SEL.
- To improve health outcomes for people with long term conditions.

Our objectives

- To target and deliver prevention interventions that maximise impact on reducing health inequalities at system, place and neighbourhood levels.
- To implement a population health management approach across the SEL system to personalise care and improve the upstream prevention of ill health.
- Our overarching objective for the NHS is to step up our focus to ensure systematic action to address the burden of disease, from prevention through to early detection and intervention, combined with best practice treatment once patients have developed disease, or are ill, over the next 5 years.

develop targeted PHM interventions to meet those needs.

- Development of linked datasets to support planning, delivery and evaluation of the programme across SEL at neighbourhood (PCN), place (borough) and SEL system level.
- Establish a system-wide improvement methodology for PHM, uptake, implementation and evaluation of an approach to the consistent monitoring of the Vital 5 (smoking, alcohol, blood pressure, mental ill health, and obesity).
- Develop stronger relationships with local organisations in the VCSE sector (e.g. schools, charities) to make the most of resources that are already there in communities.

The impact of this is expected to be:

- A significant increase in the proportion of the population who are supported to self-manage long term conditions.

- In the longer term:
 - A reduction in variation in health inequalities within boroughs and across SEL.
 - Better management of demand for health care services, by preventing people developing long term conditions.

2. Go further on our primary prevention agenda, including focusing on the areas prioritised in the LTP implementation framework

Tobacco control and tobacco treatment

The current rate of smoking in SEL is 15% (over 206,500 smokers). The rate varies across SEL and is significantly higher than the national average in three of our boroughs: Lambeth 20%, Lewisham 18% and Southwark 20% (RightCare 2016). Smoking prevalence in SEL is also much higher among adults with long term mental health conditions (31%).

Our priorities over the next five years are to:

- Ensure that all residents of SEL ICS have access to high quality evidence based tobacco treatment (equity and quality).
- Ensure that the SEL ICS workforce has access to high quality tobacco treatment support.
- Ensure that SEL ICS makes a significant contribution to the priorities set out in the London Vision around tobacco control, including playing an active role in the Smoke Free London Alliance (once established) and the wider tobacco control programme as this evolves.
- Support further development of the Vital 5 concept to ensure that this is embedded into practice, so that there is a consistent approach across SEL towards the major risk factors which contribute to poor health of the population.
- Working in partnership to support the development and implementation of the evidenced based Ottawa model and embed into acute and community settings, with a particular focus on high risk groups such as pregnant women, patients with long term conditions and users of mental health services (see also: [maternity](#), [respiratory disease](#), and [preventing cardiovascular disease](#)).
- Across SEL ICS explore opportunities for cross borough working and sharing of good practice to deliver a consistent approach to tobacco control via the ICS tobacco delivery group.
- Enhance support at SLaM, through employing staff dedicated to smoking cessation support,

enabled by new investment in community mental health services ring-fenced for this purpose. Service user feedback indicated that relapse to smoking could be minimised and prevented if tobacco dependence treatment is maintained with the same staff working both within the hospital and community setting, providing a seamless service.

Obesity and Type 2 diabetes

The rate of obesity is higher than the national average in four of our six CCGs. Child obesity and excess weight is a significant issue (SEL is above the national average). The prevalence of diabetes is increasing across SEL.

Our priorities are to:

- Develop our response to the Health and Care Vision for London and the London Childhood Obesity Taskforce ambitions, which both promote a broad systems approach to addressing unhealthy weight, including tackling the obesogenic environment.
- Further develop the Vital 5 concept and embed a consistent approach to addressing the risk factors associated with unhealthy weight and weight related ill health.
- Review the support offer for treating obese children and families and increasing referral, capacity and access to high quality weight management services for all residents who meet eligibility criteria by 2021-2023 (see also: [children and young people's outcomes](#)).
- Deliver improvements in the quality and consistency of the SEL offer in relation to the prevention, management and care associated with maternal obesity across primary, community and secondary care.
- For people at risk of Type 2 diabetes, we will deliver the SEL diabetes programme (for more information see: [diabetes](#)).
- Deliver a comprehensive and seamless pathway for management of obesity in adults across the SE London.

Alcohol

The rate of alcohol related admissions (per 100,000 population) is higher than the national and the London average in four of our boroughs (Southwark, Lambeth, Lewisham and Greenwich). The highest rate is in Southwark (2,660, compared to the national average of 2,200). None of our boroughs is in the top 25% nationally.

Our priorities are to:

- Continue delivering a seven day-a-week alcohol care team at a GSTT.
- Extend the KHP assertive outreach treatment model to LGT and Oxleas, following full evaluation and return on investment. This service focuses on supporting high need, alcohol-related frequent attenders; interim evaluation shows this service is helping to reduce length of stay by half, resulting in a net saving of £10,500 per patient in year 1 (100 participants were evaluated).

Antimicrobial resistance

Much work has been done across the south east London footprint by CCGs, by trust-level antimicrobial stewardship groups and as part of the SEL Area Prescribing Committee. The current Area Prescribing Committee work plan focuses on an antimicrobial stewardship campaign and scoping the feasibility of a single antibiotic guideline for primary care.

Discussions on taking forward a single primary care antibiotic guideline have highlighted the need for this to be done in collaboration with microbiology leads and as part of a proposed network within SEL.

The challenges signalled in the five-year UK antimicrobial resistance strategy are significant. To address these challenges, the ICS will establish a SEL Antimicrobial Resistance Network across primary and secondary care that also connects with the London Region Antimicrobial Resistance and Stewardship Group (a subgroup of the London Region Medicines Optimisation Committee).

The SEL Antimicrobial Resistance Network will:

- Scope a single SEL antimicrobial guideline for primary and community care to harmonise antibiotic use and to facilitate achievement of local and national targets in line with the Area Prescribing Committee expectations of 2019/20.
- Develop a dataset (or act upon a provided dataset) on antimicrobial resistance and stewardship whilst providing a single point of contact for information within SEL.
- Identify variation and incorporate best practices across the whole sector.
- Act as an exemplar for antimicrobial resistance and stewardship within London and nationally.
- Develop services across sector to improve patient journey: admissions avoidance (particularly from

care homes); improving outpatient parenteral antibiotic therapy; facilitating earlier discharge.

- Manage introduction of new therapeutic agents into practice.
- Engage and collaborate across primary care, secondary care and public health for collective actions on antimicrobial resistance.
- Ensure a consistent approach to the delivery of national indicators and strategies and support the involvement of care home and PCN pharmacists.

Immunisation

Vaccination is the safest and most effective way of protecting individuals and communities from many preventable diseases, however across the population there are inequalities in the uptake of vaccines. For instance children who are disadvantaged, looked-after, minority ethnic or from larger families are less likely to be fully immunised. (see also: [children and young people's outcomes](#)).

In 2017/18 NHS London published a 2-year plan to improve uptake and coverage. To improve equity of access and reduce variation in vaccination uptake across in SEL, we will:

- Work with local partners in reducing or removing known local barriers to accessing vaccination services and information.
- Serve underserved populations by partnership working across the health, public and voluntary sectors as an ICS.
- Conduct needs analyses across SE London using intelligence from a wide range of sources.
- Consider how best to consult with parents and other residents on immunisation barriers and solutions.
- Be more explicit and ambitious on the design of our programmes to reach the underserved and be informed by intelligence.

Air pollution

In April 2019 the London Evelina Children's Hospital hosted the official launch of TfL's Ultra Low Emission Zone. To continue to improve air quality across south east London the ICS procurement workstream is leading a project to reduce delivery volumes into our hospitals.

In August 2019 GSTT opened a new consolidation centre in Dartford which has removed over 35,000 (90%) truck deliveries from two hospital sites. All consolidated deliveries are now being made by electric trucks. The new supply chain model is intended to be scaled up across partner organisations in the ICS, with the aim of removing over 100,000 deliveries a year from our roads.

Sexual and reproductive health

Lambeth, Southwark and Lewisham have the highest rates of HIV and STIs in England, and there are persistent inequalities in sexual and reproductive health with young people, men who have sex with men, and black and minority ethnic communities suffering the greatest burden. To address these specific needs the three boroughs have a joint sexual health strategy for 2019-2024.

Across the ICS our shared priorities are:

- To enable people to live and age well with HIV. Ensuring that those with HIV know their status and through effective antiretroviral therapy maintain an undetectable load and have effectively no risk of sexually transmitting the virus (undetectable = untransmittable). Supporting the aim of 0-0-0: zero HIV stigma, zero HIV transmissions and zero HIV related deaths.
- To enable people to effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives resulting in a reduction in unwanted pregnancies and reproductive health inequalities.
- To improve outcomes for mothers and children as a result of planned pregnancy. Taking the opportunity to address risk factors that impact pregnancy outcomes including smoking, alcohol, obesity, taking folic acid and early booking (see also: [maternity](#)).

The impact of this is expected to be:

- A reduction in the prevalence of smokers, and in the longer-term, smoking-related long term conditions (e.g. cancer, CVD).
- A reduction in obesity, and in the longer-term, obesity-related LTCs, most notably diabetes.
- A reduction in A&E attendances and admissions for alcohol-related conditions and alcohol-related mortality.
- Progress in implementing the Government's five-

year national action plan, Tackling Antimicrobial Resistance, to reduce overall antibiotic use and drug-resistant infections.

- A reduction in the variation of vaccination uptake across SEL boroughs.
- A reduction in HIV transmissions and HIV related deaths.
- A reduction in reproductive health inequalities and unwanted pregnancies and improved pregnancy outcomes.

To undertake our priority actions, we will require the following key enablers to be in place:

- Commitment amongst system leaders to work together to address prevention and health promotion across SEL (including local people, community groups, schools, NHS organisations and networks, public health and academic partners) to improve outcomes and reduce health inequalities in the context of a diverse urban area which includes some extreme levels of deprivation.
- Agreement amongst system leadership on a PHM approach for the SEL system that includes shared prevention priorities, while ensuring flexibility to meet local needs.
- Patient-level linked data sets across SEL at neighbourhood (PCN), place (borough) and system level; this is to inform both the prioritisation of PHM initiatives and identification of individuals who would benefit from them (see also: [digital](#)).

3. When people do develop long term conditions improve early detection, intervention and management so that people can stay as healthy and independent for as long as possible in their own homes

Early detection

Earlier we set out our priorities to improve early detection and intervention of the major health conditions in SEL. For example, we demonstrated how we will improve detection and early intervention in [cancer](#), [preventing CVD](#), [respiratory disease](#), [heart disease and stroke care](#), [diabetes](#), and [learning disabilities and autism](#).

Enhanced community support to manage long term conditions

In our section on integrated community based care we also set out our priorities to support older people and people with complex needs to stay as healthy and independent as possible in their own homes. We will support people with moderate to severe frailty, multiple conditions and dementia to receive timely and personalised care, coordinated or delivered by one of our community based multidisciplinary neighbourhood teams, integrated with our 35 PCNs.

This will enable us to:

- Optimise quality of life for people with complex needs and reduce inequalities in health outcomes.
- Prevent unnecessary attendances at ED and unplanned acute admissions.
- Eliminate delays in discharge from hospital.

The impact of this is expected to be:

- Generally, when people do develop long term conditions, we will be able to detect and intervene, so that people are supported to stay as healthy and independent for as long as possible in their own homes.

Financial assumptions, return on investment and downstream impact

Our objective is to secure an increased focus within our plans on proactive prevention across every service.

- We will secure an approach that combines and embeds Every Contact Counts approach with enhanced targeted support and intervention.
- We will need to ensure that our prevention offer is embedded within our core service offer and our annual funding uplifts for each area.
- Further work is required to consider approaches to incentivise these approaches, which will over time also have a positive downstream impact. In the short term any downstream impact will be offset by increased activity, as we roll out systematic approaches to risk identification and targeted intervention.

Digital First primary care

Current challenges

- High demand for general practice services and patients having limited options to interact with practices using digital services.
- Limited clinical system interoperability in GP practices, preventing population based digital service delivery.
- Unclear uniform definition of 'Digital First' and all the constituent elements.
- Multiple existing 'online consultation' solutions across the SEL ICS footprint pose additional interoperability issues.
- Ensuring the Lambeth Digital Accelerator learning is shared across the whole of the SEL ICS footprint.
- Ensuring we embed all constituent 'pillars' of Digital First (e.g. NHS App, telephony, online consultations, social prescribing) in practices and that the various technology integrates as seamlessly as possible.
- Our residents have told us that they would welcome telephone and video appointments, providing they still have the option of face-to-face appointments.

Alternative easy booking methods for [GP] appointments. The use of more digital technology would be welcomed by some. They would like the option to book appointments and receive prescriptions via mobile phone apps. Also, they would like to be able to email or text concerns and have consultations via telephone or Skype. However, a large number of people wish to continue to use the telephone as their preferred booking method. – Healthwatch recommendation

The delivery of local Digital First visions by 2023/24 is a commitment within the NHS Long Term Plan, encompassing both scheduled and unscheduled care pathways, and providing us with the foundations to build a sustainable, digitally-enabled ICS.

In this sense, Digital First is as much a process as a product, and we have jointly invested with the national programme to develop new ways of working with care providers, technologists, and innovation partners that promote a culture of co-production, based on a more agile change model, which is a

Our vision for the future

Delivery of equitable access to primary care digital services for every patient in SEL. Digital technology supports patients to be directed to the correct levels of clinical and / or administrative support first time. Seamless functionality of the 'Digital Front Door' (NHS App) to current operational delivery by traditional general practice. Digital primary care procurement respects and accommodates the needs of each population.

Our objectives

- Implement digital services which better support patients to obtain information, manage their conditions and interact with primary care services.
- Support general practice to transform the way they manage demand and support their patients.
- Define what 'Digital First' means in primary care.
- Establish a SEL-wide Clinical Steering Group to help shape and implement our strategy.
- Ensure our Accelerator Programme accommodates individual population needs to aid scaling.

necessity when integrating novel digital solutions into local care pathways.

We will deliver our vision and objectives through the following priority actions

1. Deliver an online consultation offer in each GP practice by April 2020

- Drive the overall Digital First strategy for the ICS and ensure delivery of the LTP milestones for SEL through the Digital First Steering group.
- Each borough has procured their own online consultation solution to deliver the April 2020 deadline. Work with each SEL borough to ensure they have implemented the online consultation solutions in every GP practice.
- From 2020/21, work with patients and clinicians to evaluate the variety of different online consultation solutions in use in SEL and share the work from the Lambeth Digital Accelerator programme.

- Agree through the steering group an ICS plan to rationalise the number of systems in use and achieve economies of scale.
- Develop plans which integrate the different elements of Digital First into seamless (for the patient) solutions (e.g. video consultations, integrated voice recognition telephony).
- Transition to a smaller number of digital providers in SEL and ensure full integration with the NHS App.

2. Deliver a video consultation offer in each GP practice by April 2021

It was important that patients were able to book online appointments, in particular with their GPs and manage access to their online record in a reliable way. Some residents wanted primary care services to offer “online chat” access to doctors. – Healthwatch recommendation

- The SEL Digital First Steering group was recently established to define the overall strategy for the ICS and lead on developing and delivering the LTP milestones.
- The group will develop and agree an ICS strategy for video consultations which gathers and consolidates requirements in each SEL borough.
- The group will also review models of delivery as this technology may be better delivered from e-hubs rather than from individual practices.
- Standardising solutions where possible, sharing lessons learned.
- Continue to test and develop solutions through the Lambeth Digital Accelerator programme; upscale the capabilities developed within the accelerator site to whole ICS level.
- From 2020/21, establish funding levels for video consultation solutions.
- Procure and implement video consultation solutions across all SEL boroughs.
- Continue to ensure the chosen video consultation solutions fit with strategic plans to integrate the different elements of Digital First into seamless (for the patient) solutions (e.g. online consultations, integrated voice recognition telephony).
- From 2021 – 2023/24, work with patients and clinicians to evaluate the video consultation solutions in use in SEL and ensure full

integration with the NHS App.

The impact is expected to be:

- Each practice will have a functioning online consultation solution by April 2020.
- Each practice will have a functioning video consultation solution by April 2021.
- Increased uptake of online and video consultations where people want or need them.
- Patients can utilise the latest digital innovations and the NHS App as a ‘front door’ to access integrated health and care services consistently online as and when they need to.
- Technology will be used to support sustainability by ensuring patients are triaged effectively to the right levels of clinical support and demand can be efficiently managed.
- Coordinated pathways of care through digital technology (e.g. enabling urgent care providers to directly book GP appointments).

Digital First is not a temporary solution, but instead one that promotes sustainability in how we operate over the next 10 years, empowering patients to stay well, recognise important symptoms early, and to manage their own health needs through the use of digital tools and interoperable technology.

To undertake our priority actions, we will require the following key enablers to be in place:

- Investment in organisational and individual development to embed change. Digital transformation is as much about people and processes as it is about products; we operate under the core principle of “bringing the workforce and patients on the digital journey”, by co-designing solutions and preparing the system for any change with adequate education and training.
- NHSE&I has defined a series of enabling workstreams and foundations which need to be in place (shown in the **exhibit overleaf**). SEL will drive the plan and delivery of these enablers through the Digital First steering group and ICS digital governance.

See the [appendices](#) for more information on key milestones and how we will measure success.

Digital First



Ensuring we have the foundations to support robust NHS service design

Functions and capabilities

SNOMED coded Data	Integration & Interoperability	Digital access to patient records	Digital Champions	Digitally literate Workforce	Agile QI working Methodology
Pharmacy services for patients	Patient triage & signposting	Innovation (Workforce Tools)	Accessibility to Services	Promotion of online Services	Education & training mechanism
IT Hardware	User Experience	Aligned comms strategy	Change Management	Strong & collaborative supplier relationships	Commissioning
Data & Performance monitoring	Benefits analysis & Outcomes	Digital Maturity assessment	Proxy access	Information Governance & Data Sharing Agreements	Assurance & risk

Personalised care

Current challenges

- Whilst we have areas of good practice in SEL, we do not currently have a comprehensive strategy for personalised care / support to drive an approach which ensures that people with more complex needs have greater choice and control over the care they receive.
- There is a need for us to take a two-pronged approach to personalisation, focusing on:
 1. A whole population approach to shared decision making.
 2. Proactive personalised care and support planning for 30% of the population with physical and mental health conditions.

Our approach will be underpinned by a range of enablers, including social prescribing, supported self management and personal health budgets.

Our vision for the future

In SEL, people with long term conditions and their carers are supported through a comprehensive model of personalised care which ensures that people are:

- Supported to manage their physical and mental health and make informed decisions when their health changes.
- Supported to build knowledge, skills and confidence to manage their conditions.
- Offered a personal health budget to give them more control over the support they receive, if they are eligible.

Our objectives

- To develop and implement a comprehensive model of care which delivers a personalised approach to LTCs.
- To offer everyone who is eligible a personal health budget, and ensure we have clearly articulated our personal health budget offer (referencing Right to Ask and Right to Have guidance).
- To support people to build knowledge, skills and confidence to manage their condition.

Treatment should be person-centred. – Healthwatch recommendation

We will deliver our vision and objectives through the following priority actions

1. We will develop a plan to implement the NHS Comprehensive Model of Personalised Care in SEL

Patients wish to have time to consider options and make the choices that are right for them. – Healthwatch recommendation

We have made significant progress on embedding personalisation and patient choice within diabetes services (see also: [diabetes](#)). For example, people with diabetes can choose any education course across all of the 12 south London boroughs, enabled via digital Book & Learn. Progress has also been made in other areas such as:

- Integrated respiratory team in Lambeth (including strong links to IAPT).
- Multiple long term conditions work across Lambeth and Southwark.
- Use of digital approaches to support personalisation

such as the My IBD App.

For 2019/20 we have appointed an ICS Personalisation and Personal Health Budget (PHB) lead to work with commissioners, providers and patients.

To build on this progress, our priority actions are:

- Map areas of good practice around personalisation across SEL to develop a baseline assessment, using the categories and information contained in “Universal Personalised Care: Implementing the Comprehensive Model”.
- Identify opportunities to roll out areas of good practice and areas where we have gaps and need to improve our approach to personalised care (with a focus on inequalities and identifying particular cohorts who may not be experiencing personalised care).
- Develop principles to ensure consistency of offer from services across SEL (e.g. integrated discharge teams).
- Develop a comprehensive implementation plan for further development of personalised care across identified areas.

- Develop a strategic approach to patient activation, including an approach to implementing the Patient Activation Measure tool in an effective way (e.g. potential move from paper based to digital), to increase the number of people supported through that tool and through supported self-management programmes in south east London.

2. Implement the further roll-out of personal health budgets

PHBs are currently available for continuing health care patients across SEL. Variable progress has been made around additional patient cohorts but there are areas of good progress (e.g. PHBs are available for wheelchair users in Bexley, and there are PHBs for mental health service users in some boroughs which we are looking to build on in the next year).

In 2018/19 we delivered over 1,170 PHBs, exceeding the agreed trajectory for south east London CCGs. To build on this progress, our priority actions are:

- Develop plan for further roll-out of PHB offer to new client groups in south east London; we will build on the target of 1,672 PHBs for 2019/20 to deliver a total of 6,400 PHBs across south east London by 2023/24.
- Review and revise contracts to enable personalised offer for all patients accessing wheelchairs.
- Scope out infrastructure required to support the expansion of PHBs and develop a plan for implementation.
- Establish framework for the review of quality of PHBs and their impact on improving patient outcomes and wellbeing.
- Work with providers to discuss sector commissioning intentions for personal health budgets and expectations around care delivered through PHBs.
- Complete audit of PHBs and evaluation to gather feedback on people's experience of having a PHB and the support they received.

3. Implement clear and effective pathways for social prescribing

The ideas behind social prescribing are already at the heart of what the VCSE sector does. We learnt from our engagement activities with voluntary sector organisations that there is a huge opportunity for us to work in genuine partnership with community organisations – moving beyond

simply seeking contributions, to collaborating to improve health and care.

In particular, social prescribing can be used to address issues with social isolation. There was also broad agreement among those who participated in our engagement activities that social isolation is a key issue of concern, particularly affecting the elderly and chronically ill, and that it is important to tackle the challenges of social isolation and loneliness, and the surrounding stigma.

A number of participants also felt it was important to highlight that this issue affects people of all ages. Participants agreed that the VCSE sector had a key role to play in supporting people to better connect to their communities. There was also broad agreement about the value of, and need to support, VCSE organisations and protect community resources.

There is an established network of services within each borough that could support social prescribing, e.g. trust-based and local authority-funded volunteer services and borough-based voluntary sector services that offer support, advice and interventions. In addition, three boroughs have wellbeing hubs that can take referrals from primary and community services, assess people's social needs and link them with existing services.

As described in [integrated community based care](#), we plan to leverage this network within each borough through our PCNs. We will:

- Recruit new link workers to deliver social prescribing.
- Develop a SEL social prescribing group, consisting of PCN, local authority and voluntary sector representatives, under the governance of the CBC Board to support consistent development of these posts within PCNs; a competency framework for care navigators and social prescribing (link workers) has already been agreed.

4. Implement a personalised approach to care to improve end of life care

We have made progress with the implementation of an EPaCCS system (Coordinate My Care) for coordinating palliative care. The system is currently actively used by GPs, community nursing, London Ambulance Service and community palliative care teams. Other areas of good practice around local end of life care include:

- Our Southwark services, which include overnight visiting; Macmillan night sitting service; consultant-led community palliative care; dedicated end of life community nursing team and use of single set of comprehensive documents across GSTT community services; and St Christopher's hospice.
- Strong academic and research basis through the King's Health Partners Palliative Care Clinical Academic Group and the Cicely Saunders Institute.
- High quality advance care plans and planning processes are a key enabler to delivering personalised care at end of life. We have secured Big Lottery Funding to develop our approach to advance care planning.
- Work alongside the [integrated community based care programme](#) to ensure CBC services facilitate choice at the end of life and have a core offer around service, pathways and staff training to ensure people are supported at end of life.
- Review of fast track processes to identify areas for improvement and develop implementation plan.
- Work with primary care as part of the quality improvement cycle to drive improvements and innovation in end of life care.
- Expand work on de-prescribing in the last year of life by implementing systems to systematically review medication.
- Develop a plan to capture people's experience of end of life care to identify areas / population cohorts where there are opportunities for improvement.

The impact is expected to be:

- More patients will receive personalised care and supported planning to achieve the outcomes that matter to them, improving health and wellbeing.

5. Ensure that all patients diagnosed with cancer have access to high quality personalised care

By 2021 everyone diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health wellbeing information and support. For more information on our progress in delivering this vision and next steps, see: [cancer](#).

To undertake our priority actions, we will require the following key enablers to be in place:

- Secure elements of the comprehensive model in

provider contracts and fund a transformation and operational infrastructure working across ICS partners.

- Ensure we support and train staff to have the conversations which help patients make the decisions that are right for them.
- Design and implement the infrastructure to support roll out of PHBs.

See the [appendices](#) for more information on key milestones and how we will measure success.

Case examples

Personalised care in diabetes: Book & Learn

In SEL we are offering patients multiple choices of courses for diabetes education with choice of venue, location, time, borough, course provider, face to face or remote / digital. This enables patients to choose and book a course of their choice at their convenience either via a website, over the phone or with their clinician. We have identified alternatives for hard to reach groups (with services provided in sports venues with the aim of attracting men and dedicated courses tailored to African and Caribbean communities).

The diabetes Book & Learn service provides a website offering full details of courses available, including details on accessibility, facilities and course content available as well as standardised information on location, times and dates to help people choose the course that best meets their needs. We have initiated a social prescribing element to the website that will provide a range of additional information to support health and wellbeing.

The use of digital technology supports patient choice across South London, pulling patients' data securely from the GP system and sending it to the course provider. Once the patient has completed their course their results are sent back to their GP practice and a year after completion data is again collected to measure patient outcomes. Building on this progress, our priority actions to 2023/24 include:

- Enhancing the site to offer a full social prescribing aspect with further information on stopping smoking, mental health, housing and finance support.
- Developing the IT that auto-populates GP systems with patients' attendance details and results, reducing the workload of primary care.
- Liaising with North West London who are keen to replicate the course booking function of our service.
- Understanding how we can roll this out into other areas, e.g. diabetes prevention courses; additional long term conditions; stop smoking services; prescribed weight management courses.

Pharmacist-led virtual clinics

Locally and nationally it was recognised that the rates of anticoagulation in AF were sub-optimal and that there was significant variation in treatment between CCGs and between individual GP practices, including variation in rates of exception reporting. Southwark and Lambeth CCGs recognised that the rate of anticoagulation in AF could be increased through systematic clinical review of all patients with AF, who were not currently prescribed anticoagulant therapy by a specialist anticoagulation pharmacist.

The CCGs introduced pharmacist-led virtual clinics to ensure all atrial fibrillation patients at risk of stroke were offered anticoagulation, if appropriate. Over a 12-month period, the programme reviewed over 1,500 patients with AF not receiving anticoagulation, which resulted in an additional 1,200 patients being anticoagulated.

Over three subsequent years, the 2 CCGs have seen a 25% reduction in the rate of AF-related stroke, compared to a 3% fall nationally. This virtual clinic model is being used locally to address other areas of unmet clinical need for people with diabetes, chronic obstructive pulmonary disease and hypertension.

Research, innovation and genomics

Current challenges

- There is a need to remove barriers to innovation between NHS organisations and research partners, including aligning and streamlining governance, data sharing and contracting as well as pooling expertise and resources.
- A key challenge is in translating research and testing into clinical practice; more collaboration is required to reduce the translational pipeline, including working with the Applied Research Collaboration South London, Health Innovation Network (South London) and King's Health Partners.
- There is a need to address healthcare inequalities so that local people from all backgrounds have opportunities to access and benefit from research.

Our vision for the future

To improve the health and wellbeing of our population, improve clinical outcomes and provide more personalised care through sustainably spreading world-class innovations and translating leading research into practice.

Our objectives

- Benefit from the opportunities arising from having a number of major research centres on our doorstep, in particular in speeding up the practical application of research for the benefit of patients.
- Participate actively in research activities to help support the development of better outcomes for local residents from all backgrounds.
- Make SEL the best place to come to for research, attracting both professionals and patients who want to be referred to SEL or become involved in projects.

We will deliver our vision through the following priority actions

1. Support research and innovation to improve outcomes and efficiency in the NHS

- Work closely with King's Health Partners, ensuring that strategies are aligned as far as possible.
- Play an active part in the Health Innovation Network (HIN) to ensure that local residents have access to the best innovations available and that good ideas are spread as quickly as possible. This includes working with innovators from the DigitalHealth.London Accelerator programme and supporting the NHS Innovation Accelerator Fellows.
- Ensure that KHP and HIN work programmes are informed by the needs of local clinicians.
- Aim to have more than 70,000 people participating in health research by 2023/24 compared with roughly 60,000 in 2018/19 (thereby achieving our share of the 1 million ambition nationally).

The impact is expected to be

- SEL will contribute to the national ambitions to

increase the numbers of people participating in research.

- Local residents from all backgrounds will have access to the best innovations available, as we work to increase the rate of local adoption and spread proven innovations.
- ### 2. Drive innovation in genomics to expand access to genomic testing and support the translation of testing into clinical practice (see also: [cancer](#))
- Complete development of London South Genomic Laboratory Hub by April 2020, so that local residents get early benefit from the translation of genomic testing into clinical practice. In October 2018 it was agreed that the Hub would be established and led by GSTT; consortium partners include KCH, SLaM, St George's, Royal Brompton, Maidstone and Tunbridge Wells, and (more recently) Brighton and Sussex University Hospitals and Surrey and Sussex.
 - Continue to deliver the Genomic Innovation Unit at GSTT, to further drive innovation and rapid translation of research into new genomic tests and technologies.

- Expand our existing network of Clinical Genomic Champions to lead clinical engagement, education and local access to testing across all providers and specialties in the region; the expansion will support the roll out of Whole Genome Sequencing (WGS), education and genomic testing coverage.
- Develop our existing Regional Genomic Tumour Advisory Board (GTAB) structure (e.g. with tumour specific boards) in line with the expansion of WGS as a routine diagnostic services; GTABs are responsible for the interpretation and reporting of WGS and other next generation sequencing genomic tests.

The impact is expected to be:

- All eligible patients receive access to appropriate genomic testing and that requests for genomic testing are consistent with the national genomic test directory and delivered by the designated provider.

To undertake our priority actions, we will require the following key enablers to be in place:

- Successful reaccreditation of King's Health Partners as an Academic Health Sciences Centre for 2019-2024.
- Continuity of National Institute for Health Research infrastructure including biomedical research centres and clinical research facilities.
- Collaborative working across the London South Genomic Laboratory Hub and the NHS Genomic Medicine Centres to ensure clinical pathways are in place, operating to national standards and protocols.

Case example

London South Genomic Laboratory Hub

Genetic testing for people in south London and south east England will be transformed through the London South Genomic Laboratory Hub, a consortium led by GSTT.

The network will be one of the largest providers of genomic testing in the UK, delivering services to south London, Kent, Surrey and Sussex, as well as providing a national centre for specialist testing for cardiology, gastro-hepatology, haematology, neurology, respiratory and skin conditions.

The national hub and network model will not only improve patient access for genetic testing but will also support the development of more personalised medicine. The ultimate ambition is for patients with rare inherited diseases and cancer to be diagnosed and treated quicker than ever before, wherever they live.

Genetic testing can be used to find out whether or not a person has inherited a specific altered gene (genetic mutation) that causes a particular medical condition. Testing usually involves having a blood or tissue sample taken. The sample will consist of cells containing a person's DNA.

The new service will allow clinicians to access testing for over 500 conditions seven days a week, with some results being available in as little as three days. It will also enable the identification of gene mutations in cancer cells which can be targeted by new drug therapies.



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

4) System development



Context

Many of the transformation plans set out in the previous section are not new endeavours for SEL. However, what history has shown is that taking an organisational specific and siloed approach to delivery has not worked in terms of translating our ambition into reality. Delivery is not within the gift of any single organisation and the transformation agenda set out in this Long Term Plan response can only be delivered through system working, and organisations collaborating to work together in new ways. We need to ensure that the system infrastructure supports organisations to work collaboratively. As a result, SEL will move forward at pace to develop our integrated care system ways of working, bringing together local organisations to redesign care and improve population health, creating shared leadership and action.

The SEL ICS is our vehicle for delivering system transformation and improved outcomes – it will underpin the delivery of our Long Term Plan commitments. Becoming an ICS is **not an end in itself for south east London**, but it is the key vehicle and infrastructure through which we will deliver the system transformation plans set out in the previous section and achieve our goals of reducing health inequalities and achieving system sustainability. Developing our ICS – its governance, infrastructure and ways of working alongside its delivery mechanisms, capacity and capability – is therefore a key element of our response to the LTP.

Our journey to becoming an ICS

Towards the end of 2018, SEL participated in the **Aspirant ICS Programme** and this enabled progress to be made in a number of key areas. At the end of the programme SEL agreed a **System Improvement Plan**, which set out our **system development commitments** aimed at supporting our transition from a sustainability and transformation partnership to an ICS and developing our ICS maturity; all partners have committed to a series of developmental ICS objectives to address long standing system challenges and drive the redesign of our system architecture.

SEL's progress was recognised nationally and in June 2019 SEL was identified as a **Wave 3 ICS**, the first in London to be part of the national programme. Our Wave 3 status will enable us to drive both our internal ICS development, as well as test ICS approaches in the London context. The SEL ICS is committed to making rapid but sustainable progress within SEL and to supporting the delivery of London's wider ICS ambition.

This section sets out our latest assessment against the ICS maturity matrix and builds on our System Improvement Plan to set out our how we will continue to develop our ICS maturity and system ways of working over the next five years, and the outcomes this is expected to deliver.

Where are we now and where do we want to be?

Our assessment against the ICS maturity matrix

Our latest assessment against the national ICS maturity matrix shows that SEL has made considerable progress against the national criteria, which reflects our Wave 3 ICS status. In the table below we set out where we are now and priority actions we will take to become a “thriving” ICS by 2023/24.

Review criteria	Current assessment: “maturing”	Work needed to “thrive”
<p>System leadership, partnerships and change capability</p>  <p>Maturing</p>	<ul style="list-style-type: none"> • Collaborative and inclusive system leadership and governance, including local government, through the OHSEL Board. • Clear shared vision and objectives, with consistent progress. • Dedicated capacity and supporting infrastructure being developed to enable change at system, place (including health and wellbeing boards) and neighbourhood level (through PCNs). • Ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels, as demonstrated through our LTP engagement events. 	<ul style="list-style-type: none"> • Further development of governance and leadership to ensure strong collaborative and inclusive system leadership, across the System of Systems; development of transparent and robust governance and mechanisms to hold each other to account, and strong clinical leadership to drive transformation work. • Dedicated clinical and management capacity and infrastructure to execute system-wide plans, working on behalf of the ICS. • Development of a strong public narrative outlining how integrated care is being developed with and benefiting the public and demonstrable impact on outcomes.
<p>System architecture and strong financial management and planning</p>  <p>Maturing</p>	<ul style="list-style-type: none"> • SEL is working with regional teams to take on increased responsibility for oversight, as demonstrated through joint chairing of Performance Oversight Meetings. • Plans to streamline commissioning are underway; our application to merge the six CCGs has been approved. • SEL has plans in place for meeting our 2019/20 system control total and has examples of system working around finance, e.g. system discussions around prioritisation and use of capital spend. • SEL has moved towards aligned incentive contracts and led an approach to planning for 2019/20 characterised by system leaders working in partnership to agree system solutions to our financial, planning and delivery challenges. • System wide plans for workforce, estates and digital infrastructure being implemented through our established SEL programmes, overseen by the Enabler Programme Board. 	<ul style="list-style-type: none"> • Further development of oversight arrangements to establish robust self-assurance alongside clear communication and relationships with regional team. • Fully embed streamlined commissioning arrangements across all partners. • Build on current approaches to sharing financial risk using more sophisticated modelling of current and future population health and care needs, working as a system to meet the financial targets and ICS control total that has been set. • Build on 2019/20 progress to continue to develop incentives and payment mechanisms which support our objectives and maximise impact for the local population. • Plans delivering demonstrable improvements in workforce, estates and digital infrastructure being seen across SEL.

Where are we now and where do we want to be? (continued)

Our assessment against the ICS maturity matrix (continued)

Review criteria	Current assessment: “maturing”	Work needed to “thrive”
<p data-bbox="89 410 272 472">Integrated care models</p>  <p data-bbox="147 648 258 679">Maturing</p>	<ul data-bbox="354 410 825 1290" style="list-style-type: none"> • 35 PCNs have formed across SEL and are developing plans to deliver the national service specifications and starting to design care models with partners to meet population need. • Each borough has plans for “integrated care teams” operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration aim set out in the LTP. • We are implementing plans to address unwarranted clinical variation, deliver the five service changes in the LTP and tackle the prevention agenda and address health inequalities. • PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use. • We have an evidence based understanding of key determinants of health inequalities and population specific prevention needs and are developing plans to address these on a systematic basis. 	<ul data-bbox="863 410 1335 1104" style="list-style-type: none"> • We need to translate our maturing plans around integrated care into fully operational models of care which are demonstrably improving outcomes for our population. • Fully mature PCNs across the system delivering care with partners that meets population needs. • Implementation of the five service changes set out in the LTP demonstrating improvement in health outcomes. • Full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care. • Implementation of priorities for prevention and reducing health inequalities as part of approaches to integrated care.
<p data-bbox="89 1321 272 1384">Track record of delivery</p>  <p data-bbox="129 1560 278 1622">Developing / maturing</p>	<ul data-bbox="354 1321 825 1819" style="list-style-type: none"> • Strong system commitment to working together, but lack of tangible progress in delivery of constitutional standards. • Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management. • Robust approach in place to support challenged organisations and address systemic issues. • Progress towards delivering national priorities especially: better access to primary care; improved mental health and cancer services; the five service changes set out in the LTP. 	<ul data-bbox="863 1321 1335 1860" style="list-style-type: none"> • Working together as a system to deliver on agreed performance improvement plans, with corresponding delivery of agreed performance trajectories for constitutional standards. • Working as a system to mitigate risks. • Evidence of delivering national priorities especially: better access to primary care, improved mental health and cancer services and the five service changes set out in the LTP. • Demonstrating early impact on improving population health outcomes. • Consistently delivering system control total with resources being moved to address priorities.

Where are we now and where do we want to be? (continued)

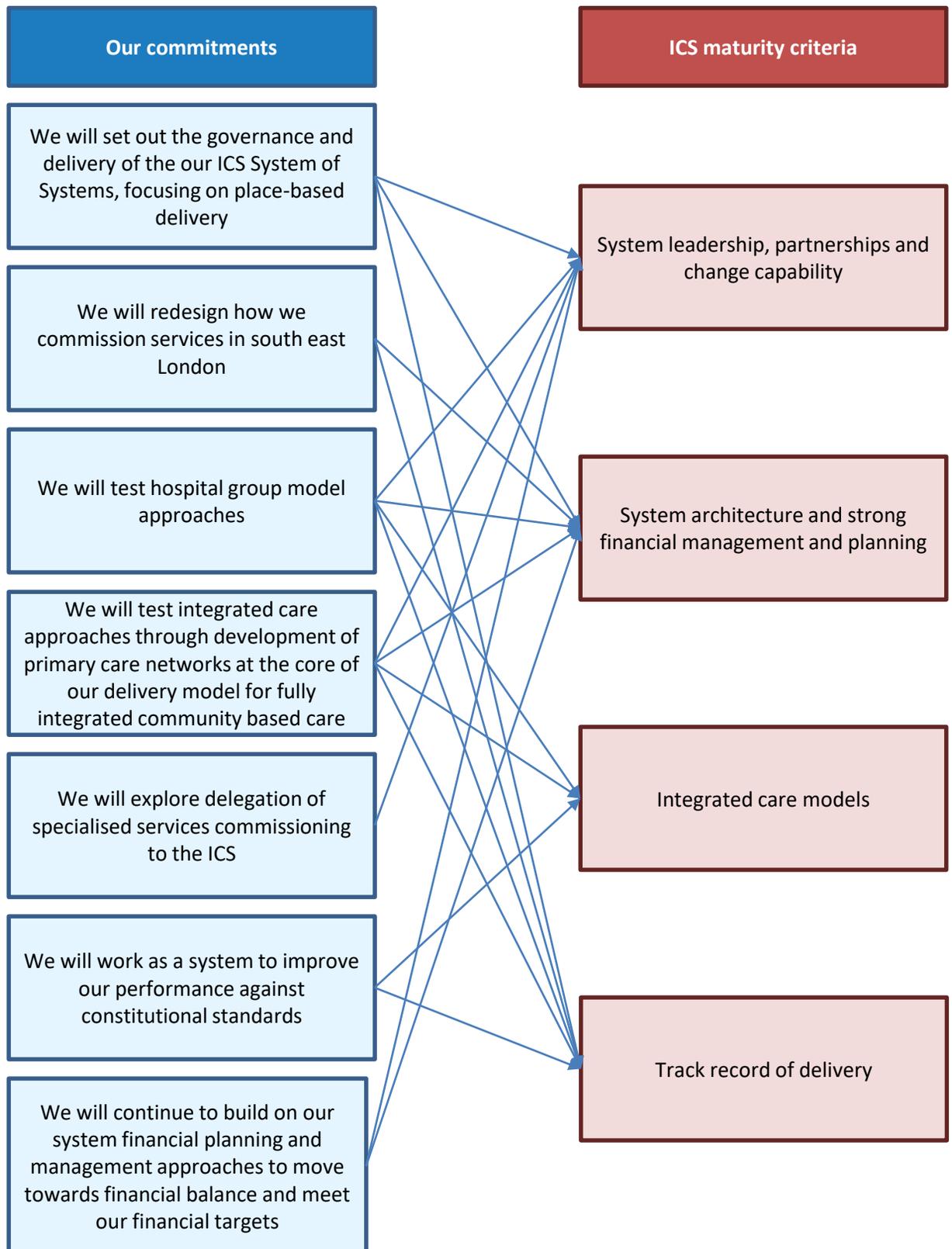
Our assessment against the ICS maturity matrix (continued)

Review criteria	Current assessment: “thriving”	Work needed to “thrive”
<p>Coherent and defined population</p>  <p>Thriving</p>	<ul style="list-style-type: none">• SEL has a meaningful geographic footprint that respects patient flows; 90% of south east Londoners receive their care within the ICS footprint.• Contiguous with local authority boundaries.• Population of 1.9m.• Our System of Systems approach ensures an appropriate focus on neighbourhood, borough and SEL-wide population approaches, to reflect acute flows alongside very local access.	<p>Our ICS development work will give focus to populations from outside of SEL who access their care through SEL providers – a key issue for specialised services where SEL providers see material flows from SE England.</p>

The following pages of this section set out a series of commitments the SEL system has made, and is currently delivering, to enhance how we work together and our system’s ICS maturity. The commitments are designed to progress various aspects of our ICS including our governance, how we commission services and how organisations work together to deliver care. For each commitment we have tangible milestones for delivery in 2019/20, a first step as part of a longer term development journey.

How will we get there?

We have made a series of system commitments to support our transition to a mature, effective and thriving integrated care system



What will success look like?

If successful, by the end of 2023/24 we be able to say....

...We are delivering our ICS development commitments.

- Demonstrable progress against the ICS development commitments we have made to support the delivery of our Long Term Plan ambitions.
- ICS Board with independent Chair in place, alongside a fully functioning ICS infrastructure, inclusive of Place Based Boards and Local Care Partnerships and an ICS Executive / Programme Management Office (PMO).
- Agreed and effective governance, with a recognised self governing ICS where our regulators are ICS partners not assurers.

...We are delivering our Long Term Plan commitments for service delivery and improved outcomes for patients and the public.

- As a system we have done what we said we would do – with delivery of the improvements that we have set out in this Long Term Plan response (including improvements to our services, patient and public outcomes and experience, performance and finance).
- This will require collaborative and integrated delivery approaches – we cannot meet our commitments through operating in organisational silos.

...We are a mature and thriving ICS.

- A movement each year towards a mature, effective and thriving ICS – with the objective of meeting 'thriving' characteristics by the end of 2023/24.
- Improved performance against the other aspects of ICS maturity – with a particular emphasis on financial management and responsibility, we will have a population health management, clinical effectiveness and quality improvement driven ICS.

...We are recognised as being responsive to the people we serve.

- The SEL ICS is recognised as mature and thriving, and receives positive feedback from stakeholders and from our staff and constituent organisations.
- The ICS is demonstrably responsive to the local population we serve – their priorities, health needs and service feedback.
- We have taken difficult decisions and decisions for the good of the system and our population.
- We have secured service redesign and improved health outcomes.
- We can and have held each other to account as part of a self-governing system.
- Our stakeholders have confidence in us and that we are responsive to them and their needs.

Commitment 1: Governance

We will set out the governance and delivery of the ‘System of Systems’, focusing on place-based delivery

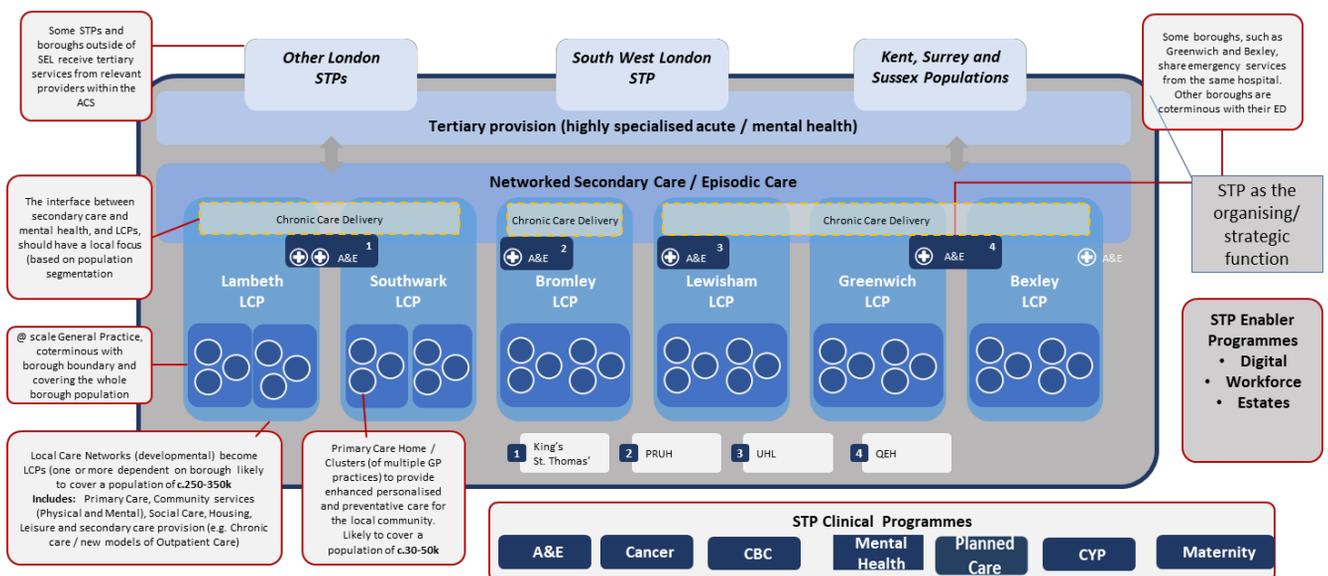
Vision

Our shared goal is to deliver ‘a clinically and financially sustainable system for the future and address health inequalities in south east London’. History has shown us that this can only be achieved through collaborative working, and we can only address unwarranted clinical variation, the Long Term Plan’s five service changes and reduce health inequalities if we work at neighbourhood, place and system level simultaneously. Through our ICS we will ensure effective leadership and governance at all levels of our system – across neighbourhood, place and system – which drives delivery at pace and enables us to hold each other to account.

Objectives

We have developed and agreed an end-state operating model for our ICS – this adopts a ‘System of Systems’ approach to planning, delivery and oversight. Our design reflects the fact that SEL is a complex system, which will need a number of health and care partnerships within the overarching SEL ICS. The operating model reflects:

- The work the ICS is doing with other ICSs / STPs, focused on tertiary and highly specialised provision and mental health.
- Work within the ICS to support neighbourhood, borough, pan borough and SEL-wide delivery models.
- The underpinning clinical programmes that will drive the underpinning care pathway redesign and enabling programmes that will ensure fit for purpose infrastructure.
- The ICS as the overarching governance, organising and strategic function.



We will deliver our vision and objectives through the following priority actions

Our governance development work is focusing on the following three areas:

1. Transitioning to an ICS Partnership Board, with the underpinning governance and infrastructure to enable delivery of our LTP commitments and ambition.
2. Further development and testing of the fitness for purpose of our operating model to underpin delivery – the mental health operating model is provided as an example below.
3. Development of place based system leadership across SEL to support ICS delivery.

Commitment 1: Governance (continued)

Transitioning to an ICS

The starting point for development of the SEL ICS Partnership Board is the existing OHSEL Board, which has many of the characteristics that the ICS Partnership Board will need to carry out its function:

- All partner organisations are represented on the OHSEL Board.
- The Board meets monthly and holds both meetings in public and private meetings.

We recognise that we need to build on our OHSEL Board arrangements to have an ICS Board that secures effective and robust overarching governance with an organising and strategic function, recognising too that our ICS Partnership Board will continue to evolve as the SEL ICS develops. Key areas of development work are summarised below. We will further review our overall OHSEL governance and infrastructure to ensure it is fit for purpose as we transition to an ICS and work collectively to secure a demonstrable mature and thriving ICS in SEL.

We are testing governance through a number of lenses – (1) overarching ICS governance; (2) what we need to put in place at place or borough level; and (3) how governance will work on an end-to-end pathway.

Overarching ICS governance

Joint work with London Region and other London ICSSs

<p>Establishing our ICS infrastructure</p> <ul style="list-style-type: none"> • Appointment of an independent Chair. • Agreement of dedicated ICS executive leadership arrangements. • Agreement of ICS PMO arrangements and resourcing. 	<p>Revised governance and Terms of Reference for our OHSEL Board and associated groups</p> <ul style="list-style-type: none"> • Ensuring the ICS can provide an effective governance, organisation and system management function. 	<p>London oversight and assurance operating model</p> <ul style="list-style-type: none"> • Work with London Region and ICSSs to agree a new regulatory operating model for London, inclusive of increased self regulation, and to implement this in SEL.
<p>Development of ICS performance dashboards</p> <ul style="list-style-type: none"> • To support effective system management and self regulation. • Including developing our population health management capabilities and quality surveillance. 	<p>Senior leadership development</p> <ul style="list-style-type: none"> • Regular facilitated workshops with ICS Chairs and Chief Executives – to support transition and agree our ICS governance approaches as well as developing senior leadership relationships and ways of working. 	<p>Wider engagement and organisational development</p> <ul style="list-style-type: none"> • Planned wider engagement with other system leads, including new clinical leadership, to secure wider staff buy in and engagement as well as developing relationships, trust and ways of working across the system.

Commitment 1: Governance (continued)

Developing our place-based leadership

Place as the cornerstone of our new ICS operating model

Place represents the core foundation of our SEL ICS – each borough is working as a system to secure an integrated delivery model at borough level, built on:

- **Joint commissioning arrangements across CCGs and local authorities;** whilst joint commissioning is at different stages across SEL there is a clear commitment in each borough to progress and further build on integrated commissioning approaches.
- **Integrated models of provision and delivery,** focused on and through our community based care plans, delivered through our Local Care Partnerships and primary care networks.

SEL Commissioning System Reform Programme – to support place based leadership

- Place Based Boards – we have agreed Place Based Boards as part of our new operating model – these will secure integrated commissioning governance and leadership at borough level in each of SEL’s six boroughs from 1 April 2020, building from the borough based governance already in place.
- Commissioning of community based care – our new operating model will delegate authority and responsibility for the commissioning of community based care to our Place Based Boards, to support local decision making and prioritisation within a core overarching SEL wide framework and a set of outcomes for community based care.

SEL System Reform Programme – place based provider development and collaboration

- Local Care Partnerships – each borough will have a Local Care Partnership as part of our new operating model – these will secure the governance to secure an integrated approach to delivery and transformation across providers, building from our existing positive collaborative relationships and arrangements.

Key outcomes and milestones

Short term (2019/20 and 2020/21)

- Establishing effective governance, planning and delivery processes at place level through which ICS partners will work together to secure jointly agreed outcomes.
- Developing agreed local implementation and delivery plans to secure agreed prevention, primary and community based care outcomes and effective acute interfaces / end to end pathways.
- Development and agreement of Memorandum of Understanding / Alliance agreements to underpin collaborative working at place level.

Medium term (2021/22 onwards)

- Development of more formalised collaborative decision making and delivery through provider and commissioner partnerships.
- Demonstrable shift to collective responsibility for and management of resource across the place based system.
- ICS infrastructure in place and utilised to drive delivery – population health management, clinical effectiveness and quality improvement.

Commitment 1: Governance (continued)

Effective delivery at different levels of the system

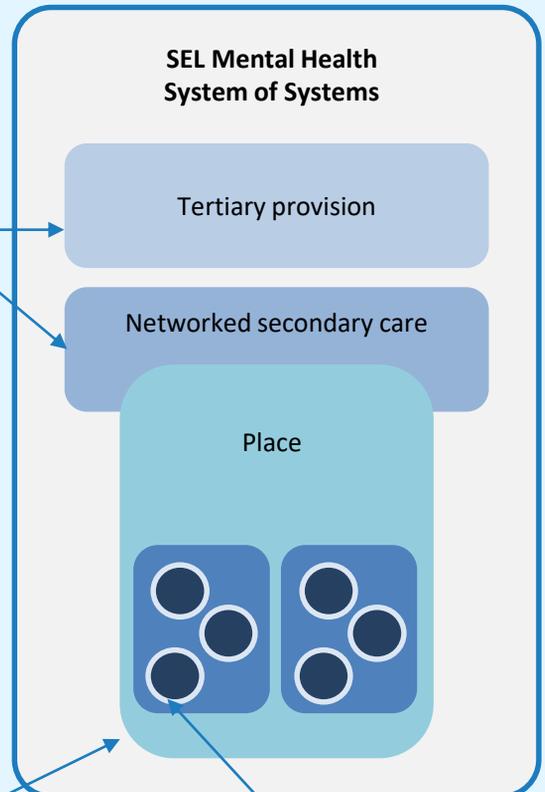
Our ICS System of Systems is complex, reflecting the complexity of delivering health and care services in a metropolitan city area. For our system to operate effectively we will need appropriate structures, clear roles and responsibilities, and strong relationships and ways of working. It will be key to ensure there is clarity over what is delivered at which level of our system, how we drive delivery at pace through these arrangements, and how we hold each other to account.

Tertiary provision and networked secondary care

- The South London Mental Health Partnership has made significant progress in developing and delivering care in new ways, through the **New Care Models programme**.
- This initially focused on tertiary provision, but is now shifting to consider networked secondary care delivery.
- Our aim is to secure economies of scale, reduce unwarranted variation and support a single high quality service offer for patients requiring specialist and secondary care. For 2019/20 and 2020/21 we have agreed that the priorities are **complex placements, perinatal, flow and bed management**.

Place

- We will continue to develop **close integrated working between health and local authorities at place** level to commission MH services and secure wider system (e.g. housing) to optimise outcomes and ensure that high quality services are delivered locally to meet local needs.
- **We will test and determine the best level at which to deliver our MH change programme across place and system, and ensure resilient place based delivery.**



Neighbourhood

We will ensure mental health **prevention** and care is embedded within the work of PCNs, to provide parity and drive delivery of integrated and holistic care across **mind and body**.

An overarching coordinating function will support:

- Understanding of need and priorities for service change.
- Ensuring an overall strategic direction for MH provision in SEL, including an agreed core offer and outcomes for patients.
- Strategic allocation of resources across the MH System of Systems to deliver priorities for change.
- Understanding what needs to be common and consistent at place level and what should be determined locally to meet the needs of the borough and its residents.
- Delivery of our infrastructure offer (e.g. for business intelligence; system monitoring).

These changes to how our system operates, and the experience people have of services they receive in SEL, will need to be embedded at each level of our ICS system to deliver on our priorities. The foundation of this is our place based partnerships at borough level which will drive a number of these system changes around integration of community based care and a shift towards preventative and personalised services. Our place based systems are at different stages of development based on their longevity, but each have a clear vision and set of aims and priorities to transform care for their local population.

An overview of each Local Care Partnership's arrangements and priorities is set out on the next pages.

Bexley Local Care Partnership



Our partnership working

Bexley CCG has worked with its providers to develop a provider alliance, 'Bexley Care'. The integration of adult and social care with Oxleas community and mental health provider is at an advanced stage with place based integration across three localities.

The Bexley Local Care Partnership was established in April 2017 and partners have agreed a Memorandum of Understanding describing the way partners work together. This has recently been developed into a vision and set of values between the following partners: Bexley Care; Bexley Health Neighbourhood Care; Bexley Voluntary Services Council; Dartford and Gravesham NHS Trust; Greenwich and Bexley Hospice; Healthwatch Bexley; Hurley Group; Lewisham and Greenwich NHS Trust; Local Medical Committee; Local Pharmaceutical Committee; London Borough of Bexley Council; NHS Bexley Clinical Commissioning Group; Oxleas NHS Foundation Trust; and primary care networks.

Bexley CCG has a strong history of joint working with the London Borough of Bexley, with shared roles and funding for integrated adult community commissioning. Our ambition for integrated working with the London Borough of Bexley is to move towards a single plan with two budgets (with the exception of the Better Care Fund).

Our priorities

The emerging Bexley Health and Wellbeing strategy 'Our health, our wellbeing, our place' identifies an overarching objective and 4 priorities for Bexley.

Objective: Preventing illness and promoting wellbeing: A system wide prevention strategy 'Start Well, Live Well, Age Well' proposes responses to the challenges facing the system under six themes:

- Giving children and young people the best start in life and throughout their lives.
- Improving outcomes for adults and older people.
- Embedding prevention in all policies and practice, and in Bexley's population health system.
- Healthy communities, workplaces and homes.

- Healthy environments, built, green and blue spaces.
- Economic independence and a thriving local economy.

Preventing obesity: Bexley has amongst the highest rates of obesity in London with almost a quarter of children entering primary school already overweight. Our aim is to halt and then reverse rates of obesity among children and adults through shaping the environment to build healthy lifestyles; this will support a community culture that sees physical activity and healthy eating as the norm and supports individuals to make healthier changes.

Mental health: In Bexley the aim is to build a sustainable mental health system where high quality responsive and accessible services result in improved outcomes for patients. Key commitments include: increasing mental health funding being spent on services for CYP who need specialist care; improved access to psychological therapies; and a promise that everyone will be able to access timely, 24/7 mental health crisis support and more mental health support in the community for those with severe mental health problems.

Children and young people: We are aiming to improve models of everyday healthcare for CYP; improve core health knowledge across the system from schools to secondary care; and improve access to services for CYP, including mental health services.

Frailty: The Bexley frailty strategy (awaiting publication) states that we will work together to prevent the development and progression of frailty by promoting active ageing and reducing social isolation.

- We will work to ensure that people are supported at home in order to avoid admission to hospital unless clinically justified.
- We will enable people aged over 80 to continue living safely in their own homes.
- We will ensure dignity in dying for older people – avoiding over medicalisation and ensuring choice of place of death.

One Bromley



Our partnership working

One Bromley comprises signatories to the Bromley Alliance, signed in October 2017, including: NHS Bromley CCG; King's College Hospital NHS Foundation Trust; London Borough of Bromley; Bromley Third Sector Enterprise; St Christopher's; Bromley Healthcare; Oxleas NHS Foundation Trust; and Bromley GP Alliance.

One Bromley will strengthen its approach by continuing to bring together providers, voluntary services and commissioners to build on the existing good work and deliver more personalised and integrated care. This plan will build on successes such as the Integrated Care Networks Pro-active Care Pathway and replicate this across many other programmes of care.

These programmes are delivered through the One Bromley Executive, made up of the leaders from each of the local partner organisations.

The strategic aims for One Bromley are:

- Improve health and wellbeing outcomes and reduce health inequalities across Bromley.
- Transform the delivery of health and care services by developing partnerships that promote and enable an integrated system with improved access and quality.
- Create a sustainable health and care economy, efficiently and effectively managing the resources and assets available to the partner organisations in an open and collaborative approach to support and sustain better services for Bromley residents.
- Collaborate to secure the best possible short-term service delivery, performance outcomes and financial duties whilst transforming models of care and integrated service arrangements for the future.
- Engage with the residents, patients and public of Bromley, together with partner agencies and stakeholders, to hear and respond to the views of local people and build community support for the One Bromley programme of transformation.

Our priorities

Over the last five years, the Bromley system has developed initiatives and projects to support improved delivery of services and health. Some of this work has

been done as part of One Bromley including:

- Proactive care pathway.
- Frailty pathway.
- Primary care networks as the basis of a population based approach.
- Pathway changes such as the virtual respiratory pathway, community heart failure, end of life and diabetes.
- Piloting of the @home service.

Priority areas for One Bromley were developed via stakeholder events. The One Bromley programme is one of wide ranging transformation which includes the following areas:

- Proactive care.
- Urgent and emergency care including @home service.
- Frailty pathway.
- End of life care.
- Care homes.
- Outpatient transformation.
- Primary care networks.
- Diabetes.
- Mental health.
- Children and young people.

Programme enablers include:

- Workforce and organisational development.
- Communications and engagement.
- Finance.
- Estates.
- Business intelligence and population health management.
- Contracting and organisational structure.
- Digital and IT.

These programmes of work will ensure that patients receive seamless integrated care across Bromley, being seen by the right partner at the right time. This multidisciplinary approach will reduce duplication for the patient, providing pro-active care whilst making the best use of the resources available.

Healthier Greenwich Alliance



Our partnership working

The local partnership, now called the Healthier Greenwich Alliance (HGA), was first established in the summer of 2018.

Membership includes: Greenwich CCG (Chair); the Royal Borough of Greenwich (Public Health, Adult and Children's Service Directors); Lewisham and Greenwich NHS Trust, Oxleas NHS Foundation Trust; Greenwich Health (GP Federation); Clinical Director representatives of the local PCNs; Healthwatch; and the community and voluntary sector represented by METRO Gavs.

Terms of Reference for the HGA have recently been refreshed and were agreed in October 2019. HGA partners have been part of implementation journey for PCNs as key stakeholders and system partners.

The Alliance has now been meeting for a year and provides an opportunity for joint discussions of relevant issues between partner organisations.

The Greenwich Commissioning Strategy published in 2018, 'Transforming our health and social care in Greenwich', has provided a clear sense of priorities for work in four key areas: prevention, mental health, frailty, and cancer, together with transformation workstreams in primary and integrated care. Progress towards the development of the Mental Health Alliance is also considered at the Alliance. An agreed implementation plan for all priorities supports our work and is monitored by a dashboard of key performance indicators.

More recently the Alliance has set out three areas as focus for work, including commissioning children and young people's services (in particular those children and young people who experience poorer health and life chances), and continuing to develop the Mental Health Alliance.

The Healthier Greenwich Alliance is in itself a vehicle to deliver transformation of services in priority areas. Through collaborating across Greenwich, Bexley and Lewisham, work is underway to progress transformation of services in planned and unplanned care, mental health, children's services and primary care.

This is supported by organisational development across the system to support the changes proposed.

Our priorities

Set out below are the main service areas where teams already work in an integrated way:

- **Development of a Mental Health Alliance** – our strategy is to work together as agencies responsible to provide wrap-around health and social care needed by people living with a physical and mental health condition. We have identified 4 transformation pathways: community mental health, crisis resolution and home treatment team, suicide prevention and dedicated 24/7 crisis line.
- **Joint commissioning to address frailty** – over the last year there has been increased and productive collaboration between CCG and council staff on a series of joint initiatives focused on Greenwich's frail population. Examples include the development of the Age UK settling service, our "discharge to assess" service and a falls and frailty community service (launching later in 2020). Plans are in development to change the way people in Greenwich receive urgent care by increasing the scope of the Joint Emergency Team, who provide urgent support to people in the community 7 days a week, to enable them to address a wider range of conditions in patients' own homes to avoid the need for a hospital attendance or admission.
- The **Transfer of Care Collaborative** works across agencies to actively coordinate discharge planning, supporting patients to not stay in hospital for any longer than is clinically needed.
- **Joint Community Learning Disability Service** – led by the council, this service comprises social care staff and a range of specialist health professionals, providing specialist health and social care services to people with learning disabilities and their carers with complex lives and needs.
- **Children and young people** – the Director of CYP services is a member of the HGA and we have forged close working relationships with CYP services at the council and these will become more formal in the coming months.



Our partnership working

Lambeth Together has been established since early 2017 as a system-wide partnership, meeting regularly since that time.

Our partners include: NHS Lambeth CCG; London Borough of Lambeth; Guy's and St. Thomas' NHS Foundation Trust; King's College Hospital NHS Foundation Trust; South London and Maudsley NHS Foundation Trust; Lambeth GP Federations / PCNs; Healthwatch Lambeth; Lambeth Patient Participation Group Network; Age UK; Black Thrive and others.

Lambeth Together has been established as a borough partnership, bringing together local government, the NHS, third sector and community partners with innovative approaches to achieving our core aim of improving health and reducing inequalities in the borough.

This vision is supported by a strategic approach that stretches from the Health in all Policies approaches, community activation and service improvement through integrating care, working in partnership with our diverse communities, and implemented through our Delivery Alliances: Living Well Network Alliance for adults living with mental health conditions, our Neighbourhood and Wellbeing Alliance, and our Children and Young People's Partnership.

We have a single Integrated Strategic Alliance Leadership Board to further develop arrangements and steer the transition to Lambeth formal Place Based Board arrangements from April 2020.

Shared leadership and teams, working across Lambeth Council and Lambeth CCG, are already in place across NHS commissioning, social care and public health responsibilities, led by a single Strategic Director for Integrated Health and Care.

An active programme of transformation is in development, bringing together professional teams and our communities around shared ways of working and culture and to address opportunities to support our workforce, to develop our digital offer and to best utilise our buildings and other community assets.

Our priorities

Living Well Network Alliance – Adult Mental Health:

Our vision is for our mental health services to be more joined up, be quicker and easier to access, and be more focused on prevention, thereby avoiding crises and unnecessary admissions to hospital. Our immediate priority areas of work are:

- Single point of access.
- Crisis outreach service.
- 3 x Living Well Centres incorporating short-term support service and integrated focused support service.
- Framework agreement for accommodation and community support services.
- Employment and vocational support strategy.

Neighbourhood and Wellbeing Alliance: The Alliance focuses on improving health, keeping people well, promoting wellbeing and reducing differences in access to services and health outcomes. Our immediate priority areas of work are:

- Develop and agree the delivery model for phase one cohort of all people living with 3 or more medium-long term conditions, +/- frailty, and people living in their last years of life.
- Design and support the setup of phase one neighbourhood 'test and learn' areas and subsequent roll out.
- Development of Memorandum of Understanding to support phase one.
- Establishment of PCNs; Extended Hours; PCN development and support; data sharing and infrastructure.

Children and Young People: This programme focuses on integrating services and support for children and young people – from maternity to early adulthood, to ensure Lambeth is one of the best places in the world for our children and young people to grow up. Priority areas of work are:

- Introduce a new Better Start programme.
- Develop the early help programme.
- Improve support for children with special educational needs and disability.
- Improve children's social care.
- Improving the emotional health and wellbeing of children and young people.

Lewisham Health and Care Partners



working together

Our partnership working

The Lewisham Health and Care Partnership was formally established in 2016, building on Lewisham's Adult Integrated Care Partnership which had been in place since 2014.

Lewisham Health and Care Partners includes: Lewisham and Greenwich NHS Trust; London Borough of Lewisham; NHS Lewisham Clinical Commissioning Group; One Health Lewisham (Pan-Lewisham GP Federation); South London and Maudsley NHS Foundation Trust; and Lewisham's Local Medical Committee.

Discussions are taking place to enhance primary care representation and input from the voluntary and community sector given the establishment of primary care networks and the increased recognition of the role of the voluntary and community enterprise sector in maintaining and improving health and wellbeing.

The Partners meet regularly through their Executive Board to provide shared system wide leadership, set the strategic direction for integration and transformation and oversee the changes required for health and care across Lewisham.

Lewisham's existing joint commissioning arrangements for children and adults are governed by section 75 agreements. The council and CCG seek to further strengthen these commissioning arrangements as part of the development of the place based system and governance underpinned by our local Health and Wellbeing Strategy.

Alongside Lewisham's integrated commissioning arrangements, the borough is building local provider collaboratives:

- **Care at Home:** brings together local health and care organisations to develop new integrated provider arrangements to deliver care and support for adults in their own homes, improving the coordination, quality and accessibility of that care and support.
- **Mental Health Alliance:** seeks to provide working age adults with a personalised approach to their treatment, care and support needs, based on the identification of assets and strengths, and facilitating the achievement of personal goals.
- **Children & Young People's Mental Health and Emotional Wellbeing Partnership:** seeks to strengthen the local offer connecting CAMHS, family support and young people's health and wellbeing services with close links to wider work within early help and schools.

Our priorities

A primary focus for Lewisham Health and Care Partners continues to be on the integrated delivery of proactive, coordinated and accessible community based care at a neighbourhood level, and on establishing an effective interface between community based care and secondary provision. This includes responding appropriately to the culturally diverse needs of local people and reducing inequalities.

Four partnership priorities have been identified for system transformation. These priorities are supported by the development of Lewisham's data and information management system which is providing the population level data and information necessary to inform and validate the improvement and transformation decisions being taken across Lewisham's health and care system. Lewisham aims to enhance the local analytical capability to identify further areas for improvement.

Frailty – a dashboard for frailty is being developed to stratify the local population into cohorts of mild, moderate and severe and map against other conditions, services and indices of deprivation. This will be used to target specific cohorts for prevention and early intervention activities and to put in place a range of coordinated anticipatory care to avoid or avert a crisis or other event.

Mental health – the Mental Health Provider Alliance is currently focusing on transforming front door and rapid crisis response, community support, and rehabilitation and complex care. These activities seek to help those living with serious mental illness by: facilitating recovery and helping people to stay healthy and engage in community life; developing and supporting community wellbeing, offering early intervention and prevention; and improving care for service users presenting in crisis. Support to local children and young people's mental health, including increasing early intervention, also remains a key priority.

Respiratory – priority actions include commissioning integrated respiratory community hubs; review of the Lung Education Exercise Programme; and delivery of multidisciplinary team working with primary care, community and social care for respiratory patients so that there is a respiratory model of care that provides a holistic person centre service.

Diabetes – following data analysis, four areas of focus have been identified: patients with undiagnosed diabetes; patients at risk of developing diabetes; patients that had gestational diabetes and have not had a 3 and / or 15 month check; patients not in range for 1, 2 or all 3 of the treatment targets. Primary and community care will work with these groups to provide an increased focus on diabetes prevention and to provide better coordinated and integrated diabetes services that fit around an individual's needs.

Partnership Southwark

Partnership
Southwark



Working together to improve health and wellbeing for the people of Southwark

Our partnership working

Partnership Southwark brings together health and care partners across Southwark to change the way services are commissioned and delivered in the borough.

Representatives from Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Improving Health Ltd, Quay Health Solutions, Southwark Council and Southwark CCG are on the Partnership Southwark Leadership Team. The Partnership Southwark Leadership Team has been meeting formally since May 2019, but started working together as a partnership in June 2017.

Through the development of the strategic case for change, the vision and ambition for Partnership Southwark has been defined and agreed. The commitment from the partners to work on the priorities and objectives in a collaborative way to deliver these is captured in a Memorandum of Understanding. Within this framework a number of workstreams developed. For each of the workstreams Senior Responsible Officers have been appointed, and the scope, objectives, outcomes / success measures, resources required, key deliverables, risks and interdependencies have been identified and agreed.

Joint communications are underway with key stakeholders and service users / patients, with a summary overview pack, neighbourhood playbook developed, and interactive personas developed for each workstream to demonstrate what will be different for service users and staff through this partnership approach.

The CCG and council have agreed to define their scope for joint commissioning during 2019/20 to enable and encourage integrated commissioning arrangements and ultimately delivery of services. This scope will be used to develop the already established joint commissioning team to ensure a fully integrated commissioning approach within Southwark by April 2021.

Our priorities

Our priorities for 2019/20 – 2020/21 include:

- Accelerating the development of neighbourhoods supporting circa 30,000 – 50,000 people. These neighbourhoods will involve primary, community and social care, wider council (e.g. housing) and the voluntary and community sector, and will better join up care and support for people with complex health, care and wellbeing needs.
- Helping more people with long term conditions / frailty to be supported in the community and their own home, which will reduce unnecessary time spent in hospital.
- Providing focused support for residents of care homes and nursing homes to ensure better outcomes and reduce avoidable hospital admissions.
- Supporting people with mental health issues in a primary and community care setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.
- Increasing focus on prevention and self-management, supporting people to live healthier for longer and working to prevent deterioration.
- Improve our population health analytics capability to better understand and proactively respond to population need at a neighbourhood and place-based level by sharing and linking data.
- Supporting people to have greater control over their own health and wellbeing, connecting them to the community and reducing social isolation.
- Developing our approach for children and young people, bringing together work within the Children and Young People's Health Partnership and the development of population-level outcomes using Southwark Bridges to Health and Wellbeing.

Commitment 2: Redesign commissioning

We will redesign how we commission services in south east London

Vision

To deliver a more effective use of our collective resources and improved outcomes for the population by transforming how we commission services, with a planned shift to a commissioning function focused on strategic outcomes based commissioning and system management.

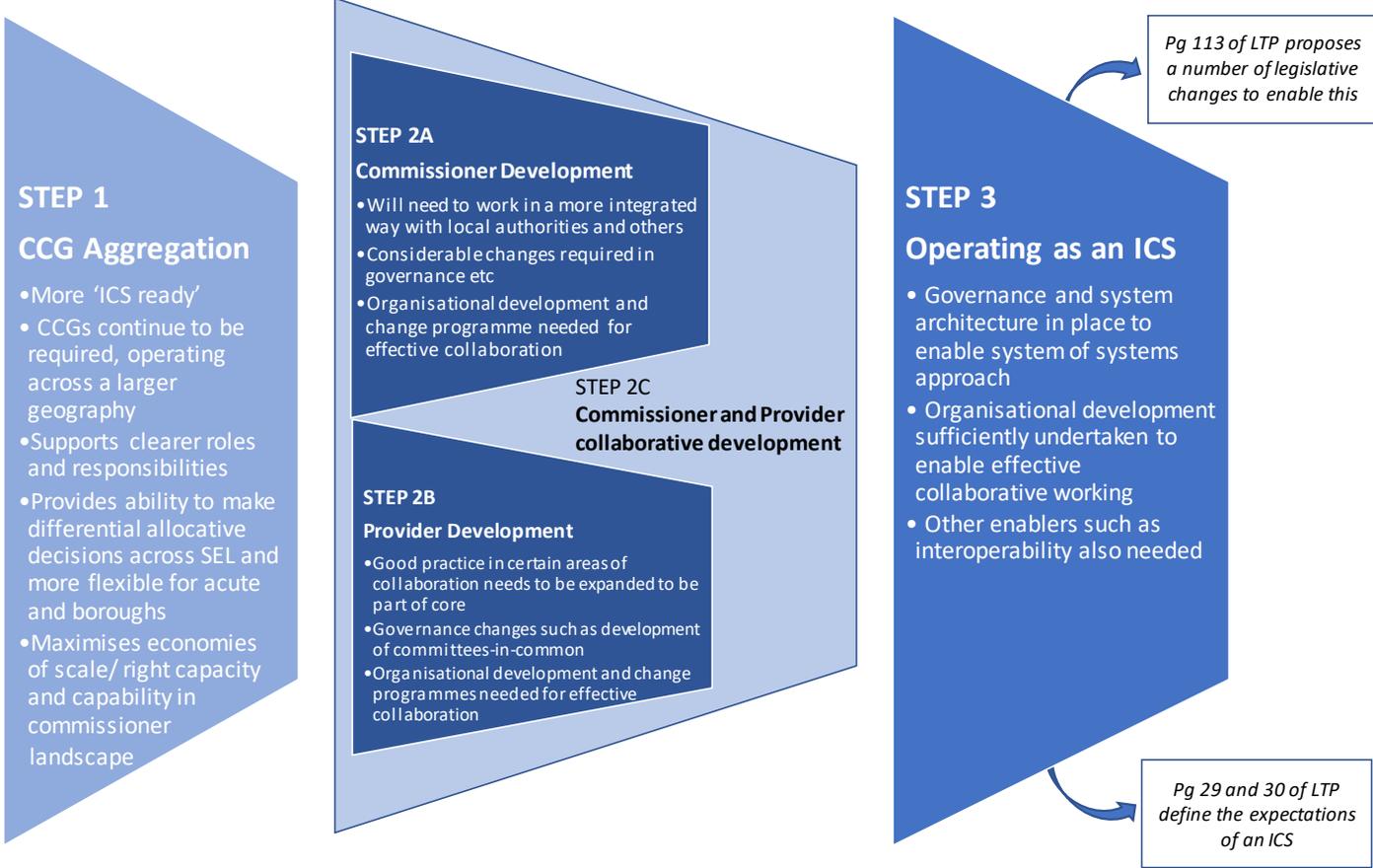
Objectives

- To define what SEL “commissioning” will look like in the future, focusing on strategic outcomes based commissioning and system management, with subsequent blurring of historical provider and commissioner role.
- As a first step towards this, we will aggregate CCG commissioning, with a merger of the current six SEL CCGs to secure a single CCG commissioner / CCG from 1 April 2020.
- We will accelerate our ICS ambitions through supporting enhanced collaborative working between different types of commissioners and with providers, at all levels of the system – with an expectation that over the next five years a number of commissioning functions will shift to our ICS PMO, with associated “whole system” focus, or to provider collaboratives, as we continue to blur the historical boundaries between providers and commissioners.

We will deliver our vision and objectives through the following priority actions

- Following approval of our merger application, undertake a process to merge the six SEL CCGs to become South East London CCG on 1 April 2020. Through the creation of a single CCG we are seeking to create a commissioning system that:
 - i. Locates and coordinates decision making for the populations we serve and the services we commission at the scale at which they are best planned and delivered.
 - ii. Brings about a greater integration of health and social care commissioning around the wider needs and wellbeing of our population and the whole person.
 - iii. Fundamentally shifts the interaction between providers and between commissioners and providers towards collaboration and collective responsibility for patient outcomes, service delivery and living within available resources.
- Transition to a commissioning model which operates both at scale and at place based level as appropriate to enable service change.
- Commissioner and provider development to work together in new ways which support and align to the ICS, with associated blurring of traditional commissioner and provider roles to focus on population outcomes and system level management.

Commitment 2: Redesign commissioning (continued)



Commitment 3: Hospital groups and network models

We will test hospital group and network model approaches across acute and mental health services as part of our SEL ICS

Vision

We will implement networked solutions to test integrated working at “system level” across acute and mental health providers, where this supports delivery of more consistent and standardised services, reducing unwarranted variation and inequality of access for our population.

Objectives

- We have committed to testing and building collaborative approaches across SEL’s secondary care providers where this will help secure sustainability for our acute and mental health sectors – and wider ICS – in clinical, quality and financial terms.
- We will work as part of our MH South London Partnership Programme and our SEL Acute Based Care Programme to identify areas of service delivery and provision that should be addressed at SEL ICS level, and those that require wider south London, London wide or pan London STP approaches.

We will deliver our vision and objectives through the following priority actions

For the acute sector, specific ICS work programmes are focused on:

- Networked hospital provision and service delivery models, where it is identified that this will support sustainability of our acute providers and support high quality consistent care for our population.
- System level demand and capacity planning and utilisation, to assess capacity requirements, gaps and solutions; our aim is to ensure a joint strategic plan to meet future demand and make best use of available capacity across the acute sector. We will continue to focus on locally delivered services where these provide good clinical outcomes.
- Governance changes to shift delivery responsibility to accountable hospital networks for secondary care services, where this is

identified as a key enabler to transforming care delivery.

- The development of a clear clinical strategy for acute provision and associated service plans.

For the mental health sector, specific ICS work programmes are focused on:

- Further development of networked provision of MH services through the South London Partnership.
- Identifying new services that can be best delivered through collaboration and at scale, meeting local needs.
- Collaboration aiming to improve retention and develop flexible workforce across south London for future mental healthcare including increased community provision.
- Development of wider system working for mental health to ensure a triangulated approach across commissioning, provision and oversight.

We believe that hospital group and networked approaches to provision will support us in delivering:

- An improved track record of delivery – through our planned shifts to networked provision, a system approach to capacity and a systematic approach to pathway redesign and the addressing of unwarranted variation.
- Sustainability – through collaborative, (rather than organisational / site specific) approaches and solutions, which will support improved outcomes.
- Collective decision making and responsibility across our providers, through our ICS governance and delivery programme.

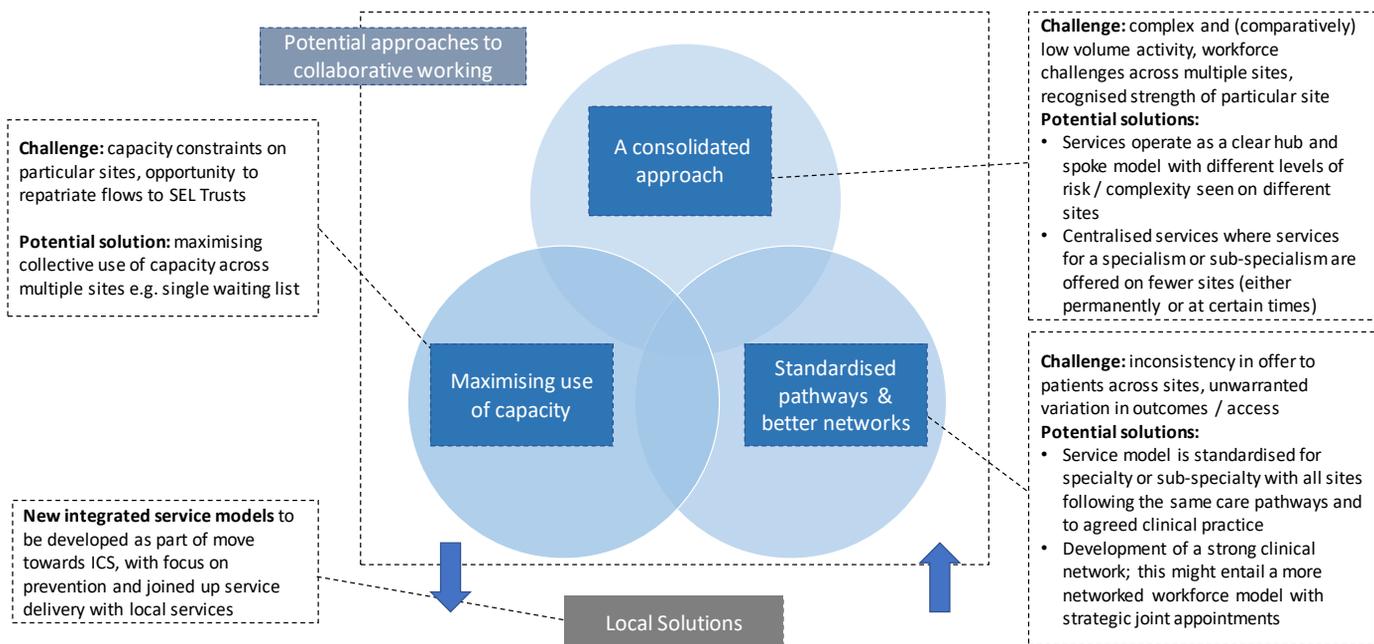
Commitment 3: Hospital groups and network models (continued)

Testing and implementing different forms of collaborative working to meet our challenges

Our Acute Based Care Board has started exploring what collaborative working solutions could look like, and how these new ways of working could help to address the challenges facing the acute sector.

The diagram below sets out some examples of potential new ways of collaborative working that the Acute Based Care Board is testing as it progresses its work plan.

As we test approaches we will also be testing whether an overarching acute partnership would help drive the pace and scale of decision making and change that we might need to meet our ICS ambition and addresses our challenges.



More detail on our plans is provided in the [appendices](#), including:

- Long term objectives and short term priority actions for acute based care.
- A site based service plan for acute services in SEL.
- Strategic priorities for mental health.
- Collaborative working arrangements across the MH trusts in south London.

Commitment 4: Integrated care

We will test integrated care approaches through development of PCNs at the core of our delivery model for fully integrated community based care

Vision

Delivery of consistent and high quality integrated community based care for adults and older people with complex needs, which keeps people as healthy and independent as possible, in their homes.

At the heart of our community based care model is the “primary care network”: groups of practices coming together locally in partnership with community services, social care and other providers of health and care services around the needs of a geographically coherent population or “local neighbourhood” (typically covering 30,000 to 50,000 population*). If we are to deliver our vision of a genuinely multidisciplinary team at this level of the population, this will need to be a collective endeavour. Organisations will need to work together to deliver a core, proactive, innovative and integrated community based care provider offer, in partnership with local neighbourhood populations – a true test of ICS approaches and ways of working.

We have illustrated our vision in the diagram overleaf.

Objectives

- To develop our ways of working at borough and neighbourhood level so that we are delivering truly integrated and MDT care in the community for those who need it, with a consistent offer across our population.
- To support the sustainability and resilience of primary and community care services through enhanced collaboration and support across and within local systems.
- To shift to a system of community care delivery which is driven by a systematic approach to population health management, with a focus on optimising quality of life and reduce inequalities in health outcomes.
- To shift to a system of community care delivery which is proactive rather than reactive in focus, demonstrating a tangible impact on managing demand seen in the acute hospital setting.

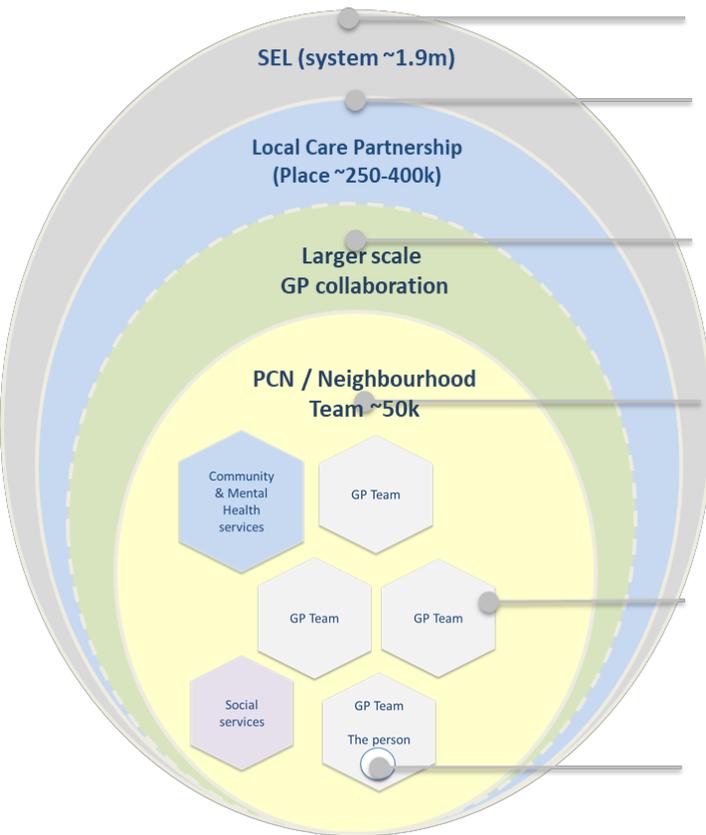
We will deliver our vision and objectives through the following priority actions

- Developing a systematic approach to addressing health inequalities within community services, as part of our wider system approach to population health management.
- Supporting the development of PCNs through a comprehensive PCN support and development strategy.
- Work across the SEL system to develop “a core community offer” which meets the needs of local populations and supports delivery of wider system ambitions, with an initial focus on improve the responsiveness of community health response service, via two-hour crisis and two-day reablement responses (as part of our national accelerator site application).

*Some partnerships in south east London have agreed PCN agreements covering patient populations larger than 50k; where this has been agreed this better meets local need.

Commitment 4: Integrated care (continued)

We will test integrated care approaches through development of PCNs at the core of our delivery model for fully integrated community based care



- **Primary care** has a seat at the table for **System level** leadership of services and strategy across SEL.
- **Primary care** interacts with **hospitals, mental health trusts, local authorities and community providers** in an alliance of **commissioners and providers** across health, social care and broader voluntary and community sector.
- Working with **PCNs** to deliver **fully integrated, community based care**.
- Operating through a common model to support the **development and delivery of PCNs**, including support for **PCNs to come together**.
- Delivering **efficiencies of scale, infrastructure, coordination, leadership support** to general practice and PCNs.
- **Interface with Local Care Partnership arrangements**
- **Practices and other health, social care and voluntary partners** collaborate as **primary care networks**.
- **Geographically contiguous** teams of practices caring for **30k+ people**.
- Delivery of **data driven** integrated MDT based services.
- **Key Scale** to deliver **integrated community services around patient needs**.
- GP team providing **resilient and sustainable core general practice**.
- Coordination and planning of **holistic, personalised accessible care**.
- **Small enough** for the benefits of **continuity of care** and a **personalised service**; **big enough** to **safely cover rotas** and provide a **balanced skill mix**.
- **Each person** can access **joined up, proactive and personalised care**, matched to **their needs**.
- Supported by **families and local communities**.
- **Enabled and empowered to access care** in a way which works for them.

Commitment 5: New model for specialised services

We will develop a new commissioning model for specialised services for the SEL ICS

The SEL ICS has been working with south west London and London colleagues to consider the future of specialised commissioning in the context of our developing integrated care system. Our work is at an early stage and is taking place as part of a wider London work programme, where we are working (as part of the ICS Wave 3) to test approaches to delegated specialised commissioning in a London context.

Vision

To shift from our current model to a **new model of commissioning and provision** in line with the broader development of the SEL ICS and national policy with regard to specialised commissioning.

Objectives

- Secure the **delivery of high quality, sustainable specialised services** across south London that serve both our south London and wider populations as required.
- Secure an agreed **service and site strategy for the provision of specialised services** in south London. This should set out an agreed contribution of these services to the delivery of a sustainable ICS and end-to-end pathway population health outcomes. It should also be underpinned by networked provision across the most appropriate population base to support high quality sustainable provision.

We will deliver our vision and objectives through the following priority actions

- **Move from our current position to our end state model** and determining the steps required to get there. We will need to ensure effective risk management and mitigation as we transition to new ways of working and delivery, ensuring effective leadership, governance, infrastructure and organisational development to support our new ICS models.
- **Develop and implement south east London potential test bed proposals** to support both SEL ICS and wide London development – this includes the consideration of:

- An end to end commissioning and contracting provider test bed.
- End to end pathway commissioning test beds.
- Understand, assess options and agree handling of the following:
 - **Population focus** – the current model is provider not population driven. Future models need appropriate population focus and must also be clear about commissioning arrangements for populations outside of the SEL footprint who receive their care in SEL providers.
 - **Funding and risk management** – management of risk associated with specialised services, including budget transfer approaches, future growth funding, risk management and incentive approaches that will best support effective risk mitigation and delivery of system savings.
 - **Agreement of a south London specialised commissioning model** – consideration and agreement of options to include devolution of commissioning or a direct move to a lead provider / provider network model. We will also need to consider the infrastructure required to support the effective delegation of commissioning functions and how this is resourced.

See the [appendices](#) for more information on our plans.

We will harness ICS approaches to enable us to deliver the NHS constitutional standards

SEL's performance and specifically the delivery of NHS constitution standards is extremely challenged – our challenges are long standing in nature and span A&E, RTT and cancer access targets in all three acute providers. We recognise that these acute challenges are symptomatic of wider systemic issues and that our solutions also need to be system focused.

Our objective is to harness ICS approaches to enable us to deliver the NHS constitutional standards. This is inclusive of robust governance and oversight to support: collective responsibility to be enacted; system approaches to and responsibility for recovery; a robust diagnostic to support the identification of sustainable solutions; and appropriate resourcing and infrastructure to support sustainable recovery.

Case example: cancer

We recognised in 2018/19 that our organisation specific approach to cancer recovery was sub optimal. Many of our pathways were shared across providers and our providers were facing and trying to grapple with common challenges.

For 2019/20 we shifted our focus from organisation specific to a system approach including:

- The development and agreement of a **system wide recovery plan**.
- The agreement of **common pathways and best practice expectations** with regards timed pathways, PTL management, patient tracking and data systems.
- The establishment of a **SEL wide expert cancer team** working as part of our Accountable Cancer Network, working alongside site / trust cancer teams to support our improvement work.
- **Revised governance and oversight**, including an emphasis on standardised and robust reporting on performance and recovery actions and a Chief Executive led Cancer Members Board.
- **Agreed system approaches to the utilisation of national transformation funds**, with investment prioritised to support 62 day recovery and a system approach to **addressing diagnostic capacity shortfalls**.

Our approach has been recognised as an exemplar, but we have yet to see the positive processes outlined above translate into performance recovery. We need to better understand why this is the case and to ensure we address identified issues, as well as applying the learning to other areas of performance challenge.



Planned ICS approach

- **Strengthened governance** – to underpin A&E, RTT and cancer recovery – we need to shift from a system that is committed to (and has positive examples of) collaborative working to one where we can genuinely hold ourselves and each other to account in relation to delivering the commitments we make.
- **System approaches to recovery** – for all performance recovery a shift from organisation to system approaches, commitments and deliverables.
- **Systematic and sustainable recovery** – a shift in focus from short term immediate recovery actions to an approach that addresses the underpinning drivers of our performance challenges; these include demand and capacity, workforce, delivery of optimised best practice pathways, system wide commitment and incentivising culture and behaviour.
- **Capacity and capability to drive recovery** – a system approach to ensuring that we have the infrastructure in place to drive and sustain the delivery of our agreed actions.

We will need to operate as a mature and thriving ICS to secure the improved outcomes to which we aspire and are committed. This is in the context of a 2019/20 position which remains challenged and within which we have not met the improvement commitments we made at the start of the year. Our ICS development commitments are designed to support sustainable improved performance – but, as for cancer, will take time to secure.

We will harness ICS approaches to support us in improving our financial position

SEL's financial position is very challenged, particularly across our provider sector, albeit with a differential level of challenge across our organisations. Securing financial improvement has and will continue to present a challenge over the next five years. We will need to focus as a system on securing a recurrent run rate improvement, to not overcommit available resource and to achieve financial sustainability at the pace defined by the control totals set.

Our objective is to harness ICS approaches to support us in securing this financial improvement – inclusive of robust governance and oversight that enables collective responsibility for: allocating and managing resource and associated risk; system approaches to and responsibility for delivery of financial savings plans; a robust diagnostic to support the identification of sustainable solutions; and appropriate resourcing and infrastructure to improve our financial position.

2019/20 planning round example

We recognised in the 2019/20 planning round that our historic bilateral approaches to planning were not securing optimal outcomes. Building from our collaborative approaches to financial recovery and management that we undertook as part of the Aspirant ICS Programme, we agreed the following approach:

- The development and agreement of a set of principles to underpin the planning round.
- The collective agreement of all key ICS partners to the allocation of CCG growth for the year.
- A consistent approach to contract form with all key contract agreements shifting to an aligned incentive (block type) contract agreement.
- A consistent approach to contractual efficiency and pathway redesign impacts, to support assumed savings related to pathway redesign and transformation.
- A system approach to the management of in-year risk associated with our contractual agreements, to support collective discussion and agreement about the use of in year reserves and flexibilities to support the best possible financial outcome for SEL as a whole.

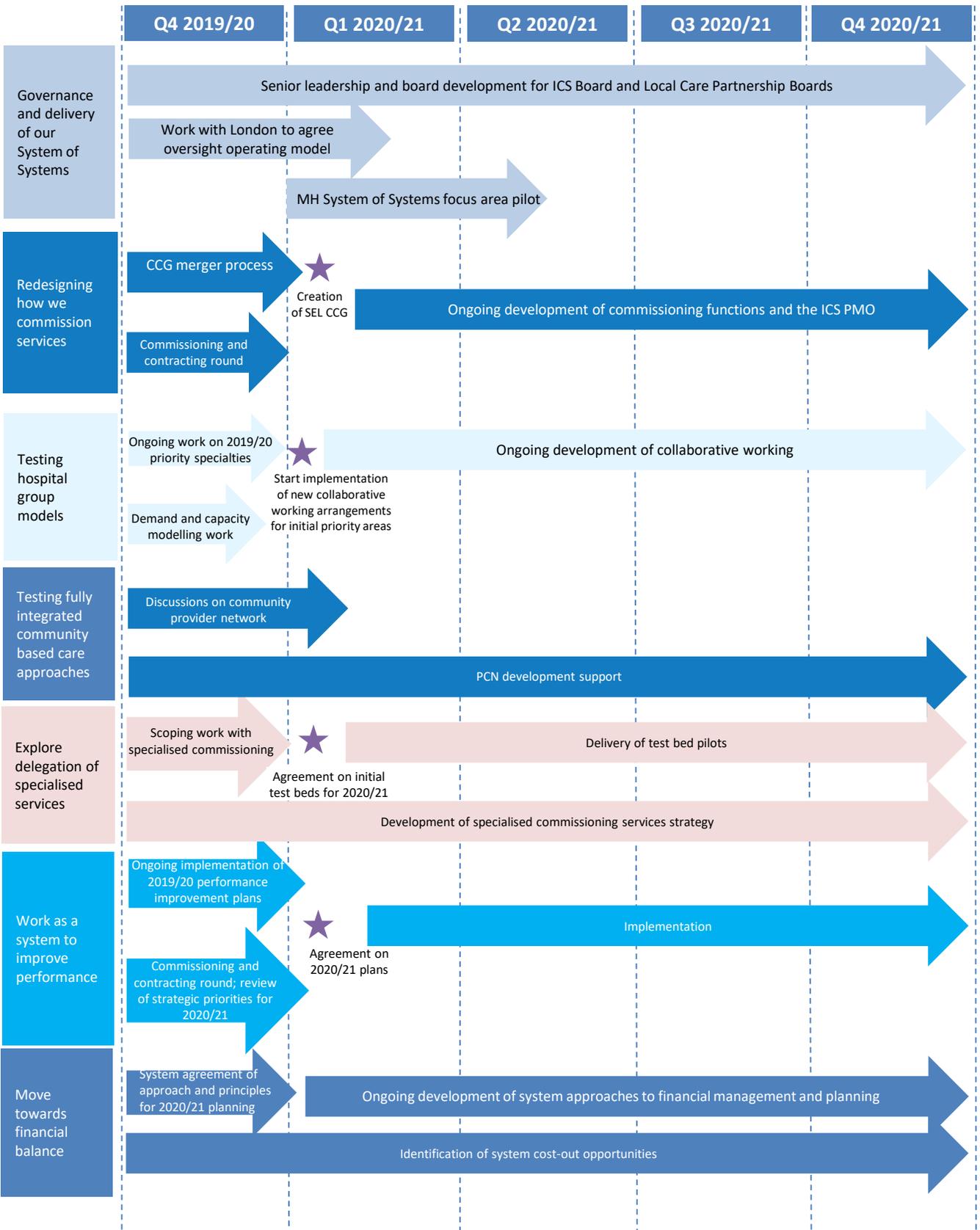
Our approach has been recognised as positive both internally and externally. However our key challenge remains to identify and secure cost out opportunities across our clinical and non-clinical cost base to ensure that our spend equals our available funding. Equally we need to move beyond our 2019/20 approaches to further develop new payment and risk share mechanisms that effectively incentivise change and financial control system wide.



Planned ICS approach

- **Strengthened governance** – to support more formalised collective financial planning, decision making and responsibility, and to oversee agreed actions and the operation of a system control total.
- **System planning** – we will agree a set of ICS principles to support future planning rounds, alongside collective agreements in relation to the allocation of resources and the management of risk. We plan to test some new approaches to risk management and incentives across providers in 2020/21, building from our 2019/20 planning approaches.
- **System approaches to improvement** – to enable the ICS to identify a number of priority cost out programmes that make explicit the relative contributions across the system, recognising that solutions for particular organisations may lie outside of that organisation.
- **Systematic and sustainable improvement** – a shift in focus from short term and non-recurrent financial improvement actions to an approach that addresses the underpinning drivers of our deficit: staffing, estates, demand and capacity, workforce, optimised best practice pathways, system wide incentives to manage patients in the most cost effective setting, culture and behaviour.
- **Capacity and capability to drive improvement** – a system approach to ensuring that we have the infrastructure in place to drive and sustain the delivery of our agreed actions.
- **New payment approaches** – to support a further shift from payment by results coupled with agreed approaches to demonstrating and securing a return on investment / productivity and efficiency across our CBC investment.

Year 1 and 2 milestone plan





A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

5) System financial management



Introduction and background

In this section we summarise our local financial context and our financial assessment of the SEL system and our strategic plan to create a more financially sustainable future for the NHS in south east London.

In overall terms the south east London health and care economy, like many others, has been in financial deficit for several years. Whilst some organisations within the system have achieved comparatively small surpluses in the last two years, these have been offset considerably by deficits in other organisations and we start this five-year planning period with significant cumulative historical deficits and an underlying in-year annual financial deficit. The south east London health system is complex and complicated with significant patient and money flows into our providers for specialised services, commissioned by NHS England, and from the rest of London and the UK. Our strategic financial plans acknowledge this complexity and our current deficit position (£237m in 2019/20) and underline our commitment to addressing our underlying recurrent deficit, as well as managing our finances over the next four years towards a sustainable position within national planning expectations.

CCG allocations

To support the Long Term Plan response NHS commissioners have received four year allocations for the period 2020/21 to 2023/24, in addition to the 2019/20 allocations. These allocations include a number of important national planning assumptions, including inflation and expected uplifts to support implementation and delivery of the LTP objectives by service area: primary care, community services, mental health, continuing healthcare and management costs. SEL CCGs are due to receive an increase in funding of £568m in total over the next four years from 2019/20, which represents an average increase of 4.1% per annum which is set out in the table below.

CCG Allocations	2020/21	2020/21	2021/22	2021/22	2022/23	2022/23	2023/24	2023/24
	£m	%	£m	%	£m	%	£m	%
CCG Programme Allocations	2,706.61	4.45%	2,821.33	4.24%	2,931.20	3.89%	3,034.57	3.53%
Primary Medical Care (Delegated Co-Commissioning)	279.18	4.51%	292.13	4.64%	306.55	4.94%	322.91	5.34%
CCG Running Cost Allocations	35.03		-		-		-	
CCG Allocations, total	3,020.82		3,113.45		3,237.75		3,357.49	

Additional system funding allocations

The table below shows that our SEL system allocation is £25.3m in 2020/21, rising to £70.3m cumulatively in 2023/24. These allocations have been specifically allocated for primary and community care, mental health, ageing well, cancer and prevention services. The allocation for 2019/20 builds on the funding we had anticipated and will continue to be used to support existing programmes:

- Primary care extended access services which continues to support the 8am to 8pm services.
- Improving cancer performance through the expansion of the Cancer Alliance.
- Improving mental health crisis services.

The additional system funding allocations in years 3 and 4 will be focused on supporting the integration of primary and community services relating to the ageing well programme and improving community provision of mental health services. The plans for these services will be developed further to support robust implementation from 2021/22 onwards.

LTP funding financial summary	2019/20	2020/21	2021/22	2022/23	2023/24
	£m	£m	£m	£m	£m
Mental health	2.90	3.14	9.44	18.99	25.52
Primary medical and community services	15.49	17.69	19.16	24.05	28.57
Cancer	3.87	3.09	2.41	2.30	2.30
Other	1.26	1.35	3.19	4.63	13.92
LTP Funding allocation	23.53	25.27	34.20	49.98	70.31

ICS financial challenge

As the table on the previous page sets out, we are expecting to receive an increased allocation over the next four years. However, our work to date has identified that our costs will rise by more than the allocation for the following reasons:

- Increasing population – in addition to standard demographic growth there are several significant new housing developments across south east London boroughs, e.g. Elephant & Castle, Thamesmead. As a result, our population is growing rapidly and at a faster pace than many other parts of the country.
- Our population forecasts show that we will see a disproportionate increase in people with more complex health needs over the next five years, as people live well for longer than they previously have.
- Medical and technological advancements in healthcare such as new drug treatments, new diagnostic and surgical procedures.
- The NHS Long Term Plan sets out a number of clear aims and goals that will require significant investment to ensure they are delivered. We will have to find ways to be more efficient across our whole system alongside ensuring we can deliver our planned investments and commitments in mental health and primary and community based care services.

As part of the planning process the ICS has been notified by NHSE&I of the financial improvement trajectories for the system for each year to 2023/24 (see table below). These trajectories recognise the level of financial challenge in south east London and consequently they seek to significantly reduce, rather than fully eliminate, the deficit in the system over the lifetime of this plan.

We are committed to delivering challenging and realistic rates of year on year improvements to the underlying financial position, in line with our agreed ICS priority of securing, over time, a financially sustainable system. Our current work indicates that in order to deliver this commitment and support the delivery of the aims of the Long Term Plan the ICS will need to deliver savings of c.£250m per annum over the period of the plan.

Financial improvement trajectories	2019/20	2020/21	2021/22	2022/23	2023/24
	Plan £m				
Guy's & St Thomas' NHS FT	(8.40)	(5.02)	(1.58)	-	-
King's College Hospital NHS FT	(167.90)	(134.22)	(108.17)	(91.38)	(86.30)
Lewisham & Greenwich NHS T	(42.40)	(39.65)	(37.48)	(35.46)	(33.72)
Oxleas NHS FT	(0.20)	-	-	-	-
South London & Maudsley NHS FT	(14.40)	(12.14)	(10.45)	(8.25)	(5.94)
South east London Providers	(233.30)	(191.03)	(157.68)	(135.09)	(125.96)
SEL CCGs	(3.90)	(4.25)	(1.19)	1.91	4.02
South east London system	(237.20)	(195.28)	(158.87)	(133.18)	(121.94)

ICS approach to securing cost savings to support the delivery of our commitments

Our work indicates that in order to achieve the year on year financial improvement we are committed to doing, we will be required to deliver significant levels of annual savings. These savings, combined with the receipt of national Financial Recovery Funds, would see the SEL system move to financial balance going forward from 2024/25: that will allow us to focus on securing the best outcomes for our residents and patients from a financially sustainable position.

We have agreed to focus on the following thematic approaches and opportunities for reducing system cost over the next four years, recognising the need to deliver efficiencies to meet financial targets alongside the need to deliver services within the resources available to commissioners and passed through to the provider system:

1. Realising the productivity and efficiency and clinical care pathway gains that exist within our system.
2. Realising the productivity and efficiency opportunities that exist across non clinical services and ensuring that we use our assets, such as buildings, as effectively as we can.
3. Ensuring that we have system wide schemes to moderate demand growth and enable the care of patients in the least intensive, most appropriate and cost effective setting possible.

Our Long Term Plan submission represents the start of our detailed financial planning for the next four years rather than the finish. We are committed to delivering our system financial improvement trajectories. In doing so we are required to deliver significant levels of savings over the planning period. The pace and scale of improvement requires operational, strategic and structural change as well as resourcing to drive cost improvement programmes alongside system transformation. After the publication of the operational planning guidance for 2020/21, we will enhance the detail underpinning our financial plans and savings requirements for 2020/21 as solid foundations for the subsequent 3 years of this strategic plan.

Strategic financial planning assumptions

Our detailed planning assumptions are summarised below:

- We have applied the national LTP planning assumptions.
- We recognise that the underlying 2019/20 position is the starting point for 2020/21, to ensure our plan does not include non-recurrent factors.
- Activity growth has been modelled on the basis of population and incidence forecasts, split by provider on the basis of three year average historical trends from 2016/17. We have aligned our activity plans between SEL CCGs and providers for 2020/21, forming a strong basis for the subsequent years.
- Investments have been included where there are specific identified funding sources, such as the Long Term Plan additional allocations. We will bring forward additional investment plans over the course of this plan where we can demonstrate a positive return on investment that improves our financial sustainability.
- Savings assumptions demonstrate the national requirement of 1.1% (1.6% for deficit organisations), efficiency savings per annum, plus a commitment to additional local stretch targets, recognising the scale of the deficit to be addressed in SEL.

The NHS Long Term Plan sets out five key financial tests which will require our system to work together to deliver through increased collaboration between commissioners and providers, and for finances and funding to be pro-actively managed on a whole system basis. In south east London we have moved to a more system focused approach to annual and long-term planning, which drives a greater consistency across SEL. The SEL ICS submitted plans for 2019/20 that achieved the nationally set financial control totals, secured aligned activity assumptions, and complied with the national rules on the Mental Health Investment Standard and primary care funding. We will build on this model of collaborative system wide working to support the delivery of the NHS Long Term Plan aims and to secure greater financial sustainability over the coming years.

Test 1: Return to financial balance (living within our means)

As a system we have committed, for SEL CCG commissioned services, to live within the available resources as per the published CCG allocations. Recognising that our underlying position is in deficit, we have committed to delivering a year on year improvement in our underlying financial position.

Test 2: Achieve cash-releasing productivity growth of at least 1.1% per year

As an ICS our focus is on improving our productivity and efficiency as part of business as usual processes. The scale of deficits in our system requires us to target higher levels of savings than assumed within the LTP, and for 2020/21 our expectation is that each organisation will deliver savings of at least 4% of turnover.

Our LTP commitments set out a number of areas where our planned service redesign and pathway improvements should result in improved productivity and efficiency, e.g. outpatient transformation and community based care investment in admission avoidance and supported discharge services. Our focus will be on the expected return on investment and downstream impact of our initiatives, securing genuine cost reduction associated with activity shifts, and on maximising the productivity and efficiency opportunities across the system; clinical and non clinical.

Tests 3 and 4: Reducing growth through better integration and prevention and reduced variation in performance across the ICS

The Long Term Plan focuses on delivering services in new and different ways and supporting this through focused investment in specific service areas: mental health, primary care and community services, cancer, ageing well and prevention. These align with our OHSEL priorities and the aims of the ICS. We welcome the focus on services in community settings and we will ensure our investments deliver both our own local commitments and the LTP commitments. We will also focus on ensuring our community based investments help to moderate acute activity growth to within affordable levels and drive productivity and efficiency within our acute services.

We will continue to work with clinical networks to reduce unwarranted variation and to ensure that we appropriately gain the benefits of working at scale. For example, there are several Operational Delivery Networks that operate across south London. The cardiac network has reduced length of stay by reducing the time that patients wait for transfer to a tertiary centre; this is better, more cost-effective care.

Test 5: Making better use of capital investment and its existing assets to drive transformation

We will build on the work we have already done to continue to prioritise our scarce capital resource as a collective system. We are committed to delivering a comprehensive digital strategy and investment plan that ensure our digital services meet the needs of our clinicians and patients, support transformation and are able to seamlessly talk to each other (see also: [digital](#)).

Our estate has a varied ownership, not just comprising SEL ICS organisations. We are working collectively to ensure the asset utilisation plans are right sized for our system transformed healthcare model and are not reactionary based on current organisational demand pressures. The ability to fund estate procurement, maintenance, change of use (etc.) is a key consideration in our future plans and in ensuring that we optimise return on investment and return on capital employed (see also: [estates](#)).

Our Long Term Plan response represents the start of our detailed financial planning for the next four years rather than the finish. Over the course of the coming months we will work to develop our plans in more detail and incorporate this into our future operating plans starting with 2020/21.

Our plans acknowledge our current deficit position and our commitment to address our underlying recurrent deficit, as well as managing our finances over the next four years towards a sustainable position within national planning expectations.

We recognise the scale of the challenge and are committed to managing within available resources and delivering our LTP commitments. We will seek to do this by securing a service offer that combines better care pathway redesign, productivity and efficiency across clinical and non clinical services and supporting population health management. We recognise that improving population health and supporting the prevention of illness will not only improve residents' and patients' lives, but will also reduce the demand for the most costly elements of our health and care system.

Our strategic plan demonstrates the delivery of the LTP priorities and the SEL NHS system moving back towards financial balance over the next 4 years by 2023/24. As we develop the detailed plans to support our aims we will also seek to implement a single financial framework across our ICS that has collective responsibility at its heart. The increasing shift to system responsibility and delivery supports the need for greater collective oversight of our planning, enhanced in year monitoring and management to ensure that we deliver the financial improvement required alongside ensuring the delivery of the LTP priorities.

We are committed to delivering our system financial improvement trajectories. The pace and scale of improvement requires operational, strategic and structural change as well as resourcing to drive cost improvement programmes alongside system transformation. After the publication of the operational planning guidance for 2020/21 we will enhance the detail underpinning our financial plans and savings requirements, and incorporate this more detailed work into our 2020/21 operating plans as solid foundations for the subsequent three years of this strategic plan.



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

6) Enablers



Enablers

Digital

Current challenges

- Interoperability – the systems used daily across hospitals, GP surgeries, care homes, pharmacies and community care facilities do not talk to each other.
- Integrated data – the NHS operates with disparate and disconnected data sources and has a lack of integrated data sets to support decision making.
- Infrastructure – some staff who work in the health and care system have out of date technology that prevents them from doing their jobs effectively.
- Data protection and cyber security – maintaining a safe and secure data infrastructure against evolving cyber threats and maintaining public trust in how we hold, share and use data.
- Changing culture – digital transformation programmes need to persuade NHS staff to change the way that they work and patients to change the way they interact with services.

Better use of technology across the NHS. There should be much more that is standardised / mandated. Linked systems allowing access to patient records. – Healthwatch recommendation

Better communication of my care between hospital and community services. – Healthwatch recommendation

Digital technology is a key enabler of the transformation required in SEL. We have reviewed the Secretary of State's 'The future of healthcare' (Tech Vision) and utilised the recent NHSE&I London work on the Strategic Development Investment Framework to develop a comprehensive digital strategy and prioritised investment plan to underpin the wider transformation plans over the next five years.

The SEL ICS is also working with the STPs across London to align strategies and work on joint programmes to achieve consistency for our population and deliver economies of scale.

There are five core components to our SEL digital strategy:

Our vision for the future

To provide integrated digital solutions to improve the quality of care and experience of our patients when interacting with health and care services, and to support our clinical workforce in providing safe and efficient care with the latest technology, digital solutions and integrated data.

Our objectives

- Agree standards to support system interoperability, capture high quality data at the point of care and to enable clinicians to access a secure integrated care data set to inform care delivery.
- Empower patients to use digital technology to take more control of their conditions and to offer choices of how to interact with health and care services (e-consultations, secure messaging and video consultations).
- Improve the digital maturity of all SEL providers.

1. Delivering collaboration and system leadership across SEL for digital transformation and accelerating digital maturity

Providers and commissioners across London are to work collaboratively to improve individual and joint digital maturity. The Healthcare Information and Management Systems Society assessment framework provides a benchmarking facility and outlines the levels of maturity acute providers should be striving for. We will also build on the foundation of strong digital governance arrangements in SEL.

- The SEL Digital Delivery Group are to oversee development and implementation of the system investment and digital strategies, and coordinate bids for investment opportunities (such as via ETTF and HSLI).
- We will address the areas for improvement highlighted in the recent London wide strategic review of digital maturity and also develop individual plans with each provider around how they will achieve the full digitisation by 2024 target (including identifying required investment levels).

- KCH and GSTT are currently planning to jointly procure a new Electronic Health Record in 2020 which will significantly increase their joint digital maturity.
- LGT has invested in infrastructure to support population health management work and is looking to deliver outcomes and scale the work beyond the borough of Lewisham.
- SLaM and Oxleas are working as a Global Digital Exemplar and fast follower to implement e-prescribing, e-referrals and a patient portal.
- Improving primary care digital infrastructure through Health and Social Care Network roll out.
- HSLI funding has also been utilised by several providers to improve e-prescribing, electronic discharge letters, bedside monitoring and self check-in for patients.

2. Empowering people and transforming care through digital tools, information and services

Full access to joint up records which would allow [patients] to see their entire medical history and have a greater understanding of any health conditions. – Healthwatch recommendation

- Adopt a ‘Digital First’ approach to enable primary care and outpatient care across pathways to enable digital appointments in appropriate care settings, order medications, access clinicians digitally for appropriate triage and ‘virtual’ GP or outpatient consultations (see also: [Digital First primary care and planned care](#)).
- Work with STPs across London to develop a digital personal health record, to give people more control over their health and care and increasingly support more personalised care; these systems will support patients to view their care record, care plans, expectations, appointments, results and medications. Patients will also have access to a variety of condition-specific structured education solutions (e.g. HeLP diabetes digital education – see also: [diabetes and personalised care](#)).
- Create a ‘digital front door’ through the NHS App, with links to other appropriate apps. Local infrastructure will be put in place to enable integration with other services and, where appropriate, into patient pathways.
- Ensure that services continue to remain highly accessible to those people with low digital literacy and those less able to access technology.

3. Supporting health and care professionals

through improved information and technology

All information on my health and care is held in one data file which is accessible by authorised professionals. – Healthwatch recommendation

- SEL is part of the OneLondon LHCRE (Local Health and Care Record Exemplars) programme and is working to deliver technology which will underpin wider transformation programmes and to develop interoperability through:
 - **A single view of the patient data (L1 LHCRE)** across whole pathways of care. In SEL the Local Care Record supports King’s Health Partners and the Boroughs of Lambeth, Southwark and Bromley. We also have Connect Care which supports Lewisham and Greenwich Hospitals and the Boroughs of Lewisham, Greenwich and Bexley. As part of the ‘One London’ plan, we will consolidate the multiple solutions onto one (Cerner HIE) and link up to the rest of London. The system will enable clinicians to see key information about patients quickly at the point of care (including any relevant patient flags such as the ‘reasonable adjustment’ for patients with learning disabilities and autism; see also: [learning disabilities and autism](#)).
 - **LHCRE Level 2** – A secure and trusted data repository to create a longitudinal health and care record linking NHS and local authority organisations across London. This will enable analytics / dashboards to support identifying gaps in care, quality improvement efforts and population health management.
 - Continue to implement a set of data sharing frameworks for providers, which ensure the privacy and security of patient data and compliance with legal requirements.

Further areas SEL is developing to support the Tech Vision, London priorities and to support clinicians and patients are:

- Undertaking projects to improve IT infrastructure and network connections between clinical locations (including ensuring widespread roll out of the Health and Social Care Network, and patient and staff Wi-Fi programmes to support mobile working). The improved infrastructure will support initiatives such as improving access to specialist opinion in primary care through wider adoption of digital tools (e.g. Consultant Connect – see also: [planned care](#)).

- Supporting the pan London Architecture Advisory Group to ensure that the systems we develop or procure conform to open data standards, interoperability and openness requirements.
- Developing plans with each provider to deliver robust cyber security to protect clinical systems and patient data; by summer 2021, SEL will ensure 100% compliance with mandated cyber security standards across all NHS organisations.
- Work with the ICS workforce programme and individual providers to support the development of the right digital skills, digital literacy and culture of our workforce to drive the capture of health and care information digitally at the point of care.
- Build on existing work (e.g. LAS accessing mobile devices) to support community based clinicians to have access to effective mobile digital solutions (e.g. expansion of access to MSK support services in the community). This work also includes access to the patient's care record and care plans.
- Working with specialists to develop digital services and decision support tools for clinicians which utilise the OneLondon data service and begin to free up clinical capacity by supporting the automation of clinical and administrative tasks.
- Share learning from our Global Digital Exemplar sites in SEL (SLaM) with Oxleas and the South London Partnership.
- Work with King's Health Partners and the Health Innovation Network to ensure local adoption and spread of proven innovations where appropriate.

4. Improving population health – deploying PHM solutions to identify the areas of greatest health need and match services to meet them (see also: prevention and reducing health inequalities)

- Participate in a nationally funded NHSE&I PHM development programme to make faster progress in the use of PHM techniques, through the adoption of data-led proactive care projects.
- Utilise the de-personalised data from OneLondon LHCRE infrastructure to enable the identification of at risk population, in line with information governance safeguards. This approach will continue to support better care for major health conditions through the improvement, prevention, early detection and treatment by:

- Identifying cohorts of patients who are at risk of adverse health outcomes.
- Identifying, recording, and sharing Vital 5 data between all health partners and our patients and acting on the results across our population.
- Predicting patients who may benefit from evidence based interventions.
- Highlighting place-based health and care inequalities and outcomes.
- Highlighting patients with missing elements of care pathways.

5. Supporting research and innovation (see also: research, innovation and genomics)

SEL ICS leadership and care providers across SEL work very closely with King's Health Partners, the Health Innovation Network and the Healthy London Partnership; these organisations bring together clinical and academic informatics colleagues from across SEL partner organisations as well as local patients, primary care and GP federations to drive research and innovation. Many of the ICS and London wide initiatives will provide valuable data and insight for the research community.

KHP, Healthy London Partnership and the HIN have already been linking London wide and for south east London initiatives:

- King's Health Partners Informatics initially developed the Local Care Record which enables care professionals to view a patient's medications, previous treatments, test results and any other relevant care information. This will transition into the LHCRE L1 / Health Information Exchange work across London.
- CogStack is an information platform that uses advanced search techniques, language processing, analytics and visualisation technologies to unlock health records and assist in clinical decision making and research. There has been positive engagement across London with the OneLondon strategy including CogStack as part of its delivery framework.
- The Institute and Network programmes have been undertaking informatics and IT projects supported through the governance processes of the host organisation (King's Health Partners Haematology through King's College Hospital NHS Foundation Trust, and King's Health Partners Cardiovascular through GSTT).

- The HIN is leading on work to use digital technology and pathways in outpatients to support delivery of the LTP target to reduce face to face outpatient appointments by 30% (initial work focusing on rheumatology) – see also: [planned care](#).
- Healthy London Partnership is leading work on developing solutions for online consultations and Digital First in primary care (see also: [Digital First primary care](#)).

Workforce

Current challenges

The workforce challenges are complex and multiple; the most significant for SEL are described below.

1. **System workforce planning:** We do not currently have the workforce infrastructure to enable workforce planning at a system level.
2. **GP retention:** Whilst our primary care trajectories highlight growth in all areas, progress with GP numbers is challenging due to lower than anticipated international GP programme recruits and a range of threats to retention.
3. **Leadership culture:** Gaps, vacancies and variable stability in leadership and team structures are all considered as threats to enhancing our leadership cultures.
4. **Nursing workforce shortages:** Improved nurse retention and expanded recruitment is required across our system as a result of vacancies, demand, and age profiles.
5. **Enabling transformation and growth:** Enabling transformation across a large number of employers is challenging, requiring knowledge and culture and behaviour change. Access to OD expertise is also frequently limited.
6. **Volunteer strategy:** We are yet to define a volunteer strategy which will start with learning from existing, local good practice.

Many people are aware of the pressure that health and social care services are under, with considerable pressures on staff. It is desirable that future changes are equitable for staff and service users alike, with good levels of support available to all. – Healthwatch recommendation

Our strategy for workforce is comprehensive, as we recognise that our people are essential to the delivery of our plans to improve quality and health outcomes across south east London. This section outlines our key workforce challenges in line with the NHS Interim People Plan themes and describes the breadth of our 2019/20 activities, the vast majority of which are in delivery phase. Our detailed 2019/20 delivery plan

Our vision for the future

We want to develop the right people, with the right skills and behaviours, at the right place, at the right time to deliver high quality, personalised, integrated care across SEL.

Our objectives

- Make the NHS the best place to work through valuing and investing in our people and working collaboratively to improve working lives, workloads and wellbeing.
- Improve leadership culture by promoting and role-modelling positive leadership behaviours and working together to enhance diverse and inclusive cultures we know benefit our staff and patients.
- Ensure a continued, multi-faceted approach to increasing all levels of our nurse workforce.
- Continue to lead on non-clinical workforce development, apprenticeship support and multi-professional team expansion to help deliver clinical and financial sustainability.
- Build system capacity and capability in readiness for greater workforce planning and responsibility.

(see [appendices](#)) is structured to align with the workforce chapter of the NHS Long Term Plan. The current strategy will be reviewed once the full NHS People Plan is published.

This section describes workforce activities **directly delivered or coordinated at a system level** which may also be reflected in organisational, place and local development and delivery plans. Whilst a larger proportion of the workforce is employed in trust roles, our response has an enhanced focus on primary care support, in recognition of the vulnerability of this workforce, the relative lack of coordinated support and the need to enable this strategic, transformation priority area.

Workforce matters relating to Long Term Plan clinical priorities have been addressed previously in this document as an integral part of the individual service transformation responses in [chapter 3](#); brief reference, is made here however, in relation to plans for workforce growth in ICS priority areas.

Considerable additional workforce activities are underway across the system, commonly led by employers as part of their duties and responsibilities to employees and patients, and whilst these undoubtedly contribute to fulfilling the requirements of the Long Term Plan, they are not covered in this description.

We will deliver our vision and objectives through the following priority actions, which align with the Interim NHS People Plan themes

1. Workforce planning and collaborative working

System plan for primary care: We continue to work with SEL training hubs and CCGs (GPFV) to develop a system plan for primary care. The focus is on optimising collaborative working, avoiding duplication and facilitating alignment of plans, all of which support efficient use of resources. Training hub delivery group meetings are now co-Chaired by the ICS and HEE, building our enabling engagement with system partners in readiness for new models of working.

Realistic local and system workforce plans: Recently all SEL providers have completed their first eWorkforce submission, enabling a refresh of our ICS plans as submitted and discussion on new and existing local and system-wide workforce interventions. These assumptions will continue to be refined over time, in line with commissioner and provider planning cycles. We have also started to use our new ICS access to the London Workforce Intelligence Portal to explore London supply and retention intelligence which will further support realistic planning. Future considerations will also include defining how to track key workforce metrics such as retention in key staff groups or cohorts.

In September 2019 our SEL Human Resources Directors (HRDs) strategy meeting focused on exploring existing workforce planning capacity and capability and early considerations of the infrastructure required for effective system workforce planning. The key outcome was an agreement to establish a new pan ICS workforce planning group, to enhance existing approaches and

build future system readiness.

2. Make the NHS the best place to work

GP retention: Making the NHS the best place to work for our existing and new GPs will mean ensuring they feel valued, receive the support they need and work in roles and teams which make the most of their skills and expertise.

Our GP survey undertaken in autumn 2018 collated vital local evidence about the factors affecting GP retention. The key threats reported included workload leading to long hours and work-related stress, excessive administrative and clerical demands and difficulty recruiting and retaining staff / other clinical support staff: all factors that have helped shape our subsequent plans.

We are developing and piloting a range of GP support projects designed to improve GP retention as a means of closing the gap between supply and demand. We have enrolled 27 experienced GPs onto a support programme that will involve 1:1 coaching and mentoring and skills training, to allow a pay-forward of support to early career GPs. Evaluation will span impact on job satisfaction, likelihood of leaving the profession, workload management and resilience.

In response to the LTP GP trainee retention target (90% retained after completion of specialist training) we have enlisted a local clinical champion to help distil best practice from the range of existing SEL initiatives (with GP vocational training scheme leads, training hubs and employers) and promote additional local action. A related project is planned to deliver a simple, good practice early years GP portfolio working model for local adoption.

We have also directed GP Retention Fund resources to eight local projects investing in enhancing the working lives of GPs for example: trialling roles with extended support at the point of qualification; and flexible working schemes. Outcomes and learning will be shared at an ICS organised event prior to 2020/21, to help inform local plans.

Investment in people – mental wellbeing and resilience training: Further to positive uptake and feedback on SEL commissioned training in 2018/19, we commissioned 12 further courses to support up to 240 more of our primary care workforce in coping with stress and identifying similar signs in colleagues.

High level outcomes will be communicated out to encourage PCNs to integrate wellbeing actions into future strategies.

Investment in people – career development: Staff at all levels value career development and improved opportunities can result in increased effectiveness and morale and improved longer term retention, whilst providing our workforce with new and enhanced skills.

We have successfully supported cohorts of aspiring and experienced practice managers with access to diploma level training and recently offered a bursary to a new cohort to commence a level 7 Diploma programme, equipping them with the skills to manage primary care leadership at scale. Our training hubs and PCNs will be encouraged to consider the value of continuing to support this development programme as they develop their own local workforce strategies and plans.

Our two-year investment in the development and implementation of a postgraduate career pathway for nurses new to urgent and emergency care is seeking to support retention and succession planning and aims to enable 60 nurses to attain this qualification by close of 2019/20.

System action – Local Workforce Action Board (LWAB): ‘Making the NHS the best place to work’ was 1 of 3 workshop sessions at our most recent Local Workforce Action Board. Views on good practice underway and recommended actions will be revisited to move towards an agreed shared action plan.

System action – Staff Survey and workforce race equality standard: As SEL HRDs have identified, responding to the NHS staff survey results is a shared priority; greater alignment of actions including tracking workforce sentiments and tackling bullying and harassment are being explored. This relates strongly to the planned development of workforce metrics to monitor staff wellbeing.

With regards to the Workforce Race Equality Standard, we welcomed and reviewed the draft London Strategy and have since initiated SEL-specific engagement with regional experts, also putting in place a plan to extend action discussions through our established Workforce Strategy and Delivery Oversight Group. Bringing together workforce data, from eWorkforce and ‘the Portal’, and Staff Survey

intelligence and the linked actions will also inform consideration of SEL aspirations for BME representation as highlighted in the LTP. This clearly has a strong link to diverse and inclusive cultures that we know are highly valuable to patients and employees.

Enabling flexible working – e-rostering systems: All SEL providers use a range of e-rostering and job planning tools and this will be further developed to enhance the use of apps. HRD leads have additionally noted there may be scope for greater alignment of the systems used across SEL.

3. Improve leadership culture

Whilst all staff have a role in achieving and sustaining a positive, inclusive leadership culture, senior leadership roles are of importance. Our nursing collaborative programme has identified the lack of a strategic, system level nurse leadership role as a factor limiting progress, for example. Our provider colleagues have also cited significant board level changes and, in some cases, vacancies in key senior level posts. Gaps, vacancies and variable stability in leadership and team structures are all considered as threats to enhancing our leadership cultures.

System action – LWAB: Our most recent LWAB also incorporated a session on leadership culture and encouraged role modelling of positive leadership behaviours recognising everyone plays a part.

4. Talent management: Diagnostic pilot

In Q2 2019/20 we coordinated cross-system engagement in the NHS Leadership Talent Management Diagnostic pilot. The opportunity initiated our exploration of talent management approaches and maturity across the ICS, using a standardised tool at the same point in time and created scope for further system collaboration. We will come together again later in 2019/20 to discuss local progress and shared next steps.

5. Addressing urgent shortages in nursing

Adult nursing – London context: We fully appreciate that despite recent growth across London, nursing remains a shortage occupation. Furthermore, whilst London growth is projected to continue, this will not reach demand and additionally close our vacancy gap.

We know from NMC and regional data that the retention of nurses under the age of 25 is the greatest challenge. These younger nurses leave the NHS sooner than more experienced colleagues and turnover of this group is also higher. Overseas supply is also critical to the nursing workforce, accounting for 50% of the growth over the last 5 years.

Current SEL position – vacancies: The recent eWorkforce data suggests the adult nursing establishment in SEL is just over 10,300 WTE as at March 2019. The data also indicates in the region of 1,390 adult nurse WTE vacancies in SEL, representing a vacancy rate of 13% (where the range is 6% to 24%). Reducing the vacancy rate from 13% to the target of 5% based on today's workforce would require an additional 857 nurses. We know however that as growth is required throughout the target period, the true numbers required to close the vacancy gap are significantly greater.

Current SEL position – growth: With regards to growth, the eWorkforce data also shows every provider plans to expand their establishment year on year. Whilst the scale of growth required is exacerbated by the relatively high vacancy levels, the collective demand far outweighs projected supply. This new data therefore offers an important opportunity for the ICS and providers to explore the issues of vacancies, growth and supply further and reflect on our existing strategy.

Recent and ongoing interventions – strategic collaboration: Action to improve our position on nursing has been underway for some considerable time. We commissioned work in 2018 to review and model the acute provider workforce and report a case for change. As anticipated, the recommendations included a focus on nurses. This work provided a critical baseline and rationale for enhanced strategic collaboration.

SEL nurse workforce programme: In response to the key 2018 review, we established a provider-led nurse workforce programme which spans 4 key areas:

1. Placement optimisation;
2. Widening participation;
3. Workforce intelligence; and
4. Workforce development.

Every element of the work seeks to enhance

growth, recruitment and retention and support progress towards the 2028 LTP ambition of 5% nurse vacancies.

More specifically, the placement optimisation programme, running intensively over a 9-month period, will develop a coherent strategy for clinical placements across HEE, higher education institutes (HEIs) and employers, yielding additional capacity, increased assessor and mentor numbers and enlisting new placement offers.

Emerging opportunities: Whilst we have made positive progress in building networks, sharing good practice and deploying a range of interventions to support, develop and retain our nurses, more needs to be done to ensure we achieve and sustain the nursing workforce required for SEL. We will revisit and strengthen the measures of success and impact of our current activities and use the opportunity of consistent data to refresh our shared system strategy for nursing.

We anticipate an even stronger focus on retention, in particular of the younger cohort, and greater engagement with the NHSE&I retention programme and further expansion of our CapitalNurse collaboration. We will also explore new opportunities to extend existing preceptorship models and career planning support within and across providers and specialties, to support retention and succession planning. International recruitment is already well-established mainly from non-EEA regions but it may be possible to yield greater system benefit through increasing the collaboration.

As a system, we have also recognised the opportunity that a more coordinated approach to apprenticeships, using the significant levy at our disposal, can have on both recruitment and retention of the nursing workforce. The refresh of our shared system strategy for nursing will also involve defining our ambitions more clearly and supporting greater consistency in monitoring so the impact for the system can be more clearly understood.

Support to nursing and midwifery: The support workforce is also key, offering critical capacity and helping to ease the demand on qualified professionals.

The first iteration of the eWorkforce data also suggests this area may require greater consideration: the average vacancy rate is 17% with a range of 1% to 25%. This will be explored with our providers and form an integral part of our review.

SEL general practice nurses (GPNs): Although our 2019 data shows good alignment between planned and actual nurse numbers in primary care, we know from our 2018 modelling that the age profile of our GPNs is a key threat to achieving our trajectory (50% of SEL nurses are over 55). Our GPN 10-point plan delivery group has overseen the important recruitment of a SEL practice educator to work with HEIs, CCGs and training hubs to develop and promote the GPN role as a career destination of choice for newly qualified nurses.

To enhance attractiveness and retention, education and development of the GPN workforce, including healthcare assistants, is becoming more joined up; for example, enhancing supervision arrangements for GPNs. A placement coordinator has also been recruited in 2019/20 to support efforts to increase practice placements for pre-registration nurses.

Nursing associates: The nursing associate role offers a new formal step in the support staff career ladder and an alternative route towards becoming a registered nurse. We established an out of hospital task and finish group in Q1 of 2019/20 to work together in response to the HEE nursing associate target. In October 2019 we delivered local roadshows to build system understanding of the role and fit within the nursing and wider team and to support aspiring trainee nursing associates and their employers to access apprenticeship levy and programme enrolment.

Our provider-led nursing programme has also scoped a new project intended to 'nurture the supply pipeline', in recognition of the difficulties in identifying suitable nursing associate candidates with the requisite functional skills and the need for support with applying successfully for a trainee place.

The ICS workforce team is also supporting HEE to take stock of SEL plans for trainee nursing associate growth and develop new resources to enable realisation of these plans.

6. Deliver a holistic approach to workforce transformation and workforce growth

Non-clinical workforce development: One third of the workforce works in a non-clinical capacity, yet there has never been a unified career pathway within the health and social care sector. We took the lead in addressing this issue, developing and testing a unique competency framework (Levels I-IV) to facilitate skills development and career progression. The impact of both Level II (care navigator) and Level III (general practice assistant) includes improving the patient journey and experience and freeing up clinical time by reducing the administrative burden on them. Having worked with a key training partner, ILM accredited training for Level II has been developed in an online format.

Following a successful pilot, this unique 'Excellence in Healthcare' accredited online training programme was launched at national level and is now available to all non-clinical staff working in a clinical and / or care setting. Work to develop a more advanced programme for Level III staff is progressing at pace with a view to launching early in the next financial year.

The requirements of social prescribing covered in Level II and in further depth in Level III will complement and support progression into social prescribing link worker roles and the associated modular training programmes now being made available by HEE through eLearning for Health (see also: [integrated community based care](#)).

This work demonstrates system-wide action to improve workforce efficiency and release 'time to care', whilst developing and embedding a structured career pathway for the non-clinical workforce and its importance has been recognised nationally.

International recruitment: Further to recruitment of 3 GPs in 2018/19, SEL continues to engage in the regional international GP recruitment programme. A further 2 GPs are expected to join SEL later in 2019/20.

Development of a south London apprenticeship approach: We are working with south west London to understand plans and spend with levy payers. Achievements to date include clear dashboards identifying apprenticeships and levy spend, and modelling at provider and ICS to inform strategic planning.

The intelligence has enabled extensive levy gifting within the ICS areas and is already a key success of 2019/20.

We are now developing a coordinated approach to apprentices across our extended system. This will: broaden entry points to a range of health and care careers, improving supply and, by recruiting from within our local communities, also support diversity and retention; expand workforce numbers with new apprenticeship roles; and invest in the existing workforce aiding career progression and retention and improving morale.

Expanded multi-professional teams – physician associate: We delivered a SEL-wide event in Q4 of 2018/19 to raise awareness of the capacity and skills this relatively new and intensively trained clinician offers to primary care. The number of physician associates working in SEL practices has increased and we are now collaborating with an HEI on increasing SEL physician associate student placements in primary care, which in turn is anticipated to support increased recruitment.

We are also planning to support PCN and practices to engage first contact practitioner physiotherapists through new project work scheduled for later in 2019/20.

Workforce growth – ICS clinical priorities: In addition to exploring the growth plans for adult nursing and trainee nursing associates as described above, we have also extracted SEL eWorkforce data in relation to our ICS clinical priorities:

- **UEC:** we will support discussion on emergency medicine consultants looking at existing vacancies (which appear large in two providers) and plans for growth alongside supply projections and trends in trainee volumes already accessed with support from HEE (see also: [urgent and emergency care](#)).
- **Cancer:** Work to map the SEL clinical and medical oncology workforce has already been undertaken as part of our response to the phase 1 cancer workforce plan. We will now support the cancer network to integrate this local mapping with the eWorkforce and supply pipeline projections we have gathered and consider if any additional interventions are required to facilitate achieving the growth required (see also: [cancer](#)).

- **Maternity:** eWorkforce data covering midwifery and midwifery support workforce was prepared for further consideration at the first maternity workforce workstream meeting which took place in December 2019 (see also: [maternity](#)).
- **Endoscopy and gastroenterology:** In support of system level work on endoscopy services, we have also extracted eWorkforce data for endoscopists and gastroenterologists and with support from HEE, supply projections for gastroenterology CCT holders. This data will be made available to programme leads and we will advise on how it may further strengthen current workforce and models of care considerations (see also: [planned care](#)).

Workforce growth – primary care: We have reviewed the most recent (June 2019) data to refresh our SEL primary care trajectories to September 2020 as shown in the [appendices](#). Our primary care workforce continues to grow. We have however, modified our GP growth assumptions considering the significantly lower than anticipated international GP recruitment. There has been notable progress in growth of physician associates and clinical pharmacists, however.

Beyond September 2020, as our emerging PCNs become more established, we will work with them and our training hubs, using the tools developed by HEE, to develop workforce plans that meet current and future need, based upon current and future growth projections and informed by population health data, as well as the need for primary care to respond to the challenges of delivering enhanced community based care (see also: [integrated community based care](#)).

Efficiency – bank and agency: SEL wide work on bank and agency has now delivered savings of £5.5m from September 2017 to August 2019. This shows significant success against the target set of £3.3m by 2021. The next steps are to support the migration of agency covered roles to substantive positions. Providers are also collaborating to explore increased local employment opportunities and links with schools, job centres and other organisations to help reduce our significant band 2-5 support vacancies and associated temporary staffing spend.

Volunteer strategy: We recognise that a well-coordinated volunteer strategy could deliver significant benefits. As good practice already exists in our system, for example hospice care volunteer programmes, we will take steps to learn from the considerable experience of our partners and plan our approach in the context of our outlined challenges.

7. Change the workforce operating model

Workforce system development – governance and transformation: Delivery of the current priorities is overseen by our established Workforce Strategy and Delivery Oversight Group with support and broad stakeholder engagement provided by our LWAB. The final workshop of our most recent LWAB explored the key issue of ICSs as the main organising unit for local health service and the session outputs will further inform ongoing development towards a system wide workforce architecture.

The invitation to respond to the NHS Confederation consultation on the role of integrated care systems in workforce development provided us with an invaluable opportunity to engage with our partners across the ICS on future activities and responsibilities and we will build upon the outputs of this exercise in the coming months.

We are monitoring the progress of the workforce maturity matrix tool currently in development and recognise that once available, focused consideration of our capacity and capability for system workforce planning will be critical.

We are also gathering information on workforce infrastructure from wave 1 and 2 ICSs to support the breadth of our transformation considerations. Our long-standing collaboration and support to training hubs and more recent engagement with emerging primary care networks are further key foundations for ongoing development of our operating model.

Estates

Current challenges

- Of the more than 200 buildings in SEL located outside main hospital sites, many have reached the end of their useful lives.
- Whilst as a system we aspire to reduce our overall estate footprint to reduce running costs and enable investment in our core buildings, in some cases, estate capacity will also need to be expanded to meet growing demand, particularly for planned care.
- We must change how we plan and manage our properties and other assets across SEL, moving to a coordinated and strategic whole system approach.

Across SEL we provide health services from a property holding of more than 400 buildings.

Our collective secondary and specialist estates portfolio covers over a million square metres across eight acute sites. This includes a number of new, modern PFI hospitals alongside older hospital estate, with some buildings housing inpatient services dating back to the 1800s. We also have some recently developed, high quality LiFT buildings for community services.

However, of the more than 200 buildings located outside main hospital sites, many have reached the end of their useful lives, are in the wrong place and lack the flexibility to be able to support our out-of-hospital care ambitions and to meet the health and care needs of our future population. It is essential that we change how we plan and manage our properties and other assets across SEL, moving from a single provider silo perspective to a coordinated whole system approach, unlocking opportunities for reinvestment in estate to support adequate and sustainable healthcare provision.

Our vision for the future

To have a flexible, high quality property base that provides the right capacity, in the right place and at that right time; responding to the needs of our patients by improving access and ensuring safe, standardised care regardless of location or provider.

Our objectives

- Improve utilisation and efficiency of our core estate, through collaborative working across all of our ICS partners. In part this will involve integration with the wider public sector, collaborating on sharing and co-locating back-office and other functions.
- Maximise opportunities to enhance community based care, by establishing community 'hubs' for integrated, multidisciplinary working.
- Maximise opportunity through coordinated estate rationalisation to reinvest in the local estate.
- Expand estate capacity to meet growing demand for planned care.

Our comprehensive estates strategy (which will be refreshed) and detailed plans for delivery are underpinned by our vision and principles for collaborative working, developed and agreed across our partnership. Our priorities are:

1. Improving the utilisation and efficiency of our core estate

- Progress optimisation projects at five of the community sites across the ICS, enabled by capital funding we received in excess of £5m.

2. Identifying opportunities to share estate between health and care

- Progress One Public Estate initiatives; for example in Lewisham, where NHS provider (GP, acute and mental health), commissioner and local authority partners are working together to develop four community sites to offer local integrated services aligned to the communities that they serve.

3. Make better use of capital investment to enhance community based care

- Build or upgrade existing community ‘hubs’, to support integrated multidisciplinary working within and across local primary care networks; across the ICS there are more than a dozen such CCG-led schemes (enabled by funds from NHS Capital, ETTF, Section 106 and One Public Estate fund) (see also: [integrated community based care](#)).

4. Realising value from unused and under-utilised estate

- Release land for redevelopment from underused and under-utilised estate, including building of new homes for key staff:
 - 13 sites have already been disposed of by acute and mental health providers, generating capital receipts of £35m.
 - 15 further disposals are likely to generate capital receipts in excess of £140m.
- Reinvesting disposal proceeds into the health system to support necessary improvements and upgrades, address backlog maintenance issues and support new ways of working.
- Taking fixed costs out will reduce running costs and contribute to addressing our deficit (see also: [system financial management](#)).
- Through our community estate optimisation programme, further disposal of outdated and no longer fit for purpose estate will generate further receipts for reinvestment in our core buildings and release more land for redevelopment.

5. Expand estate capacity to meet growing demand for planned care

- Review and reduce back-office occupation on acute sites.
- Collaborate on sharing clinical and non-clinical support services which will be located away from our congested hospital sites (see case example).
- Shift outpatient activity into the community where appropriate, aided by the development of digitally enabled outpatient care, bringing care closer to home and creating additional capacity on our hospital sites (see also: [planned care](#)).

We will work to a collaborative governance model to oversee delivery and prioritise investment, enabled by a single strategy and approach to support the best estates solutions across SEL.

Case example

Off-site logistics centre

GSTT are leading on behalf of the ICS an approved Wave 4 capital scheme.

The Patient Centric Supply Chain project is developing an off-site logistics centre that will support an integrated supply chain for hospital and community sites across the ICS.

The centre will:

- Reduce storage space requirements;
- Allow consolidation of support services on to a single site;
- Reduce clinical time spent on non-clinical duties;
- Improve the patient experience;
- Achieve a reduction of more than 30,000 truck deliveries per annum, with significant air quality benefits, further enhanced by the adoption of electric and gas-powered vehicles; and
- Ultimately realise significant financial benefits.



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

7) Roadmap



7) Roadmap

Summary of what we will deliver over the next five years

The NHS Long Term Plan sets an ambitious and challenging agenda for the development of health and care in England. This response has set out how we will deliver those ambitions in our local context.

We have worked to ensure all of our plans align with major milestones of the LTP. On the next pages we provide a summary of the major milestones for the foundational elements – where additional expectations of progress in the early years of implementation are expected.

For further information milestones and how we will measure success for the foundational elements, please see the [appendices to chapter 3](#).

Major milestones set out in the Long Term Plan

We have worked to ensure all of our plans around foundational commitments align with these milestones

LTP foundational commitments	2019/20	2020/21	2021/22	2022/23	2023/24
Integrated community based care	<ul style="list-style-type: none"> Continuation of GP Forward View commitments and begin PCN development. NHS 111 to start direct booking into GP practices. 	<ul style="list-style-type: none"> From 2020/21, PCNs to assess population by risk, and with community services make support available where needed. Over 1,000 trained social prescribing link workers nationally will be in place by the end of 2020/21 rising further by 2023/24. 		<ul style="list-style-type: none"> Upgraded NHS support to care homes residents via EHCH model (by 2023/24). PCNs to have helped improve early cancer diagnoses of patients in their own neighbourhoods (by 2023/24). 	<ul style="list-style-type: none"> Primary and community health service funding guarantee directly applies.
Urgent and emergency care	<ul style="list-style-type: none"> 24/7 IUC service, with clinical assessment¹ (in 2019). Record 100% of patient activity (in A&E, UTCs, and SDEC) via emergency care data set (by March 2020). SDEC² in every hospital with a major A&E for at least 12 hours a day, 7 days a week (by the end of 2019/20). Test and begin implementing new standards from Clinical Standards Review (when agreed). NHS 111 to start direct booking into GP practices. 	<ul style="list-style-type: none"> Implement urgent treatment centre model (by autumn 2020). 		<ul style="list-style-type: none"> By 2023 the clinical assessment service will act as the SPoA⁴ for patients, carers and health professionals for integrated UEC and hospital discharge. 	
Shorter waits for planned care	<p>From 2019/20 to the end of 2023/24:</p> <ul style="list-style-type: none"> Use allocated funds to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list. Continue to provide patients with a wide choice of options for quick elective care. Systems will build on work already undertaken to ensure patients have direct access to MSK First Contact Practitioners and physiotherapists working in PCNs. Implementation of NHS-managed choice for 26 week waits. 				
Cancer	<ul style="list-style-type: none"> Continued development of rapid diagnostic centres. HPV primary screening for cervical cancer (by 2020). Implementation of faster diagnosis standard and timed pathways (from 2020). Stratified follow up for pathways for breast (2019) and prostate and colorectal (beginning in 2020). 	<ul style="list-style-type: none"> Where appropriate, every person with cancer has access to personalised care plan (by 2021). 	<ul style="list-style-type: none"> Lung health check model will have been extended (by 2022). 	<ul style="list-style-type: none"> Stratified follow-up pathways in place where appropriate (by 2023). Nationally over 100,000 people a year can access genomic testing (by 2023). PCNs to have helped improve early cancer diagnoses of patients in their own neighbourhoods (by 2023/24). 	

Notes: 1. Single multidisciplinary clinical assessment service within integrated NHS 111, ambulance dispatch and GP out of hours; 2. Same day emergency care 3. Delayed transfers of care; 4. Single point of access.

Major milestones set out in the Long Term Plan

We have worked to ensure all of our plans around foundational commitments align with these milestones

LTP foundational commitments	2019/20	2020/21	2021/22	2022/23	2023/24
Mental health	<ul style="list-style-type: none"> 24/7 community-based mental health crisis response for (older) adults is available across England (by 2020/21). No acute hospital without an all-age MH liaison service in A&E / inpatient wards, and at least 50% of these services meet 'core 24' standard (by 2020/21). 			<ul style="list-style-type: none"> New models and integrated models of primary and community care for (older) adults with SMI¹ (by 2023/24). NHS 111 as the universal SPoA² for people in MH crisis / increased forms of provision for those in crisis³ (by 2023/24). By 2023/24 an additional 380,000 people per year nationally able to access IAPT services.⁴ Nationally 70% of MH liaison services at 'core 24' standards (by 2023/24). MH transport vehicles and MH nurses in ambulance control rooms to have been introduced (by 2023/24). 	
Digitally enabled primary care and outpatient care	<ul style="list-style-type: none"> Online consultation offer available in each practice by April 2020. 	<ul style="list-style-type: none"> Video consultation offer available in each practice by April 2021. 			<ul style="list-style-type: none"> Every patient in England will be able to access a 'Digital First' primary care offer. Redesigned outpatient services: patients nationally will be able to avoid up to a third of face-to-face outpatient appointments.
Personalised care		<ul style="list-style-type: none"> Over 1,000 trained social prescribing link workers nationally will be in place by the end of 2020/21 rising further by 2023/24. Where appropriate, every person with cancer has access to personalised care plan (by 2021). 		<ul style="list-style-type: none"> Systems will have implemented the six components of the NHS Comprehensive Model for Personalised Care model so that nationally the model reaches 2.5 million (by 2023/24). Up to 200,000 nationally people will benefit from a personalised health budget (by 2023/24). 900,000 people nationally will have been referred to social prescribing schemes (by 2023/24). 	

Notes: 1. Serious mental illness; 2. Single point of access; 3. Including non-medical alternatives to A&E and alternatives to inpatient admission; 4. Improving access to psychological therapies.



Appendices

Contents

- Appendices to chapter 3: Service transformation
- Appendices to chapter 4: System development
- Appendices to chapter 6: Enablers
- Long Term Plan headline metrics
- Equality impact assessment
- Abbreviations list





Appendices to chapter 3: Service transformation

Contents

More information on our service transformation actions and priorities, including key milestones and how we will measure success for the foundational elements of the NHS Long Term Plan:

- Integrated community based care
- Urgent and emergency care
- Planned care
- Cancer
- Mental health
- Digital First primary care
- Personalised care



Priority 1: Integrated community based care

Deliver integrated community based care through the development of primary care networks at the core of our delivery model

Our key milestones are:

A systematic approach to addressing health inequalities within community services

- **2019/20:** establish a more formal community provider partnership; start definition of 'core offer' framework and publish timetable for completion; agree risk profile work programme with King's Health Partners.
- **2020/21:** agree core offer / best practice for all SEL community services with associated realistic workforce assessment in each borough; review impact of risk profiles for crisis services and extend programme if useful; identify / provide training for more integrated community / mental health and learning disability service response.
- Implement e-rostering and e-scheduling for all clinic and home visiting staff. Develop workforce plans for community nursing, utilising the apprentice standard for the district nursing qualification and a plan to increase the number of undergraduate clinical placements.

What we will measure:

- We will explore the development of a multi-agency borough-based dashboard that will measure:
 - The impact of a 'core offer' on place-based systems of health and social care.
 - The usefulness of the crisis risk profiles.
- The number of joint QI initiatives between the providers that has resulted in improved service outcomes (data available from each initiative).
- New screening routes within provider services for depression, anxiety and cognitive functioning.

A comprehensive PCN support and development strategy across SEL and within our local borough based system

- Detailed plans to be developed (high level plan is below).

What we will measure:

- The maturity of local PCNs against the national

maturity framework.

- Appointment availability and utilisation (in and out of hours).
- Workforce development against baseline.
- Patient satisfaction on availability of appointments and overall patient and carer satisfaction including measures of feeling in control of their health.
- Delivery against quality modules.
- Unplanned hospital admission for people with long term conditions.

Deliver fully integrated care through the development of anticipatory pathways with PCN / integrated neighbourhood networks (INNs)

- **2019/20:** with PCN agreement, realistic plans for integrated neighbourhood networks within each PCN footprint.
- **2020/21:** dependent upon the publication of the national specification and timeline and in conjunction with PCNs, design anticipatory care processes with all stakeholders and associated investment and workforce plan; assessment of the wider community and voluntary services network to support anticipatory care with associated workforce assessment; systems in place for data driven decision making and regular review mechanisms of PCN / INN-based activity with the LAS and acute partners.
- **2021/22:** implementation of anticipatory care as per the national specifications; effective data and information sharing protocols in place between community and social care services and primary care and with PCN agreement; continuous QI approach within INNs.

What we will measure:

- The multi-agency dashboard will provide information on the impact of the new developments on acute unplanned activity, primary care activity and social care services within each borough.

- In addition, PCNs will be supported to establish a dashboard to measure anticipatory care processes (e.g. number of care plan reviews, use of personal health budgets, carers signposted for support, etc.).
- The CBC Board will monitor that boroughs are undertaking self assessments of the wider service network and putting an associated prioritised development plan in place.

A core community offer to improve the responsiveness of community health response services (2 hour crisis / 2 day reablement response)

The implementation date of the 2 hour / 2 day targets has not yet been published – timings below may need to change.

- **2020/21:** commission a demand and capacity review of current crisis and reablement provision to meet the national specification. Develop a costed plan and trajectory (assumption of moderate growth) to deliver the new targets, including investment plan and workforce requirements by borough.

With each provider, review capacity to project manage the implementation of the LTP requirements.

Through place-based boards, develop integrated place-based pathways within current resource, with costed plan for increased level of pathways that meet demand; review provision of bed based intermediate care across SEL; establish same / next day reporting including of admissions.

- **2021/22:** Deliver the 2 hour / 2 day targets as per the national specifications; identify how community crisis services can be accessed through the new clinical assessment service, including costs and enabling IT developments; have a electronic shared record in place that allows sight of the care plan by relevant agencies; implement recommendations of intermediate beds review.

What we will measure:

Place-based dashboard for defined cohort (e.g. 65+ / frail / multi-morbidities) that pulls indicators from primary, community, social care and acute services to monitor:

- Optimisation of quality of life.
- Management of growing demand in ED;

presentations / unplanned admissions.

- Reduction in delayed transfers of care.
- Management of growing demand for care / nursing home admissions and impact on care packages (use of ASCOF and SALT indicators).
- Management of growing demand on primary care.

System wide and local priorities to deliver enhanced care in care homes

- **2019/20:** Explore how PCNs (with community providers) will be able to adopt the EHCH service specification.
- **By start 2020/21:** full coverage of NHS mail in care homes by completing 'entry met' standards requirements of the Data Security and Protection toolkit.
- **By end 2020/21:** consistent implementation of enhanced primary care service models across SEL.

What we will measure:

- Number of care homes receiving an enhanced primary care service model that includes all of the best practice sub-elements included in the EHCH framework (and including flu vaccinations as an additional measure).
- LAS call outs and A&E attendances from care homes.
- Number of care homes with access to NHS mail.
- Impact of telemedicine pilot reduction in demand for unscheduled care (indicators TBC).
- 111*6 line uptake.

High level three year plan for primary care

Area	An outline high level 3 year plan for primary care – to be developed further as part of our response to the NHS Long Term Plan		
	2019/20	2020/21	2021/22
Network	<ul style="list-style-type: none"> Ensure that PCN arrangements registration requirements have been met in line with the SEL principles and that all PCN footprints make long term sense for service delivery. To implement a core standardised primary care offer through new GP core and network contract and through broader alignment of local incentives and services at a neighbourhood and place level. 	<ul style="list-style-type: none"> Test and develop approach to addressing health inequalities via new dashboard to monitor progress on network metrics. Continue to support PCN delivery of national and local service requirements and the release of incentives such as the impact and investment fund to support improvement. Dependent on outcome of final contract negotiations this could include: anticipatory care requirements; Enhanced Health in Care Home requirements; structured medication review; personalised care requirements; early cancer diagnosis support. 	<ul style="list-style-type: none"> Test and develop SEL approach to cardiovascular disease case finding requirements using a clinical effectiveness model supported by learning from innovation fund projects. Embed delivery of prevention and health inequalities requirements via a fully embedded system wide approach.
Workforce	<ul style="list-style-type: none"> To take forward our 2019/20 workforce priorities aligned the intent of GPFV and contract reform. To provide SEL support to development of clinical pharmacists and place based support to social prescribers. 	<ul style="list-style-type: none"> Development of PCN support to management of MSK via first contact physiotherapists; continue to embed learning from SEL testing of physician associates. Support primary care training hubs' establishment. 	<ul style="list-style-type: none"> Embed learning from retention programmes and developed SEL approach to establishment of community paramedics within PCNs.
Quality	<ul style="list-style-type: none"> Support implementation of the <i>Quality Improvement Modules</i> for 2019/20 on prescribing safety and end-of-life care including alignment to Quality Outcomes Framework.. To submit interest in taking forward new primary care testbeds. 	<ul style="list-style-type: none"> Support implementation of new QI modules and changes to vaccination and immunisation arrangement. 	<ul style="list-style-type: none"> Support implementation of new QI modules.
Digital	<ul style="list-style-type: none"> To support all practices in ensuring at least 25% of appointments are available for online booking. Embed learning from Lambeth Digital Accelerator and agree SEL approach to online consultations. 	<ul style="list-style-type: none"> Ensure PCNs meet requirement for online presence, to give patients access online to correspondence and to no longer be using fax machines for either NHS or patient communications. 	<ul style="list-style-type: none"> Embed SEL wider Digital First support offer and ensure all patients will have the right to online and video consultations by April 2021.
Access	<ul style="list-style-type: none"> Build on success to date on continued delivery of GPEA, maximising utilisation and integration with the wider system (NHS 111 / redirection from UTCs). 	<ul style="list-style-type: none"> Embed learning from national access review into local models. 	<ul style="list-style-type: none"> Fully implement new access model and support performance improvement against patient reported access and waiting times data to be published monthly.

Priority 2: Urgent and emergency care

Reduce pressure on urgent and emergency care services

Our key milestones are:

We will deliver an integrated and consistent community based UEC offer across SEL

For milestones and metrics around population health management, proactive community based care, rapid response and care homes, see the [appendices to integrated community based care](#).

- **2019-2020:** Agree and implement referral pathways into relevant SEL services to take direct referrals from the 111 IUC service, LAS 999 crews and LAS 999 clinical hub.
- **2020:** Implementation of direct booking into all 210+ SEL GP practices.
- **2020:** Implementation of patient record sharing capabilities for the 111 IUC service with SEL providers.
- **2020-2021:** Develop referral pathways for the 111 IUC service and improve the interface between 999 and 111.
- **2020-2022:** Review, develop and improve mental health pathway.
- **2020-2025:** Develop a digital strategy with the 111 IUC service provider.

What we will measure:

- Proportion of mental health crisis calls resulting in a successful referral to a mental health crisis line.
- Proportion of callers with a community service need, receiving a community services response.
- Proportion of primary care dispositions resulting in a booked appointment.
- Proportion of calls receiving clinical input.
- Outcomes of all calls, including through the clinical assessment service (including proportion resulting in ambulance dispatch, referral to ED, referral to GP Out of Hours, etc.).
- Proportion of eligible patients referred to DMIRS / NUMSAS / CPCS.

We will implement services and streaming models which ensure that patients requiring an urgent / emergency care pathway are directed and seen in

the least intensive setting for their needs

- **By March 2020:** complete review of urgent treatment centres in SEL.
- **By the end of 2019/20:** SDEC in place for medical, frailty and surgical, with ongoing work to increase the number of patients treated via SDEC.
- **March 2020:** Review of SDEC and streaming services / activity recording via emergency care data set.
- **By 2024:** Implementation of consistent models.

See also: [appendices to adult mental health](#).

What we will measure:

How each urgent treatment centre is performing against the national standards including:

- Hours of operation.
- Ability to be accessed via NHS 111.
- Timeliness of clinical assessments.
- Throughput through SDEC pathways – target for a third of patients to be discharged on day of attendance.
- Non SDEC zero length of stay admissions.
- Emergency admissions for ambulatory care sensitive conditions.

Efficient delivery of inpatient care which, alongside our enhanced community care offer, will minimise the time patients spend in hospital

- **By April 2020:** Strengthened 'Transfer of Care' arrangements on each SEL site will be developed to support complex discharges.
- **Towards the end of 2020/21:** SAFER to be fully embedded on all wards.

What we will measure:

- The number of delayed transfers of care.
- Length of stay.
- The number of long stay patients.
- Discharges before noon / weekend discharges.
- Readmissions.

Priority 3: Planned care outcomes and performance

Improve planned care outcomes and performance

Our key milestones are:

We will implement access to telephone and video services alongside face-to-face appointments

- **March 2020:** 8% of outpatient appointments will be delivered virtually across the sector.
- **March 2021:** 15% of outpatient appointments will be delivered virtually across the sector.
- **March 2022:** 22% of outpatient appointments will be delivered virtually across the sector.
- **2022 – 2024:** Exploration of feasibility of remote monitoring complete and roll out to begin if appropriate.

What we will measure:

- Percentage of outpatient appointments delivered virtually, excluding outpatient procedures.
- DNA rates and cancellation rates. Target DNA rate for virtual clinics is 5%.
- Patient experience feedback.

We will implement access to virtual services

- **November 2019:** the first virtual chronic kidney disease clinics ran.
- **July 2020:** Trial for remote monitoring using PROMs to be completed and evaluation to start.
- **December 2020:** Following evaluation of remote monitoring trial and completion of service specification, procurement to start for product which can deliver remote monitoring.
- **2021:** Product in place to deliver remote monitoring and rollout to other specialties to begin.
- **2022:** Roll out completed of remote monitoring.
- **2022 – 2024:** Exploration of opportunities using machine learning / artificial intelligence and trials within services to begin. Exploration of remote blood testing to begin with the aim of increasing the percentage of outpatient appointments delivered virtually.

What we will measure:

- Percentage of outpatient appointments delivered virtually, excluding outpatient procedures.
- Percentage of patients completing PROMs on a monthly basis.
- Audits to assess if appointments were changed on the results of the PROMs data.
- Patient feedback on their experience of all types of virtual clinics.
- 18 week referral to treatment target.

We will offer better support to primary care

- **March 2020:** all specialties on Consultant Connect to have 70% answer rates.
- **April 2020:** launch of PhotoSAF across SEL requiring all dermatology referrals to have photo attached.
- **March 2021:** 50% of all referrals sent to GSTT, KCH and LGT are being clinically triaged, and where appropriate, referrals are returned to primary care with advice and a management plan for the patient. This would thus incorporate all specialties with 'complex pathways'.

What we will measure:

- Utilisation and effectiveness of advice and guidance services e.g. Consultant Connect answer rates; call volumes; call outcomes; e-RS advice and guidance requests; response times; GP and consultant experience and satisfaction.
- Proportion of referrals being sent via RASs and the outcome following clinical triage.
- Number of services with capacity alerts and referral trends before and after their introduction.
- 18 week referral to treatment targets.

We will provide appointments closer to home through community services

- **March 2021:** FCPs rolled out across three boroughs in SEL.

- **April 2021:** launch of three new community services across SEL.
- **March 2022:** FCPs rolled out across all six boroughs in SEL.
- **April 2022:** launch of three new community services across SEL.

What we will measure:

- **Community services:** metrics would vary by specialty, however, potential metrics would include: number of referrals to community services; outcome following care (e.g. number referred onto secondary care); waiting times for appointment (both in community and secondary care); DNA rates; number of referrals bypassing community service, patient experience and satisfaction.
- **FCPs:** metrics would include: number of patients seen by FCP; number directed to FCPs without seeing GP; outcome following care (e.g. medication prescribed, referred on to secondary care services); number of referrals to MSK services.

We will cut long waits and reduce waiting lists by introducing clinical triage across a wide range of specialties

- **April 2020:** 3 RASs established at GSTT and KCH.
- **April 2021:** 12 RASs established at each provider, including RASs operated on a pan SE London basis.

What we will measure:

- Number of referrals returned to primary care with advice and guidance.
- Changes in referral patterns to clinics and proportional increases in straight to test pathways.
- Referral to treatment targets.
- PTL size.
- Appointments per pathway to demonstrate reduction in non-value adding follow-ups.
- Proportion of appointments delivered non-face-to-face.

We will cut long waits and reduce waiting lists by developing clinical networks in some specialty areas to ensure safe and sustainable services

- **April 2020:** Completion of Phase 1 of Dermatology Network plans with GSTT.

- **April 2021:** Demand and capacity refresh completed and plans to right size capacity developed.
- **Post April 2021:** Implementation of capacity improvement plans.

What we will measure:

Performance will be measured against the following:

- Referral to treatment targets for outpatients and surgery.
- 2 week wait, 28 day referral to diagnosis and 62 day cancer treatment targets.
- Number of referrals into secondary care.

Priority 4: Delivering better outcomes for major health conditions

Cancer

Our key milestones are:

Work with national and regional teams to improve uptake and coverage of bowel, breast and cervical screening in London

- **Year 1:** Complete SEL screening improvement pilots and identify priority recommendations for implementation.
- **Years 2-5:** Improve SEL screening coverage and work towards achieving national standards.

What we will measure:

- Improvement in screening uptake for bowel, breast and cervical cancer screening programmes.
- Improvement in screening coverage for bowel, breast and cervical cancer screening programmes.

Implement an early diagnosis interventions bundle

- **Year 1:** Use SEL and pan-London work to develop SEL action plan of priority interventions.
- **Years 2-5:** Implementation of action plan – prioritised according to available resources and emerging evidence base.

What we will measure:

- Proportion of cancers diagnosed at stage 1 and 2.
- Proportion of cancer admissions diagnosed for the first time via emergency presentation.
- 1 and 5 year survival.

Support delivery of the national specification on rapid diagnostic centres in South East London

- Additional roles recruited to enable expansion (additional clinics) – Q4 2019/20.
- Patients with tumour site specific symptoms to go through model – Q4 2019/20.
- Longer term plan and resource requirements, including additional LTP allocations for cancer, to be defined in line with national timetable for five year plans.
- There is no national capital funding available

specifically to support the expansion of the rapid diagnostic centre service. We will continue to liaise with the National Cancer Programme Team on the likelihood of capital funding being available.

What we will measure:

- Patient feedback on the service.
- Agreed national minimum dataset to contribute to evaluation, including:
 - Time taken for diagnosis for cancer patients and non-cancer patients.
 - Route of referral.
 - Staging.

Implement a comprehensive SEL clinical programme across all tumour sites supported by cross-cutting groups to drive improvements in cancer performance, outcomes and experience and deliver the cancer five year plan

Year 1:

- All tumour group have agreed and implemented SEL 62 day timed pathways.
- Clinical agreement of optimal diagnostic model or pathway to deliver the faster diagnosis standard.
- Development of quality dashboards – phased approach starting with colorectal and OG pathways.
- Agreement of joint work to improve patient experience – priorities evidenced by National Cancer Patient Experience Survey.

Years 2-5:

- Ongoing use of local and national data to understand variation in access and quality to inform priorities of clinical programme and address inequalities.
- Sustainable implementation of tumour specific diagnostic pathways to support delivery of FDS and cancer waiting times standards.

- Working with personalised care team to support delivery of HNAs, treatment summaries and HWBE.
- Robust patient engagement with the work of the tumour and cross-cutting groups and to enable co-design.

What we will measure:

- Reducing variation in access.
- Improvement in faster diagnosis standard and other cancer waiting times performance.
- Improvement in patient experience and clinical outcomes.

Roll out the faster diagnosis standard and improve performance on cancer waiting times standards

Year 1:

- Trusts deliver compliant levels of completeness against all FDS pathways.
- Implementation of the national FDS pathway in upper gastrointestinal.
- Improving compliance against the other national priority pathways.
- Complete recruitment of additional sector operational staff.
- Understand workforce plan for key SEL staff group – oncology.
- Deliver sector wide EBUS service moving from 1 to 3 sites.

Years 2-5:

- Agreed methods for communicating diagnosis or ruling out cancer diagnosis to patients across tumour groups and deliver communications.
- Improving compliance against the standard – trajectories to be agreed.

What we will measure:

- Data completeness rates – across all FDS pathways.
- Compliance rates – at tumour and trust level.
- Percentage of cancers diagnosed within 28 days.
- Compliance rates – at tumour and trust level for FDS.
- Performance for 31 day and 62 day pathways.
- ITT and reallocated performance metrics for GSTT.

- PTL size and backlog size and configuration.
- Diagnostic turnaround times.
- Compliance against clinical pathways – audit and cancer data system.

Implement a range of high quality treatment interventions across the Alliance. This will ensure patients receive the most effective, precise and safe treatments, with fewer side effects, shorter treatment times and reduce variation in access and outcomes

Year 1

- Establish radiotherapy network and start implementation of clinical programme.
- Start implementation of priority MDT quality standards.

Years 2-5

- Delivery of radiotherapy network.
- Provision of genomic test as specified national test directory.
- Improved participation in clinical trials – adult and TYA.

What we will measure:

- Clinically agreed cancer pathway milestones and treatment times.
- 1 and 5 year survival.
- Patient experience.
- Clinical outcomes.

Work with NHSE&I and our London South Genomic Laboratory Hub partners to increase genetic and genomic testing coverage and ensure equitable access to all tests covered by the National Genomic Test Directory

- **March 2020:** completion of the London South genomic laboratory hub target operating model and full provision of the national test directory.
- **April 2020-23:** ongoing review of testing coverage, performance against quality indicators and test repertoire.

What we will measure:

- Performance against hub contractual KPIs, including equitable access to test directory tests across our whole patient population, including whole genome sequencing, and performance against quality metrics including turnaround times.

Improve delivery of personalised care with the aim of ensuring that all patients diagnosed with cancer will have access to high quality personalised care

- **Year 1:** Continue working towards personalised care metrics and appropriate data recording; HNA, treatment summaries, health and wellbeing information and support delivery of cancer care reviews in primary care.
- All tumour groups to have personalised care / Living With and Beyond Cancer metrics in their annual workplans.
- All trusts to have implemented Somerset to support recording of personalised care priorities for data.
- **Years 2-5:** trajectories to be agreed.

What we will measure:

By 2021 everyone diagnosed with cancer will have access to personalised care, including a holistic needs assessment, a care plan and health and wellbeing information and support.

- Percentage of patients with HNA.
- Percentage of patients with a care plan.
- Percentage of patients with health and wellbeing information and support.

Implement stratified follow up pathways at end of treatment for the agreed cohort of breast, colorectal and prostate cancer patients and other tumour specific pathways as appropriate

Year 1:

- All trusts to have stratified follow up pathways in place for colorectal and prostate cancer.
- Agree clinical protocols stratified follow up pathways in place for colorectal and prostate cancer.
- All trusts to have started implementing Somerset to support remote monitoring of patients on self-management pathways.

Year 2:

- All trusts to have stratified follow up pathways in place for colorectal and prostate cancer.
- All trusts to be providing personalised care data via COSD function in Somerset.

Years 3-5: Develop core principles for stratified follow up that can be applied to other tumour specific cancer follow up pathways.

What we will measure:

- Percentage of patients with breast cancer on a stratified follow up pathway.
- Percentage of patients with prostate cancer on a stratified follow up pathway.
- Percentage of patients with colorectal cancer on a stratified follow up pathway.
- Percentage of trusts with a remote monitoring system in place.
- All tumour sites to be using agreed treatment summary templates, agreed with primary care.
- Roll out of national QOL metric to all cancers in SEL as defined by national programme.

Support the development, resilience and productivity of the cancer workforce in south east London

Year 1

- Complete oncology workforce baseline and model to inform business planning for 2020/21 onwards.
- Complete MDT improvement programme and identify lessons that can be shared with other tumour groups by end March 2020.
- Agree SEL priority staff groups for focused work within Q4 2019/20.
- Evaluate sector roles including operational roles and patient navigators March 2020.

Years 2-5

- Transition all current cancer transformation funded posts to a sustainable funded basis where appropriate (by the end of year 2).
- SEL cancer workforce strategy or approach agreed and in implementation.

What we will measure:

- Change in numbers of posts in priority areas for cancer in SEL – as per Cancer Workforce Plan Phase 1, including oncology workforce.
- Time from outpatient appointment to decision to treat (measure relating to MDT process and decision-making improvement) in relevant tumour groups.
- Staff turnover for key staff groups.
- Relevant data from National Cancer Patient Experience Survey – improvement in overall patient experience score and particularly questions relating to workforce.

- Course evaluation.
- Although SEL has identified challenges in the histopathology workforce and the potential of network working, we are currently awaiting the outcome of the SEL pathology tender before progressing work.

Involve patients and carers in our patient experience and service improvement work

- **Year 1:** Complete patient involvement training of all Cancer Improvement Managers. Formalise the patient involvement pools (database). Hold the first SEL Cancer Alliance PPI Board meeting. Agree a strategy to address common and cross cutting issues around patient experience.
- **Years 2-5:** Ensure the culture of a patient-centred approach within the SEL Cancer Alliance workstreams is fully embedded.

What we will measure:

- The number of projects and initiatives where patients have been involved or consulted.
- The impact of patient involvement.
- The experience of patients being involved in co-design.
- Improvement in National Cancer Patient Experience Survey results – particularly review trends where SEL Cancer Alliance or individual providers report lower satisfaction scores.

Priority 4: Delivering better outcomes for major health conditions

Adult mental health

Our key milestones are:

Implement new integrated community mental health models of care wrapped around primary care networks

- **2020/21:** Development of SEL MH prevention and early support strategy working with Public Health England to support those who experience being mentally unwell but do not meet IAPT and secondary care access thresholds for support.
- **2020/21:** System agreement of core principles to enable a SEL needs approach to how transformation investment is prioritised locally.
- **2021/22:** Mental health interface with primary care to have a core set of principles for what will be committed to by primary care networks and community mental health services.
- **2021/22:** Agreed framework to measure population health outcomes and the indicators.

What we will measure:

MH outcomes will be measured using standardised outcomes measures which give a sense of how the system is performing as follows:

- Community contacts and number of service users on the care programme approach.
- Percentage of people on the care programme approach who had a review recorded in the last 12 months.
- Percentage of patients on the care programme approach followed up within 7 days of discharge.
- The number of completed DIALOG / HONOS outcomes recorded to ensure system compliance to enable next step to agreeing ICS outcomes framework.

Implement increased capacity to support more people in IAPT services, including people with physical health long term conditions, resulting in year on year increase in the number of people accessing IAPT services in line with national trajectories to 2023/24

- **March 2020:** Services will have reduced second

appointment waiting time to the national average.

- **2020/21:** IAPT services integrated with primary care.
- **2020/21:** All SEL IAPT services signed up to a single digital IAPT procurement and contract at a reduced cost.
- **2021/22:** Realise digital IAPT contract savings.

What we will measure:

- Access
 - Number of referrals that entered treatment.
 - Percentage of referrals that entered treatment within 6 weeks and 18 weeks.
 - Number of referrals for BME patients.
- Quality
 - DNA: percentage of IAPT appointments where patient did not attend and gave no advance warning.
 - Outcomes: percentage of IAPT referrals that showed recovery.
 - Second appointment wait times over 90 days.
- Workforce
 - Number of psychology wellbeing practitioners vacancies quarterly.

Implement annual physical health checks, EIP and IPS services for people with SMI embedded within core community mental health service offer

- **SMI PHC: March 2020** – ICS to have an agreed collective approach across all CCGs for improving number and quality of physical health checks.
- **EIP: March 2020** – 60% of EIP services delivering NICE concordat care rated at level 3 for quality.
- **IPS:**
 - **2020/21** – develop IPS growth plan.
 - **2021/22** – all 6 IPS services in SEL to have completed external fidelity review.

What we will measure:

SMI – Physical health checks

- Delivery of the physical health check standard to 2023/24 equating to 60% of registered SMI population.

EIP

- Access and waiting time standards for EIP.
- Percentage services providing NICE concordant care rated at level 3 for quality.
- Number of services using DIALOG and HONOS to report outcomes.
- Number of people having a physical health assessment (meeting PHC audit requirements) and associated physical health intervention.

IPS

- Access – Number of referrals and number of new referrals in the current financial year.
- Employment status at referral and employment status at case closed status.
- Number of clients engaged and number starting paid employment.
- Job sustainment (collected from Q3) > 13 weeks and 26 weeks (above and below 16 hours).

Implement a consistent core offer of specialist community perinatal services across SEL with links to maternity community clinics.

- **2020/21:** SLaM and Oxleas CPMH service to undertake a robust service evaluation.
- **2020/21:** Look to clinical psychology role to develop reflective practice for midwives as a first step to engage maternity services.
- **2021/22:** Develop models for listening clinics which provide mental health support integrated with maternity services for tokophobia and birth trauma.
- **2022/23:** Build on listening clinic work to formalise maternity outreach clinic model and implementation in year.

What we will measure:

- Referrals received – including demographic profiles to monitor increased access in underrepresented groups.
 - Total number of referrals received; number of women accepted.
 - Total number of women offered an

assessment appointment; number of women seen.

- Referral source.
- Number under care programme approach at referral.
- Total number of women seen for psychological intervention.
- Percentage of women referred for psychological intervention seen within 4 weeks.

Implement alternative crisis support working jointly with police, LAS and voluntary sector, and improve the quality of psychiatric liaison services.

- **2019/20:** The peer support and lived experience worker roles will be tested in two SEL A&E departments.
- **March 2020:** All EDs in SEL will deliver core 24 standard psychiatric liaison services.
- **March 2020:** Completed mapping of cohort of children and young people falling within the parameter for all age liaison psychiatry.

What we will measure:

- Number of crisis resolution and home treatment team contacts.
- Number of inpatient admissions following a crisis resolution and home treatment team response as a proportion of total responses.
- Number of A&E presentations that required MH liaison team assessment weekly / monthly / quarterly as a proportion of A&E presentations.
- Liaison activity leading to an inpatient bed as proportion of total liaison activity.
- Response times following referral (emergency department and inpatient ward).

Implement pathways with specific focus for people who have co-existing personality disorder traits, and older adults and eating disorders.

Co-existing personality disorder traits:

- **By 2020/21:** Deliver increased numbers of staff trained in dialectic behavioural therapy.

Older adults:

- National dementia diagnosis rate target.
- Memory service waiting time targets.
- IAPT targets access and LTC.

Eating disorder:

- **By 2020/21:** Enable self referral to adult eating disorder services.

What we will measure:

Co-existing personality disorder traits:

- As we develop pathways for people with personality disorder co-morbidities, we will determine metrics to monitor activity and quality for this cohort as part of the integrated community mental health team core offer.
- Admission and length of stay in acute and mental health hospitals.

Older adults:

- Dementia diagnosis rate.
- Memory service waiting times.
- Delayed transfers of care.
- Length of stay in acute and mental health hospitals.
- IAPT access rates.

Eating disorder:

- Referrals – self referrals and other routes.

We will implement increased provision for suicide bereavement, problem gambling and rough sleeping

Suicide bereavement support:

- **2020/21:** Complete ICS mapping of provision of suicide postvention / bereavement support, (activity; access) and identify need to ascertain gaps in provision.
- Develop an ICS suicide prevention and bereavement support plan to deliver at least a 10% reduction in the number of suicides from the latest ONS figures published in 2017.

Rough sleeping:

- **2020/21:** Evaluation of the Lambeth model with a view for role out across SEL.

Problem gambling:

- **2021/22:** We will review the delivery models and shared learning from early implementor sites to be able to identify need and develop our strategy to support problem gambling.

What we will measure:

Suicide bereavement support:

- As we continue to develop our plans to

understand the support need and potential unmet need in SEL we will seek to develop outcome-based measures and metrics to track and monitor progress in line with national and regional performance to baseline and track a reduction in suicides across the sector.

Rough sleeping:

- Percentage of clients registered with a GP within 3 months of entering service.
- Percentage of clients engaged with mental health service for a minimum of five intervention based contacts.
- Percentage of clients receiving a structured motivational and harm reduction package of interventions.
- Percentage of clients living in / sustaining accommodation by discharge from START+ or by end of project.
- In addition, we will monitor the following specific KPIs:
 - Percentage of clients accessing secondary specialist health services / treatment for specific physical health needs by end of project.
 - Percentage of clients experiencing an improvement in health and social functioning (reduction in HONOS score by appropriate clinician; reduced CORE service user rated).

Problem gambling:

- As we continue to develop our plans to understand the support need and potential unmet need in SEL we will seek to develop outcome-based measures and metrics to track and monitor progress in line with national and regional guidance.

Digital First primary care

The delivery of local Digital First visions by 2023/24 is a commitment within the NHS Long Term Plan, encompassing both scheduled and unscheduled care pathways, and providing us with the foundations to build a sustainable, digitally-enabled ICS.

Our key milestones are:

Delivery of an online consultation offer in each GP practice by April 2020

- **2019/20**
 - Establish the South East London Digital First Steering Group to define the overall strategy for the ICS and lead on developing and delivering the LTP milestones.
 - Each borough has procured their own online consultation solution to deliver the April 2020 deadline. Work with each SEL borough to ensure they have implemented the online consultation solutions in every GP practice.
- **2020/21**
 - Work with patients and clinicians to evaluate the variety of different online consultation solutions in use in SEL and share the work from the Lambeth Digital Accelerator programme.
 - Agree through the steering group an ICS plan to rationalise the number of systems in use and achieve economies of scale.
 - Develop plans which integrate the different elements of Digital First into seamless (for the patient) solutions (e.g. video consultations, integrated voice recognition telephony).
- **2021 – 2023/24**
 - Transition to a smaller number of digital providers in SEL and ensure full integration with the NHS App.

What we will measure:

- Each practice will have a functioning online consultation solution by April 2020.
- Establish an initial benchmark of the proportion of the SEL population with access to online consultation tools and measure the trend each month.
- Report the number of patient enquiries / consultations per month which have taken place by an

online consultation route.

Deliver a video consultation offer in each GP practice by April 2021

- **2019/20**
 - Establish the south east London Digital First Steering Group to define the overall strategy for the ICS and lead on developing and delivering the LTP milestones.
 - Define an ICS strategy for video consultations which gathers and consolidates requirements in each SEL borough. This will also review models of delivery as this technology may be better delivered from e-hubs rather than from individual practices.
 - Continue to test and develop solutions through the Lambeth Digital Accelerator Programme.
- **2020/21**
 - Establish funding levels for video consultation solutions.
 - Procure and implement video consultation solutions across all of the SEL boroughs.
 - Continue to ensure the chosen video consultation solutions fit with strategic plans to integrate the different elements of Digital First into seamless (for the patient) solutions (e.g. online consultations, integrated voice recognition telephony).
- **2021 – 2023/24**
 - Work with patients and clinicians to evaluate the video consultation solutions in use in SEL and ensure full integration with the NHS App.

What we will measure:

- Each practice will have a functioning video consultation solution by April 2021.
- Establish an initial benchmark of the proportion of the SEL population with access to video consultation tools and measure the trend each month.
- Establish the proportion of the SEL population registered to use the NHS App and measure the trend each month. Report the number of patient enquiries / consultations per month which have taken place by a video consultation route.

Personalised care

Whilst we have areas of good practice in SEL, we do not currently have a comprehensive strategy for personalised care. Whilst we continue to develop our approach the below is an example of milestones that have been agreed to date.

Our key milestones for delivering personalised care in cancer are:

Develop a plan to implement the NHS Comprehensive Model of Personalised Care in SEL

- **2019/20**
 - Agree SEL priority staff groups for focused work within Q4 2019/20.
 - Evaluate sector roles including operational roles and patient navigators (March 2020).
- **2020/21 – 2023/24**
 - Transition all current cancer transformation funded posts to a sustainable funded basis where appropriate (by the end of year 2).
 - SEL cancer workforce strategy agreed and in implementation.

What we will measure:

- Change in numbers of posts in priority areas for cancer in SEL – as per Cancer Workforce Plan Phase 1, including oncology workforce.
- Time from outpatient appointment to decision to treat (measure relating to MDT process and decision-making improvement) in relevant tumour groups.
- Staff turnover for key staff groups.
- Relevant data from National Cancer Patient Experience Survey – improvement in overall patient experience score and particularly questions relating to workforce.
- Course evaluation.

Involve patients and carers in our patient experience and service transformation work

- **2019/20**

- Complete patient involvement training of all Cancer Improvement Managers. Formalise the patient involvement pools (database). Hold the first SEL Cancer Alliance PPI Board meeting. Agree a strategy to address common and cross cutting issues around patient experience.

- **2020/21 – 2023/24**

- Ensure the culture of a patient centred approach within the SEL Cancer Alliance workstreams is fully embedded.

What we will measure:

- The number of projects and initiatives where patients have been involved or consulted.
- The impact of patient involvement.
- The experience of patients being involved in co-design.
- Improvement in National Cancer Patient Experience Survey results – particularly review trends where SEL Cancer Alliance or individual providers report lower satisfaction scores.



Appendices to chapter 4:
System development



Context

Many of the transformation plans set out in the previous section are not new endeavours for SEL. However, what history has shown is that taking an organisational specific and siloed approach to delivery has not worked in terms of translating our ambition into reality. Delivery is not within the gift of any single organisation and the transformation agenda set out in this Long Term Plan response can only be delivered through system working, and organisations collaborating to work together in new ways. We need to ensure that the system infrastructure supports organisations to work collaboratively. As a result, SEL will move forward at pace to develop our integrated care system ways of working, bringing together local organisations to redesign care and improve population health, creating shared leadership and action.

The SEL ICS is our vehicle for delivering system transformation and improved outcomes – it will underpin the delivery of our Long Term Plan commitments. Becoming an ICS is **not an end in itself for south east London**, but it is the key vehicle and infrastructure through which we will deliver the system transformation plans set out in the previous section and achieve our goals of reducing health inequalities and achieving system sustainability. Developing our ICS – its governance, infrastructure and ways of working alongside its delivery mechanisms, capacity and capability – is therefore a key element of our response to the LTP.

Our journey to becoming an ICS

Towards the end of 2018, SEL participated in the **Aspirant ICS Programme** and this enabled progress to be made in a number of key areas. At the end of the programme SEL agreed a **System Improvement Plan**, which set out our **system development commitments** aimed at supporting our transition from a sustainability and transformation partnership to an ICS and developing our ICS maturity; all partners have committed to a series of developmental ICS objectives to address long standing system challenges and drive the redesign of our system architecture.

SEL's progress was recognised nationally and in June 2019 SEL was identified as a **Wave 3 ICS**, the first in London to be part of the national programme. Our Wave 3 status will enable us to drive both our internal ICS development, as well as test ICS approaches in the London context. The SEL ICS is committed to making rapid but sustainable progress within SEL and to supporting the delivery of London's wider ICS ambition.

This section sets out our latest assessment against the ICS maturity matrix and builds on our System Improvement Plan to set out our how we will continue to develop our ICS maturity and system ways of working over the next five years, and the outcomes this is expected to deliver.

Where are we now and where do we want to be?

Our assessment against the ICS maturity matrix

Our latest assessment against the national ICS maturity matrix shows that SEL has made considerable progress against the national criteria, which reflects our Wave 3 ICS status. In the table below we set out where we are now and priority actions we will take to become a “thriving” ICS by 2023/24.

Review criteria	Current assessment: “maturing”	Work needed to “thrive”
<p>System leadership, partnerships and change capability</p>  <p>Maturing</p>	<ul style="list-style-type: none"> • Collaborative and inclusive system leadership and governance, including local government, through the OHSEL Board. • Clear shared vision and objectives, with consistent progress. • Dedicated capacity and supporting infrastructure being developed to enable change at system, place (including health and wellbeing boards) and neighbourhood level (through PCNs). • Ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels, as demonstrated through our LTP engagement events. 	<ul style="list-style-type: none"> • Further development of governance and leadership to ensure strong collaborative and inclusive system leadership, across the System of Systems; development of transparent and robust governance and mechanisms to hold each other to account, and strong clinical leadership to drive transformation work. • Dedicated clinical and management capacity and infrastructure to execute system-wide plans, working on behalf of the ICS. • Development of a strong public narrative outlining how integrated care is being developed with and benefiting the public and demonstrable impact on outcomes.
<p>System architecture and strong financial management and planning</p>  <p>Maturing</p>	<ul style="list-style-type: none"> • SEL is working with regional teams to take on increased responsibility for oversight, as demonstrated through joint chairing of Performance Oversight Meetings. • Plans to streamline commissioning are underway; our application to merge the six CCGs has been approved. • SEL has plans in place for meeting our 2019/20 system control total and has examples of system working around finance, e.g. system discussions around prioritisation and use of capital spend. • SEL has moved towards aligned incentive contracts and led an approach to planning for 2019/20 characterised by system leaders working in partnership to agree system solutions to our financial, planning and delivery challenges. • System wide plans for workforce, estates and digital infrastructure being implemented through our established SEL programmes, overseen by the Enabler Programme Board. 	<ul style="list-style-type: none"> • Further development of oversight arrangements to establish robust self-assurance alongside clear communication and relationships with regional team. • Fully embed streamlined commissioning arrangements across all partners. • Build on current approaches to sharing financial risk using more sophisticated modelling of current and future population health and care needs, working as a system to meet the financial targets and ICS control total that has been set. • Build on 2019/20 progress to continue to develop incentives and payment mechanisms which support our objectives and maximise impact for the local population. • Plans delivering demonstrable improvements in workforce, estates and digital infrastructure being seen across SEL.

Where are we now and where do we want to be? (continued)

Our assessment against the ICS maturity matrix (continued)

Review criteria	Current assessment: “maturing”	Work needed to “thrive”
<p data-bbox="89 410 272 472">Integrated care models</p>  <p data-bbox="147 648 258 679">Maturing</p>	<ul data-bbox="354 410 825 1290" style="list-style-type: none"> • 35 PCNs have formed across SEL and are developing plans to deliver the national service specifications and starting to design care models with partners to meet population need. • Each borough has plans for “integrated care teams” operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration aim set out in the LTP. • We are implementing plans to address unwarranted clinical variation, deliver the five service changes in the LTP and tackle the prevention agenda and address health inequalities. • PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use. • We have an evidence based understanding of key determinants of health inequalities and population specific prevention needs and are developing plans to address these on a systematic basis. 	<ul data-bbox="863 410 1335 1104" style="list-style-type: none"> • We need to translate our maturing plans around integrated care into fully operational models of care which are demonstrably improving outcomes for our population. • Fully mature PCNs across the system delivering care with partners that meets population needs. • Implementation of the five service changes set out in the LTP demonstrating improvement in health outcomes. • Full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care. • Implementation of priorities for prevention and reducing health inequalities as part of approaches to integrated care.
<p data-bbox="89 1321 272 1384">Track record of delivery</p>  <p data-bbox="125 1560 279 1622">Developing / maturing</p>	<ul data-bbox="354 1321 825 1819" style="list-style-type: none"> • Strong system commitment to working together, but lack of tangible progress in delivery of constitutional standards. • Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management. • Robust approach in place to support challenged organisations and address systemic issues. • Progress towards delivering national priorities especially: better access to primary care; improved mental health and cancer services; the five service changes set out in the LTP. 	<ul data-bbox="863 1321 1335 1860" style="list-style-type: none"> • Working together as a system to deliver on agreed performance improvement plans, with corresponding delivery of agreed performance trajectories for constitutional standards. • Working as a system to mitigate risks. • Evidence of delivering national priorities especially: better access to primary care, improved mental health and cancer services and the five service changes set out in the LTP. • Demonstrating early impact on improving population health outcomes. • Consistently delivering system control total with resources being moved to address priorities.

Where are we now and where do we want to be? (continued)

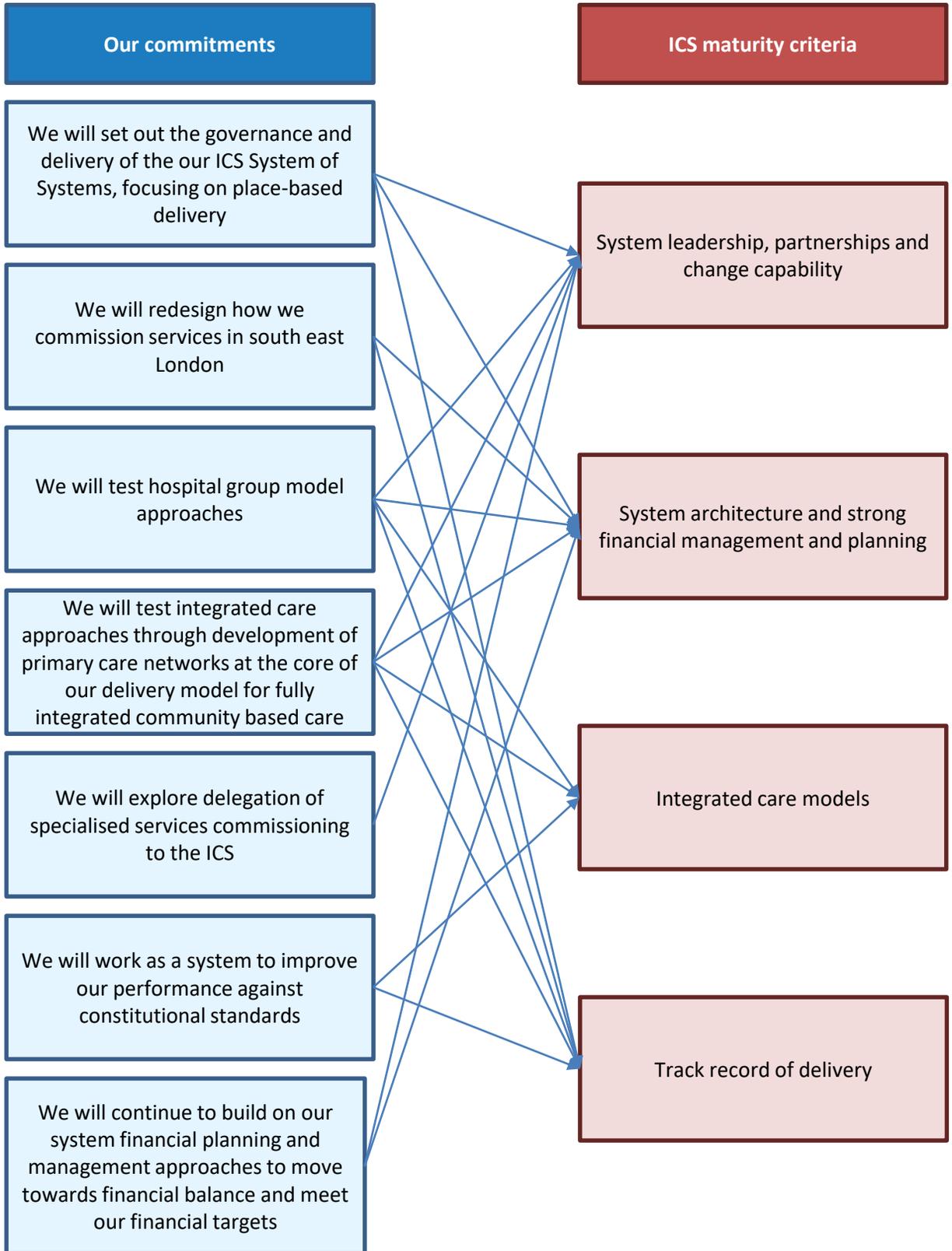
Our assessment against the ICS maturity matrix (continued)

Review criteria	Current assessment: “thriving”	Work needed to “thrive”
<p>Coherent and defined population</p>  <p>Thriving</p>	<ul style="list-style-type: none">• SEL has a meaningful geographic footprint that respects patient flows; 90% of south east Londoners receive their care within the ICS footprint.• Contiguous with local authority boundaries.• Population of 1.9m.• Our System of Systems approach ensures an appropriate focus on neighbourhood, borough and SEL-wide population approaches, to reflect acute flows alongside very local access.	<p>Our ICS development work will give focus to populations from outside of SEL who access their care through SEL providers – a key issue for specialised services where SEL providers see material flows from SE England.</p>

The following pages of this section set out a series of commitments the SEL system has made, and is currently delivering, to enhance how we work together and our system’s ICS maturity. The commitments are designed to progress various aspects of our ICS including our governance, how we commission services and how organisations work together to deliver care. For each commitment we have tangible milestones for delivery in 2019/20, a first step as part of a longer term development journey.

How will we get there?

We have made a series of system commitments to support our transition to a mature, effective and thriving integrated care system



What will success look like?

If successful, by the end of 2023/24 we be able to say....

...We are delivering our ICS development commitments.

- Demonstrable progress against the ICS development commitments we have made to support the delivery of our Long Term Plan ambitions.
- ICS Board with independent Chair in place, alongside a fully functioning ICS infrastructure, inclusive of Place Based Boards and Local Care Partnerships and an ICS Executive / Programme Management Office (PMO).
- Agreed and effective governance, with a recognised self governing ICS where our regulators are ICS partners not assurers.

...We are delivering our Long Term Plan commitments for service delivery and improved outcomes for patients and the public.

- As a system we have done what we said we would do – with delivery of the improvements that we have set out in this Long Term Plan response (including improvements to our services, patient and public outcomes and experience, performance and finance).
- This will require collaborative and integrated delivery approaches – we cannot meet our commitments through operating in organisational silos.

...We are a mature and thriving ICS.

- A movement each year towards a mature, effective and thriving ICS – with the objective of meeting 'thriving' characteristics by the end of 2023/24.
- Improved performance against the other aspects of ICS maturity – with a particular emphasis on financial management and responsibility, we will have a population health management, clinical effectiveness and quality improvement driven ICS.

...We are recognised as being responsive to the people we serve.

- The SEL ICS is recognised as mature and thriving, and receives positive feedback from stakeholders and from our staff and constituent organisations.
- The ICS is demonstrably responsive to the local population we serve – their priorities, health needs and service feedback.
- We have taken difficult decisions and decisions for the good of the system and our population.
- We have secured service redesign and improved health outcomes.
- We can and have held each other to account as part of a self-governing system.
- Our stakeholders have confidence in us and that we are responsive to them and their needs.

Commitment 1: Governance

We will set out the governance and delivery of the ‘System of Systems’, focusing on place-based delivery

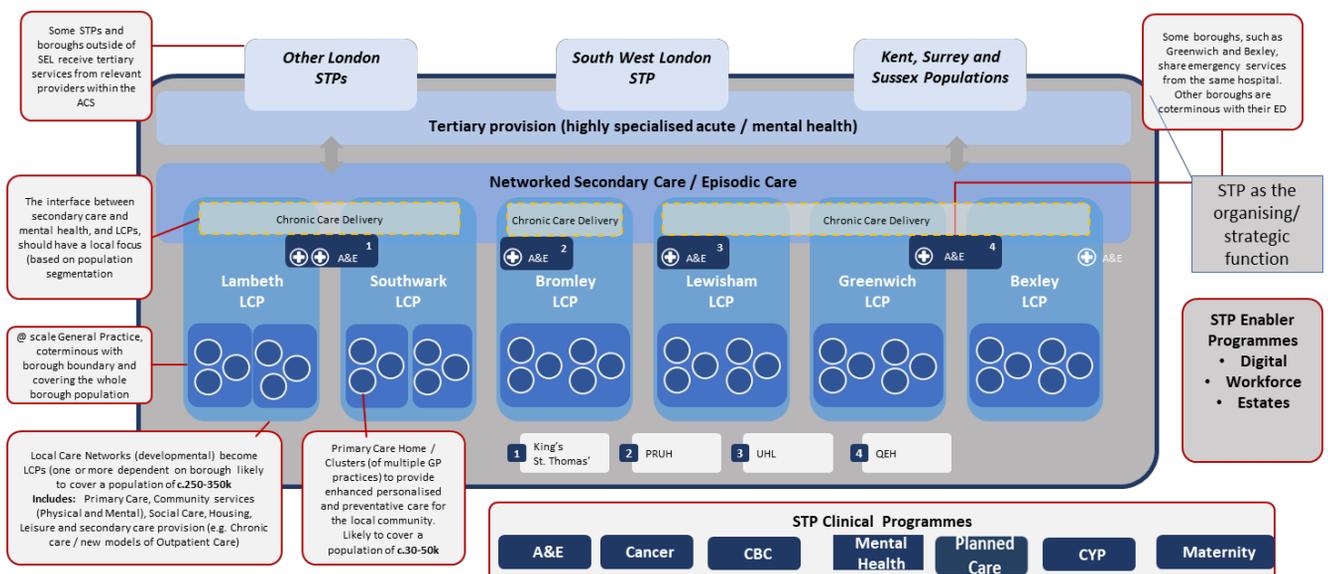
Vision

Our shared goal is to deliver ‘a clinically and financially sustainable system for the future and address health inequalities in south east London’. History has shown us that this can only be achieved through collaborative working, and we can only address unwarranted clinical variation, the Long Term Plan’s five service changes and reduce health inequalities if we work at neighbourhood, place and system level simultaneously. Through our ICS we will ensure effective leadership and governance at all levels of our system – across neighbourhood, place and system – which drives delivery at pace and enables us to hold each other to account.

Objectives

We have developed and agreed an end-state operating model for our ICS – this adopts a ‘System of Systems’ approach to planning, delivery and oversight. Our design reflects the fact that SEL is a complex system, which will need a number of health and care partnerships within the overarching SEL ICS. The operating model reflects:

- The work the ICS is doing with other ICSs / STPs, focused on tertiary and highly specialised provision and mental health.
- Work within the ICS to support neighbourhood, borough, pan borough and SEL-wide delivery models.
- The underpinning clinical programmes that will drive the underpinning care pathway redesign and enabling programmes that will ensure fit for purpose infrastructure.
- The ICS as the overarching governance, organising and strategic function.



We will deliver our vision and objectives through the following priority actions

Our governance development work is focusing on the following three areas:

1. Transitioning to an ICS Partnership Board, with the underpinning governance and infrastructure to enable delivery of our LTP commitments and ambition.
2. Further development and testing of the fitness for purpose of our operating model to underpin delivery – the mental health operating model is provided as an example below.
3. Development of place based system leadership across SEL to support ICS delivery.

Commitment 1: Governance (continued)

Transitioning to an ICS

The starting point for development of the SEL ICS Partnership Board is the existing OHSEL Board, which has many of the characteristics that the ICS Partnership Board will need to carry out its function:

- All partner organisations are represented on the OHSEL Board.
- The Board meets monthly and holds both meetings in public and private meetings.

We recognise that we need to build on our OHSEL Board arrangements to have an ICS Board that secures effective and robust overarching governance with an organising and strategic function, recognising too that our ICS Partnership Board will continue to evolve as the SEL ICS develops. Key areas of development work are summarised below. We will further review our overall OHSEL governance and infrastructure to ensure it is fit for purpose as we transition to an ICS and work collectively to secure a demonstrable mature and thriving ICS in SEL.

We are testing governance through a number of lenses – (1) overarching ICS governance; (2) what we need to put in place at place or borough level; and (3) how governance will work on an end-to-end pathway.

Overarching ICS governance

Joint work with London Region and other London ICSSs

<p>Establishing our ICS infrastructure</p> <ul style="list-style-type: none"> • Appointment of an independent Chair. • Agreement of dedicated ICS executive leadership arrangements. • Agreement of ICS PMO arrangements and resourcing. 	<p>Revised governance and Terms of Reference for our OHSEL Board and associated groups</p> <ul style="list-style-type: none"> • Ensuring the ICS can provide an effective governance, organisation and system management function. 	<p>London oversight and assurance operating model</p> <ul style="list-style-type: none"> • Work with London Region and ICSSs to agree a new regulatory operating model for London, inclusive of increased self regulation, and to implement this in SEL.
<p>Development of ICS performance dashboards</p> <ul style="list-style-type: none"> • To support effective system management and self regulation. • Including developing our population health management capabilities and quality surveillance. 	<p>Senior leadership development</p> <ul style="list-style-type: none"> • Regular facilitated workshops with ICS Chairs and Chief Executives – to support transition and agree our ICS governance approaches as well as developing senior leadership relationships and ways of working. 	<p>Wider engagement and organisational development</p> <ul style="list-style-type: none"> • Planned wider engagement with other system leads, including new clinical leadership, to secure wider staff buy in and engagement as well as developing relationships, trust and ways of working across the system.

Commitment 1: Governance (continued)

Developing our place-based leadership

Place as the cornerstone of our new ICS operating model

Place represents the core foundation of our SEL ICS – each borough is working as a system to secure an integrated delivery model at borough level, built on:

- **Joint commissioning arrangements across CCGs and local authorities;** whilst joint commissioning is at different stages across SEL there is a clear commitment in each borough to progress and further build on integrated commissioning approaches.
- **Integrated models of provision and delivery,** focused on and through our community based care plans, delivered through our Local Care Partnerships and primary care networks.

SEL Commissioning System Reform Programme – to support place based leadership

- Place Based Boards – we have agreed Place Based Boards as part of our new operating model – these will secure integrated commissioning governance and leadership at borough level in each of SEL’s six boroughs from 1 April 2020, building from the borough based governance already in place.
- Commissioning of community based care – our new operating model will delegate authority and responsibility for the commissioning of community based care to our Place Based Boards, to support local decision making and prioritisation within a core overarching SEL wide framework and a set of outcomes for community based care.

SEL System Reform Programme – place based provider development and collaboration

- Local Care Partnerships – each borough will have a Local Care Partnership as part of our new operating model – these will secure the governance to secure an integrated approach to delivery and transformation across providers, building from our existing positive collaborative relationships and arrangements.

Key outcomes and milestones

Short term (2019/20 and 2020/21)

- Establishing effective governance, planning and delivery processes at place level through which ICS partners will work together to secure jointly agreed outcomes.
- Developing agreed local implementation and delivery plans to secure agreed prevention, primary and community based care outcomes and effective acute interfaces / end to end pathways.
- Development and agreement of Memorandum of Understanding / Alliance agreements to underpin collaborative working at place level.

Medium term (2021/22 onwards)

- Development of more formalised collaborative decision making and delivery through provider and commissioner partnerships.
- Demonstrable shift to collective responsibility for and management of resource across the place based system.
- ICS infrastructure in place and utilised to drive delivery – population health management, clinical effectiveness and quality improvement.

Commitment 1: Governance (continued)

Effective delivery at different levels of the system

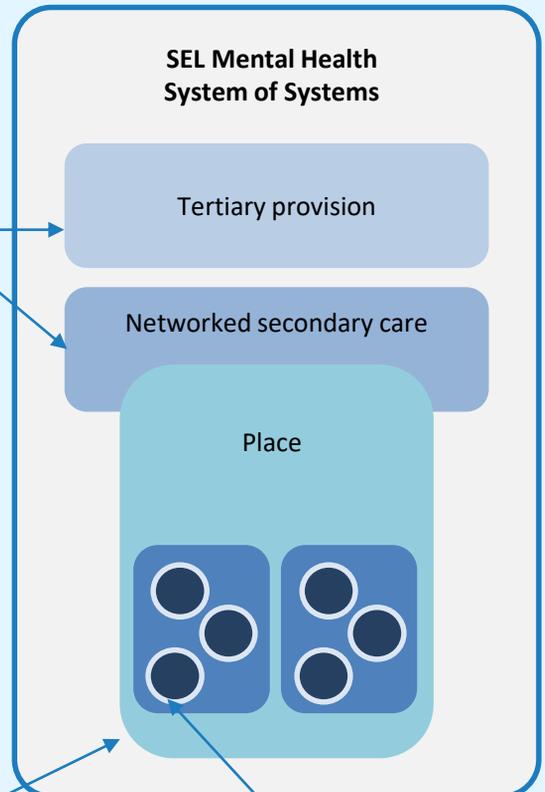
Our ICS System of Systems is complex, reflecting the complexity of delivering health and care services in a metropolitan city area. For our system to operate effectively we will need appropriate structures, clear roles and responsibilities, and strong relationships and ways of working. It will be key to ensure there is clarity over what is delivered at which level of our system, how we drive delivery at pace through these arrangements, and how we hold each other to account.

Tertiary provision and networked secondary care

- The South London Mental Health Partnership has made significant progress in developing and delivering care in new ways, through the **New Care Models programme**.
- This initially focused on tertiary provision, but is now shifting to consider networked secondary care delivery.
- Our aim is to secure economies of scale, reduce unwarranted variation and support a single high quality service offer for patients requiring specialist and secondary care. For 2019/20 and 2020/21 we have agreed that the priorities are **complex placements, perinatal, flow and bed management**.

Place

- We will continue to develop **close integrated working between health and local authorities at place** level to commission MH services and secure wider system (e.g. housing) to optimise outcomes and ensure that high quality services are delivered locally to meet local needs.
- **We will test and determine the best level at which to deliver our MH change programme across place and system, and ensure resilient place based delivery.**



Neighbourhood

We will ensure mental health **prevention** and care is embedded within the work of PCNs, to provide parity and drive delivery of integrated and holistic care across **mind and body**.

An overarching coordinating function will support:

- Understanding of need and priorities for service change.
- Ensuring an overall strategic direction for MH provision in SEL, including an agreed core offer and outcomes for patients.
- Strategic allocation of resources across the MH System of Systems to deliver priorities for change.
- Understanding what needs to be common and consistent at place level and what should be determined locally to meet the needs of the borough and its residents.
- Delivery of our infrastructure offer (e.g. for business intelligence; system monitoring).

These changes to how our system operates, and the experience people have of services they receive in SEL, will need to be embedded at each level of our ICS system to deliver on our priorities. The foundation of this is our place based partnerships at borough level which will drive a number of these system changes around integration of community based care and a shift towards preventative and personalised services. Our place based systems are at different stages of development based on their longevity, but each have a clear vision and set of aims and priorities to transform care for their local population.

An overview of each Local Care Partnership's arrangements and priorities is set out on the next pages.

Bexley Local Care Partnership



Our partnership working

Bexley CCG has worked with its providers to develop a provider alliance, 'Bexley Care'. The integration of adult and social care with Oxleas community and mental health provider is at an advanced stage with place based integration across three localities.

The Bexley Local Care Partnership was established in April 2017 and partners have agreed a Memorandum of Understanding describing the way partners work together. This has recently been developed into a vision and set of values between the following partners: Bexley Care; Bexley Health Neighbourhood Care; Bexley Voluntary Services Council; Dartford and Gravesham NHS Trust; Greenwich and Bexley Hospice; Healthwatch Bexley; Hurley Group; Lewisham and Greenwich NHS Trust; Local Medical Committee; Local Pharmaceutical Committee; London Borough of Bexley Council; NHS Bexley Clinical Commissioning Group; Oxleas NHS Foundation Trust; and primary care networks.

Bexley CCG has a strong history of joint working with the London Borough of Bexley, with shared roles and funding for integrated adult community commissioning. Our ambition for integrated working with the London Borough of Bexley is to move towards a single plan with two budgets (with the exception of the Better Care Fund).

Our priorities

The emerging Bexley Health and Wellbeing strategy 'Our health, our wellbeing, our place' identifies an overarching objective and 4 priorities for Bexley.

Objective: Preventing illness and promoting wellbeing:

A system wide prevention strategy 'Start Well, Live Well, Age Well' proposes responses to the challenges facing the system under six themes:

- Giving children and young people the best start in life and throughout their lives.
- Improving outcomes for adults and older people.
- Embedding prevention in all policies and practice, and in Bexley's population health system.
- Healthy communities, workplaces and homes.

- Healthy environments, built, green and blue spaces.
- Economic independence and a thriving local economy.

Preventing obesity: Bexley has amongst the highest rates of obesity in London with almost a quarter of children entering primary school already overweight. Our aim is to halt and then reverse rates of obesity among children and adults through shaping the environment to build healthy lifestyles; this will support a community culture that sees physical activity and healthy eating as the norm and supports individuals to make healthier changes.

Mental health: In Bexley the aim is to build a sustainable mental health system where high quality responsive and accessible services result in improved outcomes for patients. Key commitments include: increasing mental health funding being spent on services for CYP who need specialist care; improved access to psychological therapies; and a promise that everyone will be able to access timely, 24/7 mental health crisis support and more mental health support in the community for those with severe mental health problems.

Children and young people: We are aiming to improve models of everyday healthcare for CYP; improve core health knowledge across the system from schools to secondary care; and improve access to services for CYP, including mental health services.

Frailty: The Bexley frailty strategy (awaiting publication) states that we will work together to prevent the development and progression of frailty by promoting active ageing and reducing social isolation.

- We will work to ensure that people are supported at home in order to avoid admission to hospital unless clinically justified.
- We will enable people aged over 80 to continue living safely in their own homes.
- We will ensure dignity in dying for older people – avoiding over medicalisation and ensuring choice of place of death.

One Bromley



Our partnership working

One Bromley comprises signatories to the Bromley Alliance, signed in October 2017, including: NHS Bromley CCG; King's College Hospital NHS Foundation Trust; London Borough of Bromley; Bromley Third Sector Enterprise; St Christopher's; Bromley Healthcare; Oxleas NHS Foundation Trust; and Bromley GP Alliance.

One Bromley will strengthen its approach by continuing to bring together providers, voluntary services and commissioners to build on the existing good work and deliver more personalised and integrated care. This plan will build on successes such as the Integrated Care Networks Pro-active Care Pathway and replicate this across many other programmes of care.

These programmes are delivered through the One Bromley Executive, made up of the leaders from each of the local partner organisations.

The strategic aims for One Bromley are:

- Improve health and wellbeing outcomes and reduce health inequalities across Bromley.
- Transform the delivery of health and care services by developing partnerships that promote and enable an integrated system with improved access and quality.
- Create a sustainable health and care economy, efficiently and effectively managing the resources and assets available to the partner organisations in an open and collaborative approach to support and sustain better services for Bromley residents.
- Collaborate to secure the best possible short-term service delivery, performance outcomes and financial duties whilst transforming models of care and integrated service arrangements for the future.
- Engage with the residents, patients and public of Bromley, together with partner agencies and stakeholders, to hear and respond to the views of local people and build community support for the One Bromley programme of transformation.

Our priorities

Over the last five years, the Bromley system has developed initiatives and projects to support improved delivery of services and health. Some of this work has

been done as part of One Bromley including:

- Proactive care pathway.
- Frailty pathway.
- Primary care networks as the basis of a population based approach.
- Pathway changes such as the virtual respiratory pathway, community heart failure, end of life and diabetes.
- Piloting of the @home service.

Priority areas for One Bromley were developed via stakeholder events. The One Bromley programme is one of wide ranging transformation which includes the following areas:

- Proactive care.
- Urgent and emergency care including @home service.
- Frailty pathway.
- End of life care.
- Care homes.
- Outpatient transformation.
- Primary care networks.
- Diabetes.
- Mental health.
- Children and young people.

Programme enablers include:

- Workforce and organisational development.
- Communications and engagement.
- Finance.
- Estates.
- Business intelligence and population health management.
- Contracting and organisational structure.
- Digital and IT.

These programmes of work will ensure that patients receive seamless integrated care across Bromley, being seen by the right partner at the right time. This multidisciplinary approach will reduce duplication for the patient, providing pro-active care whilst making the best use of the resources available.

Healthier Greenwich Alliance



Our partnership working

The local partnership, now called the Healthier Greenwich Alliance (HGA), was first established in the summer of 2018.

Membership includes: Greenwich CCG (Chair); the Royal Borough of Greenwich (Public Health, Adult and Children's Service Directors); Lewisham and Greenwich NHS Trust, Oxleas NHS Foundation Trust; Greenwich Health (GP Federation); Clinical Director representatives of the local PCNs; Healthwatch; and the community and voluntary sector represented by METRO Gavs.

Terms of Reference for the HGA have recently been refreshed and were agreed in October 2019. HGA partners have been part of implementation journey for PCNs as key stakeholders and system partners.

The Alliance has now been meeting for a year and provides an opportunity for joint discussions of relevant issues between partner organisations.

The Greenwich Commissioning Strategy published in 2018, 'Transforming our health and social care in Greenwich', has provided a clear sense of priorities for work in four key areas: prevention, mental health, frailty, and cancer, together with transformation workstreams in primary and integrated care. Progress towards the development of the Mental Health Alliance is also considered at the Alliance. An agreed implementation plan for all priorities supports our work and is monitored by a dashboard of key performance indicators.

More recently the Alliance has set out three areas as focus for work, including commissioning children and young people's services (in particular those children and young people who experience poorer health and life chances), and continuing to develop the Mental Health Alliance.

The Healthier Greenwich Alliance is in itself a vehicle to deliver transformation of services in priority areas. Through collaborating across Greenwich, Bexley and Lewisham, work is underway to progress transformation of services in planned and unplanned care, mental health, children's services and primary care.

This is supported by organisational development across the system to support the changes proposed.

Our priorities

Set out below are the main service areas where teams already work in an integrated way:

- **Development of a Mental Health Alliance** – our strategy is to work together as agencies responsible to provide wrap-around health and social care needed by people living with a physical and mental health condition. We have identified 4 transformation pathways: community mental health, crisis resolution and home treatment team, suicide prevention and dedicated 24/7 crisis line.
- **Joint commissioning to address frailty** – over the last year there has been increased and productive collaboration between CCG and council staff on a series of joint initiatives focused on Greenwich's frail population. Examples include the development of the Age UK settling service, our "discharge to assess" service and a falls and frailty community service (launching later in 2020). Plans are in development to change the way people in Greenwich receive urgent care by increasing the scope of the Joint Emergency Team, who provide urgent support to people in the community 7 days a week, to enable them to address a wider range of conditions in patients' own homes to avoid the need for a hospital attendance or admission.
- The **Transfer of Care Collaborative** works across agencies to actively coordinate discharge planning, supporting patients to not stay in hospital for any longer than is clinically needed.
- **Joint Community Learning Disability Service** – led by the council, this service comprises social care staff and a range of specialist health professionals, providing specialist health and social care services to people with learning disabilities and their carers with complex lives and needs.
- **Children and young people** – the Director of CYP services is a member of the HGA and we have forged close working relationships with CYP services at the council and these will become more formal in the coming months.



Our partnership working

Lambeth Together has been established since early 2017 as a system-wide partnership, meeting regularly since that time.

Our partners include: NHS Lambeth CCG; London Borough of Lambeth; Guy's and St. Thomas' NHS Foundation Trust; King's College Hospital NHS Foundation Trust; South London and Maudsley NHS Foundation Trust; Lambeth GP Federations / PCNs; Healthwatch Lambeth; Lambeth Patient Participation Group Network; Age UK; Black Thrive and others.

Lambeth Together has been established as a borough partnership, bringing together local government, the NHS, third sector and community partners with innovative approaches to achieving our core aim of improving health and reducing inequalities in the borough.

This vision is supported by a strategic approach that stretches from the Health in all Policies approaches, community activation and service improvement through integrating care, working in partnership with our diverse communities, and implemented through our Delivery Alliances: Living Well Network Alliance for adults living with mental health conditions, our Neighbourhood and Wellbeing Alliance, and our Children and Young People's Partnership.

We have a single Integrated Strategic Alliance Leadership Board to further develop arrangements and steer the transition to Lambeth formal Place Based Board arrangements from April 2020.

Shared leadership and teams, working across Lambeth Council and Lambeth CCG, are already in place across NHS commissioning, social care and public health responsibilities, led by a single Strategic Director for Integrated Health and Care.

An active programme of transformation is in development, bringing together professional teams and our communities around shared ways of working and culture and to address opportunities to support our workforce, to develop our digital offer and to best utilise our buildings and other community assets.

Our priorities

Living Well Network Alliance – Adult Mental Health:

Our vision is for our mental health services to be more joined up, be quicker and easier to access, and be more focused on prevention, thereby avoiding crises and unnecessary admissions to hospital. Our immediate priority areas of work are:

- Single point of access.
- Crisis outreach service.
- 3 x Living Well Centres incorporating short-term support service and integrated focused support service.
- Framework agreement for accommodation and community support services.
- Employment and vocational support strategy.

Neighbourhood and Wellbeing Alliance: The Alliance focuses on improving health, keeping people well, promoting wellbeing and reducing differences in access to services and health outcomes. Our immediate priority areas of work are:

- Develop and agree the delivery model for phase one cohort of all people living with 3 or more medium-long term conditions, +/- frailty, and people living in their last years of life.
- Design and support the setup of phase one neighbourhood 'test and learn' areas and subsequent roll out.
- Development of Memorandum of Understanding to support phase one.
- Establishment of PCNs; Extended Hours; PCN development and support; data sharing and infrastructure.

Children and Young People: This programme focuses on integrating services and support for children and young people – from maternity to early adulthood, to ensure Lambeth is one of the best places in the world for our children and young people to grow up. Priority areas of work are:

- Introduce a new Better Start programme.
- Develop the early help programme.
- Improve support for children with special educational needs and disability.
- Improve children's social care.
- Improving the emotional health and wellbeing of children and young people.

Lewisham Health and Care Partners



working together

Our partnership working

The Lewisham Health and Care Partnership was formally established in 2016, building on Lewisham's Adult Integrated Care Partnership which had been in place since 2014.

Lewisham Health and Care Partners includes: Lewisham and Greenwich NHS Trust; London Borough of Lewisham; NHS Lewisham Clinical Commissioning Group; One Health Lewisham (Pan-Lewisham GP Federation); South London and Maudsley NHS Foundation Trust; and Lewisham's Local Medical Committee.

Discussions are taking place to enhance primary care representation and input from the voluntary and community sector given the establishment of primary care networks and the increased recognition of the role of the voluntary and community enterprise sector in maintaining and improving health and wellbeing.

The Partners meet regularly through their Executive Board to provide shared system wide leadership, set the strategic direction for integration and transformation and oversee the changes required for health and care across Lewisham.

Lewisham's existing joint commissioning arrangements for children and adults are governed by section 75 agreements. The council and CCG seek to further strengthen these commissioning arrangements as part of the development of the place based system and governance underpinned by our local Health and Wellbeing Strategy.

Alongside Lewisham's integrated commissioning arrangements, the borough is building local provider collaboratives:

- **Care at Home:** brings together local health and care organisations to develop new integrated provider arrangements to deliver care and support for adults in their own homes, improving the coordination, quality and accessibility of that care and support.
- **Mental Health Alliance:** seeks to provide working age adults with a personalised approach to their treatment, care and support needs, based on the identification of assets and strengths, and facilitating the achievement of personal goals.
- **Children & Young People's Mental Health and Emotional Wellbeing Partnership:** seeks to strengthen the local offer connecting CAMHS, family support and young people's health and wellbeing services with close links to wider work within early help and schools.

Our priorities

A primary focus for Lewisham Health and Care Partners continues to be on the integrated delivery of proactive, coordinated and accessible community based care at a neighbourhood level, and on establishing an effective interface between community based care and secondary provision. This includes responding appropriately to the culturally diverse needs of local people and reducing inequalities.

Four partnership priorities have been identified for system transformation. These priorities are supported by the development of Lewisham's data and information management system which is providing the population level data and information necessary to inform and validate the improvement and transformation decisions being taken across Lewisham's health and care system. Lewisham aims to enhance the local analytical capability to identify further areas for improvement.

Frailty – a dashboard for frailty is being developed to stratify the local population into cohorts of mild, moderate and severe and map against other conditions, services and indices of deprivation. This will be used to target specific cohorts for prevention and early intervention activities and to put in place a range of coordinated anticipatory care to avoid or avert a crisis or other event.

Mental health – the Mental Health Provider Alliance is currently focusing on transforming front door and rapid crisis response, community support, and rehabilitation and complex care. These activities seek to help those living with serious mental illness by: facilitating recovery and helping people to stay healthy and engage in community life; developing and supporting community wellbeing, offering early intervention and prevention; and improving care for service users presenting in crisis. Support to local children and young people's mental health, including increasing early intervention, also remains a key priority.

Respiratory – priority actions include commissioning integrated respiratory community hubs; review of the Lung Education Exercise Programme; and delivery of multidisciplinary team working with primary care, community and social care for respiratory patients so that there is a respiratory model of care that provides a holistic person centre service.

Diabetes – following data analysis, four areas of focus have been identified: patients with undiagnosed diabetes; patients at risk of developing diabetes; patients that had gestational diabetes and have not had a 3 and / or 15 month check; patients not in range for 1, 2 or all 3 of the treatment targets. Primary and community care will work with these groups to provide an increased focus on diabetes prevention and to provide better coordinated and integrated diabetes services that fit around an individual's needs.

Partnership Southwark

Partnership
Southwark



Working together to improve health and wellbeing for the people of Southwark

Our partnership working

Partnership Southwark brings together health and care partners across Southwark to change the way services are commissioned and delivered in the borough.

Representatives from Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, Improving Health Ltd, Quay Health Solutions, Southwark Council and Southwark CCG are on the Partnership Southwark Leadership Team. The Partnership Southwark Leadership Team has been meeting formally since May 2019, but started working together as a partnership in June 2017.

Through the development of the strategic case for change, the vision and ambition for Partnership Southwark has been defined and agreed. The commitment from the partners to work on the priorities and objectives in a collaborative way to deliver these is captured in a Memorandum of Understanding. Within this framework a number of workstreams developed. For each of the workstreams Senior Responsible Officers have been appointed, and the scope, objectives, outcomes / success measures, resources required, key deliverables, risks and interdependencies have been identified and agreed.

Joint communications are underway with key stakeholders and service users/patients, with a summary overview pack, neighbourhood playbook developed, and interactive personas developed for each workstream to demonstrate what will be different for service users and staff through this partnership approach.

The CCG and council have agreed to define their scope for joint commissioning during 2019/20 to enable and encourage integrated commissioning arrangements and ultimately delivery of services. This scope will be used to develop the already established joint commissioning team to ensure a fully integrated commissioning approach within Southwark by April 2021.

Our priorities

Our priorities for 2019/20 – 2020/21 include:

- Accelerating the development of neighbourhoods supporting circa 30,000 – 50,000 people. These neighbourhoods will involve primary, community and social care, wider council (e.g. housing) and the voluntary and community sector, and will better join up care and support for people with complex health, care and wellbeing needs.
- Helping more people with long term conditions / frailty to be supported in the community and their own home, which will reduce unnecessary time spent in hospital.
- Providing focused support for residents of care homes and nursing homes to ensure better outcomes and reduce avoidable hospital admissions.
- Supporting people with mental health issues in a primary and community care setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.
- Increasing focus on prevention and self-management, supporting people to live healthier for longer and working to prevent deterioration.
- Improve our population health analytics capability to better understand and proactively respond to population need at a neighbourhood and place-based level by sharing and linking data.
- Supporting people to have greater control over their own health and wellbeing, connecting them to the community and reducing social isolation.
- Developing our approach for children and young people, bringing together work within the Children and Young People's Health Partnership and the development of population-level outcomes using Southwark Bridges to Health and Wellbeing.

Commitment 2: Redesign commissioning

We will redesign how we commission services in south east London

Vision

To deliver a more effective use of our collective resources and improved outcomes for the population by transforming how we commission services, with a planned shift to a commissioning function focused on strategic outcomes based commissioning and system management.

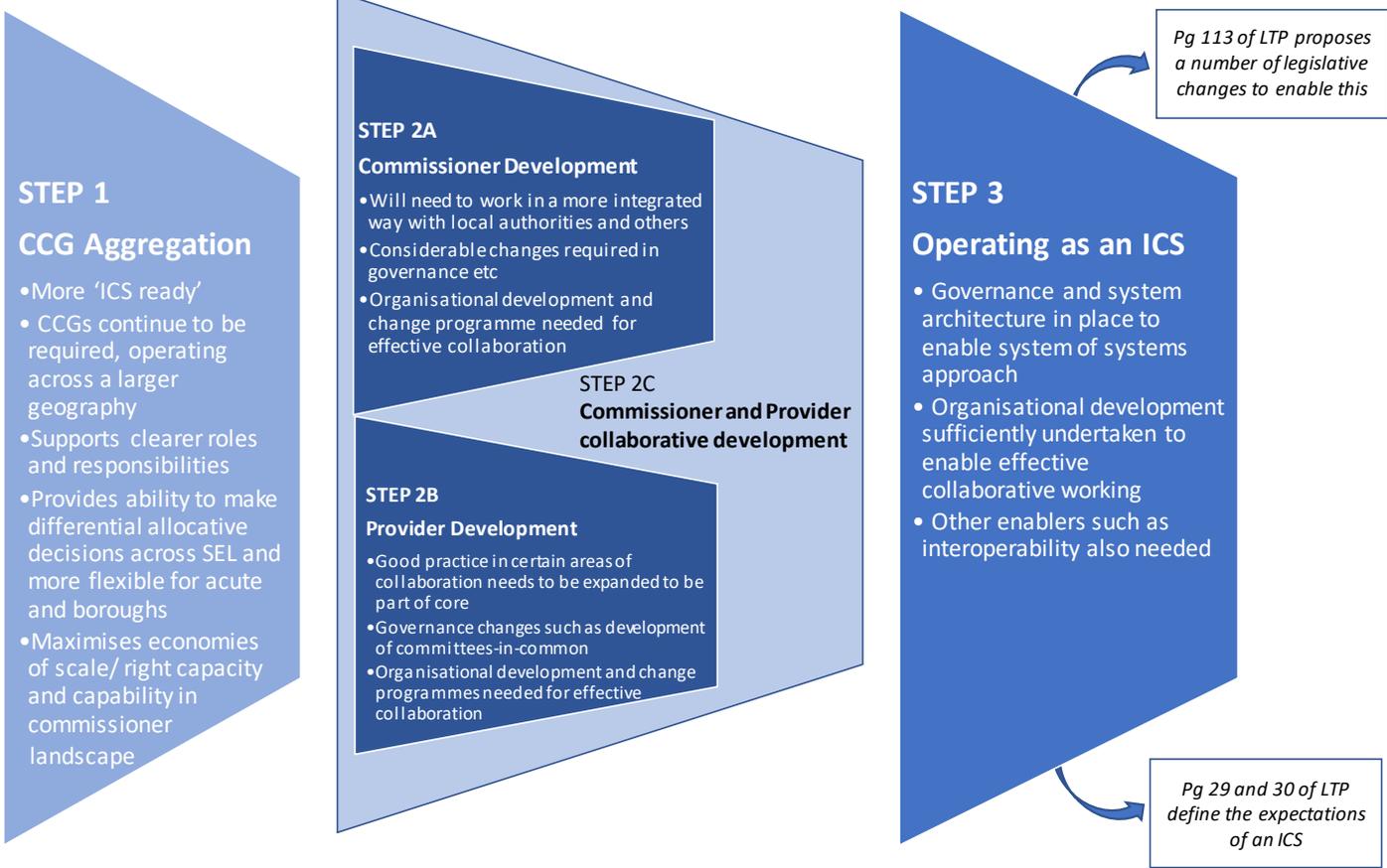
Objectives

- To define what SEL “commissioning” will look like in the future, focusing on strategic outcomes based commissioning and system management, with subsequent blurring of historical provider and commissioner role.
- As a first step towards this, we will aggregate CCG commissioning, with a merger of the current six SEL CCGs to secure a single CCG commissioner / CCG from 1 April 2020.
- We will accelerate our ICS ambitions through supporting enhanced collaborative working between different types of commissioners and with providers, at all levels of the system – with an expectation that over the next five years a number of commissioning functions will shift to our ICS PMO, with associated “whole system” focus, or to provider collaboratives, as we continue to blur the historical boundaries between providers and commissioners.

We will deliver our vision and objectives through the following priority actions

- Following approval of our merger application, undertake a process to merge the six SEL CCGs to become South East London CCG on 1 April 2020. Through the creation of a single CCG we are seeking to create a commissioning system that:
 - i. Locates and coordinates decision making for the populations we serve and the services we commission at the scale at which they are best planned and delivered.
 - ii. Brings about a greater integration of health and social care commissioning around the wider needs and wellbeing of our population and the whole person.
 - iii. Fundamentally shifts the interaction between providers and between commissioners and providers towards collaboration and collective responsibility for patient outcomes, service delivery and living within available resources.
- Transition to a commissioning model which operates both at scale and at place based level as appropriate to enable service change.
- Commissioner and provider development to work together in new ways which support and align to the ICS, with associated blurring of traditional commissioner and provider roles to focus on population outcomes and system level management.

Commitment 2: Redesign commissioning (continued)



Commitment 3: Hospital groups and network models

We will test hospital group and network model approaches across acute and mental health services as part of our SEL ICS

Vision

We will implement networked solutions to test integrated working at “system level” across acute and mental health providers, where this supports delivery of more consistent and standardised services, reducing unwarranted variation and inequality of access for our population.

Objectives

- We have committed to testing and building collaborative approaches across SEL’s secondary care providers where this will help secure sustainability for our acute and mental health sectors – and wider ICS – in clinical, quality and financial terms.
- We will work as part of our MH South London Partnership Programme and our SEL Acute Based Care Programme to identify areas of service delivery and provision that should be addressed at SEL ICS level, and those that require wider south London, London wide or pan London STP approaches.

We will deliver our vision and objectives through the following priority actions

For the acute sector, specific ICS work programmes are focused on:

- Networked hospital provision and service delivery models, where it is identified that this will support sustainability of our acute providers and support high quality consistent care for our population.
- System level demand and capacity planning and utilisation, to assess capacity requirements, gaps and solutions; our aim is to ensure a joint strategic plan to meet future demand and make best use of available capacity across the acute sector. We will continue to focus on locally delivered services where these provide good clinical outcomes.
- Governance changes to shift delivery responsibility to accountable hospital networks for secondary care services, where this is

identified as a key enabler to transforming care delivery.

- The development of a clear clinical strategy for acute provision and associated service plans.

For the mental health sector, specific ICS work programmes are focused on:

- Further development of networked provision of MH services through the South London Partnership.
- Identifying new services that can be best delivered through collaboration and at scale, meeting local needs.
- Collaboration aiming to improve retention and develop flexible workforce across south London for future mental healthcare including increased community provision.
- Development of wider system working for mental health to ensure a triangulated approach across commissioning, provision and oversight.

We believe that hospital group and networked approaches to provision will support us in delivering:

- An improved track record of delivery – through our planned shifts to networked provision, a system approach to capacity and a systematic approach to pathway redesign and the addressing of unwarranted variation.
- Sustainability – through collaborative, (rather than organisational / site specific) approaches and solutions, which will support improved outcomes.
- Collective decision making and responsibility across our providers, through our ICS governance and delivery programme.

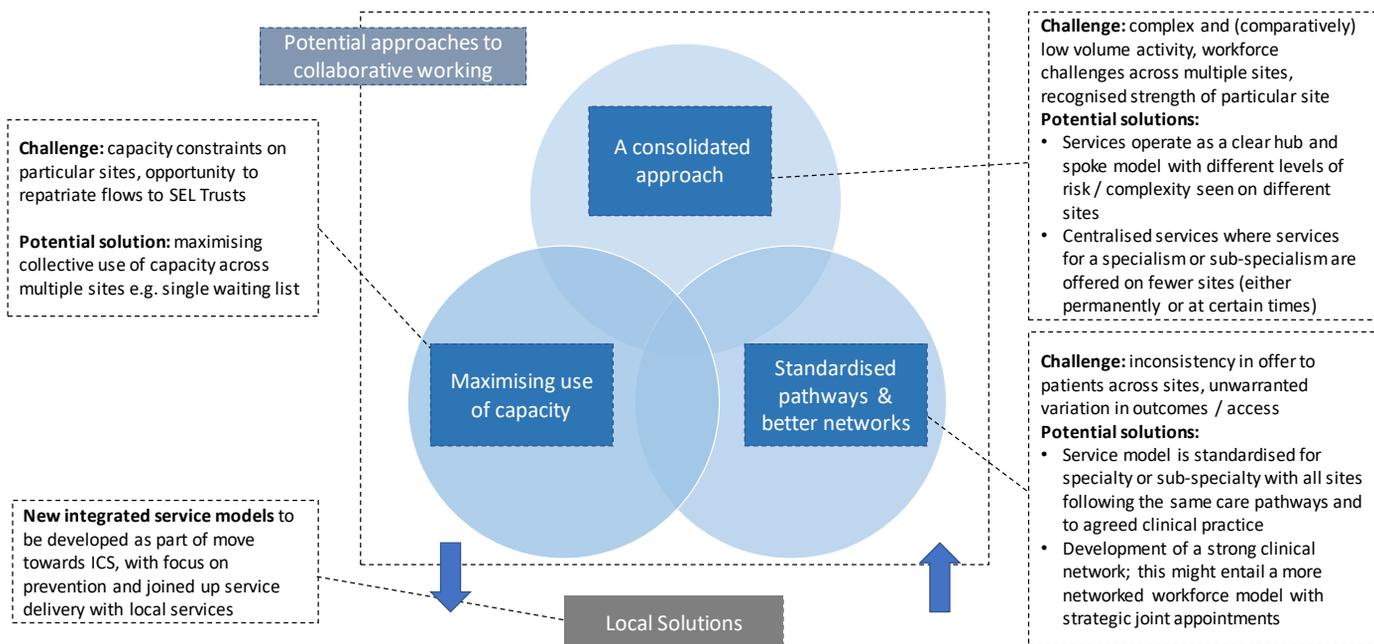
Commitment 3: Hospital groups and network models (continued)

Testing and implementing different forms of collaborative working to meet our challenges

Our Acute Based Care Board has started exploring what collaborative working solutions could look like, and how these new ways of working could help to address the challenges facing the acute sector.

The diagram below sets out some examples of potential new ways of collaborative working that the Acute Based Care Board is testing as it progresses its work plan.

As we test approaches we will also be testing whether an overarching acute partnership would help drive the pace and scale of decision making and change that we might need to meet our ICS ambition and addresses our challenges.



Commitment 3: Hospital groups and network models (continued)

We have agreed the long term objectives for our Acute Based Care Programme – we will expect to make demonstrable progress in meeting these over the next four years

Objectives of our Acute Based Care Programme

- **The acute sector in south east London is challenged**; there are significant challenges in terms of performance and providing timely care to our population, workforce challenges which impact the clinical sustainability of services, site / service configuration challenges which impact efficiency of care delivery, and a significant combined financial deficit.
- The long term strategic objective of the Acute Based Care Programme is to **support the sustainability of the acute sector** in south east London:
 - **Improve quality of care** offered to patients and deliver **performance standards**.
 - **Support clinical sustainability**.
 - **Support financial sustainability**.
- To support this objective, the programme has and continues to identify priority areas to develop **new ways of working, collaborating and delivering** across the trusts in south east London, demonstrating **practical collaboration** as part of our move towards an integrated care system.
- **Networked hospital provision and service delivery models** have the potential to support sustainability of our acute hospitals and deliver high quality consistent care for our population – we have committed to actively pursuing these where it makes sense to do so as we agree and implement solutions.
- Through these developments we will **deliver a more consistent and standardised service offer** for SEL residents, so there is a clear acute care offer for patients regardless of borough of residence or provider, reducing unwarranted variation and inequality of access for our population.
- The programme will provide the structure for **effective acute contribution to the development of the SEL ICS** – our Acute Based Care Board is Chaired by one of our acute Chief Executives and is an acute owned and led ICS programme.

We have agreed a number of short term objectives and outcomes which will support our long term strategic objective above, with an immediate focus on delivering our short term priorities to demonstrate a track record of delivery and proof of concept.

Commitment 3: Hospital groups and network models (continued)

We have agreed short term priority actions for acute based care to support our LTP delivery

The Acute Based Care Board has identified the following areas of priority for 2019/20 and 2020/21, recognising that the programme will also oversee our acute related LTP implementation over the medium term and that we would expect to build from year 1 / 2 successes with updated objectives and priorities, once we can show demonstrable progress and impact against the priorities below.

Priority 1

Develop and implement new collaborative working arrangements for priority specialties.

We will test and build collaborative working arrangements in priority specialties where this will support sustainability of our acute sector, in clinical, quality and financial terms.

- Our current priority specialties are urology, dermatology, elective orthopaedics and diagnostics.
- For each specialty we will write a case for change, appraise different options for collaborative working arrangements and develop a proposal.
- Proposals and recommendations will be presented to the Acute Based Care Board January-March 2020, with a view to mobilising new arrangements during 2020/21.

Priority 2

Steer the work of the acute related clinical leadership groups, focusing on standardising pathways and developing proactive networks to secure these pathways and promulgate collaborative delivery.

The acute element of these pathway transformations will focus on reducing health inequalities in acute service provision and access, moving towards a consistent core offer for our population regardless of borough of residence or provider. We will focus on consistent approaches to the following areas:

- Urgent care; streaming, SDEC, SAFER, discharge to assess.
- Planned care; transforming outpatients, embedding RAS.
- Maternity; delivery of Better Births in SEL.
- Cancer; delivery of time pathways across SEL.

Priority 3

Demand and capacity planning.

We will undertake system wide demand and capacity planning work at a system level, recognising this is a key issue across our acute sector currently, to give a “helicopter view” of key areas of mismatch at individual organisation and system level. We will use this information to:

- Agree actions to resolve individual organisation level demand and capacity gaps through collaborative working; additional capacity to only be sourced at the point at which the system wide capacity is exceeded.
- Agree strategic solutions to any system level demand and capacity gaps now and for the future.

Priority 4

Develop a clinical strategy and strategic site based service plan.

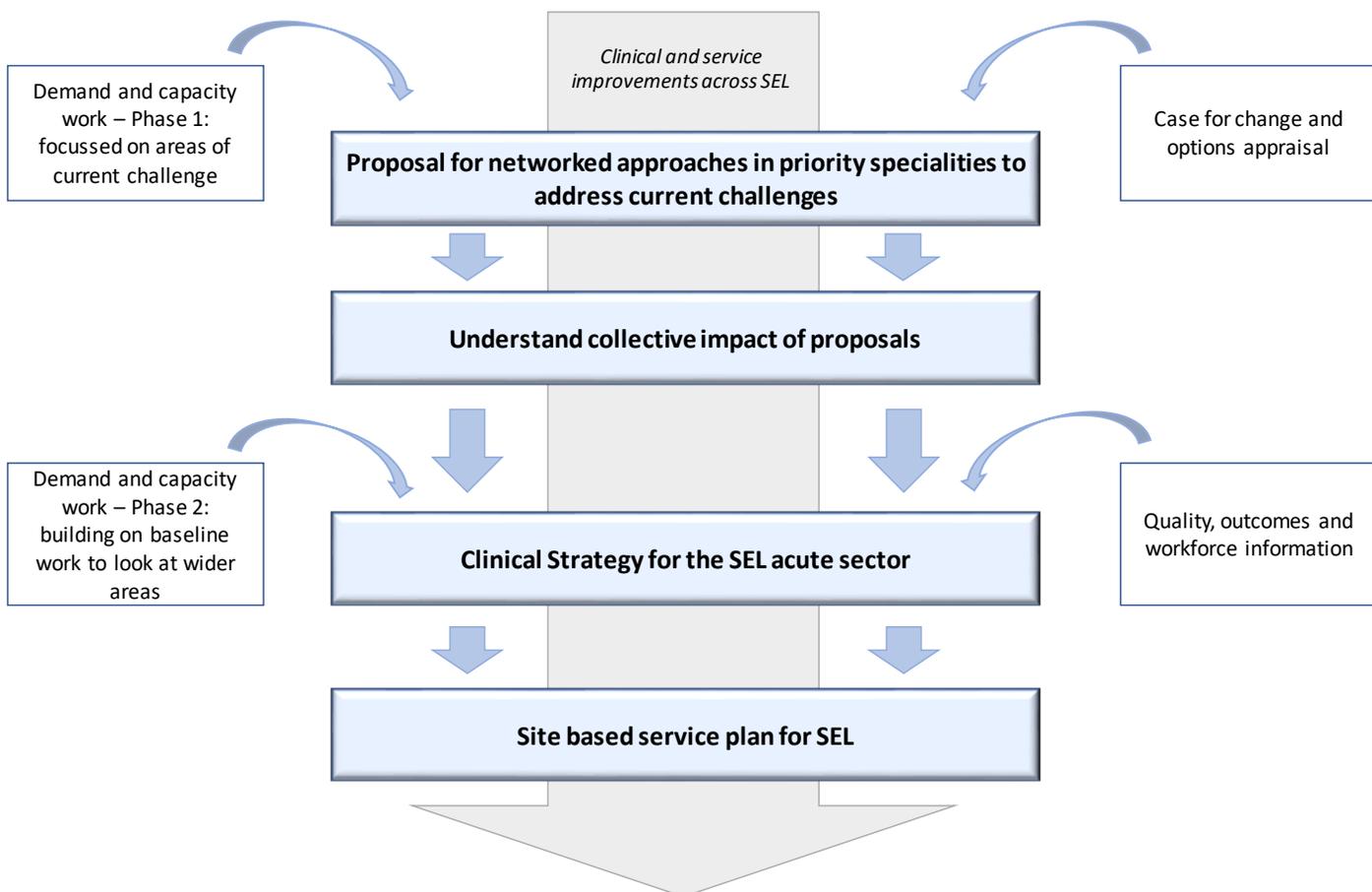
- We will initially work to understand the collective impact of our programme proposals on service and site delivery across SEL, and their contribution towards sustainability.
- We will review existing clinical strategies to understand current organisational plans / challenges, and develop a SEL Acute Clinical Strategy.
- We will develop a strategic site based service plan, bringing together proposals from the Clinical Strategy to show what will be delivered at each site in the future. The Strategic Site Based Service Plan will ensure that issues which require a solution wider than individual specialty (e.g. case mix by site) are addressed as part of our overall approach to hospital group models.
- We will develop ways of system working which support implementation of our proposals, e.g. financial risk / gain share arrangements and governance changes where needed.

Commitment 3: Hospital groups and network models (continued)

These actions build to enable us to develop a site based service plan for acute services for SEL

This diagram shows how the short term (2019/20 and 2020/21) priority work the Acute Based Care Board has identified will build to develop a sustainable clinical strategy and site based service plan for the SEL acute sector.

The overarching aim is to support sustainability of the acute sector; sustainable delivery of performance standards, clinical sustainability and financial sustainability, with demonstrable and sustainable improvement having been evidenced in each and every year of our Long Term Plan delivery. The long standing nature of many of our challenges means that this work forms part of a longer term programme of change and improvement – our model is one of incremental improvement within the context of an agreed end point ambition.



Commitment 3: Hospital groups and network models (continued)

Collaborative working arrangements across the three MH trusts in south London

- The South London Partnership (SLP) is a collaboration between Oxleas, SLaM, and South West London and St George's Mental Health NHS Trust; collectively they deliver mental health services to a population of more than 3.6 million people in south London.
- The partnership brings together clinical expertise, experience and innovation, aiming to improve quality, use resources most effectively, and deliver best practice consistently to all patients. Since 2017, the South London Partnership has:

Transformed care for forensic patients

- 90+ patients repatriated / stepped-down / discharged; 75% reduction in readmissions.
- 36% fewer patients in out of area placements.
- 19 new placements in non-partnership beds per annum versus 84 in 2016/17.
- New shared pathways across south London, clinical expertise, Quality Summit to drive best practice.

Ensured south London children and young people are cared for closer to home

- 75% reduction in out of area occupied bed days.
- Average out of area distance from home down 73 to 7 miles.
- New CAMHS PICU avoiding lengthy out of area placements.
- System-wide collaboration to manage recent surge in demand for CAMHS beds.

Made changes to complex care

- New programme for c.1,000 CCG and LA-commissioned complex 'funded and forgotten' patients.
- Key commissioning and care management responsibilities being developed by the partnership.
- New clinical pathways, local supported housing, enhanced community rehabilitation teams.
- 350+ patients assessed; many identified for step-down, repatriation and some progressed already.

Undertaken work to develop and retain nursing workforce for the future

- 100+ staff on Nursing Associate and Apprenticeship programmes.
- Nursing career development: shared competencies, career pathway, JDs.
- Employee Passport enables easier movement between trusts.
- Shared training including BAME Leadership, Band 6 Inpatient Development, Responsible / Approved Clinician.

- Our objective and ambition is to harness the SLP collaboration to secure a further step change in the delivery of services for patients with mental health problems – including approaches to mind and body health and an effective MH offer at neighbourhood, place and system level to maximise outcomes and well being for SEL residents.
- The SLP infrastructure and approach will support us in delivering our overall LTP commitments with regards MH services and outcomes.

Commitment 3: Hospital groups and network models (continued)

South London Partnership strategic priorities to underpin LTP delivery outcomes

SLP strategic priorities

- **Improve care, experience and outcomes for patients** in south London; including providing care closer to home and enabling quicker step-down, recovery and rehabilitation and discharge.
- Contribute to **improving overall mental health and wellbeing** of south London population.
- **Workforce development, retention, recruitment:** staff can learn, develop and grow (particularly nursing).
- **Delivering Long Term Plan goals:** outcomes-based commissioning, moving away from purchaser-provider split to area-based planning and much closer provider collaboration.
- **Reduce unwarranted variation:** consistent assessment, commissioning and joined-up pathways.
- **Catalyst for improvement:** working in integrated care systems and partnerships based on local patients' needs.
- **Develop and improve pathways:** data-driven at population health level; more community inpatient integration.
- Leverage larger scale to ensure **equal access** to high quality services in most appropriate care setting.
- Achieve **best value for money; reinvest savings** in new, more effective local services.
- Deliver services that offer a greater range of preventative mental health care and **exploit opportunities to advance improvements in the physical health of mental health service users.**

Strategic priorities are aligned to and agreed with MH commissioners and will support the ICS in delivering both its overall objectives and the MH related aspects of our Long Term Plan response. SLP is already well developed and our ICS development work will further seek to ensure that we are applying learning from SLP to our wider provider collaborations as well as working as a partnership to integrate the SLP offer within our Local Care Partnerships, system reform related to commissioning development and the planned shift of commissioning responsibilities to providers as part of a new care models approach.

Commitment 3: Hospital groups and network models (continued)

SLP has a strategic approach to further collaborative working across partner organisations

SLP strategic delivery objectives – driven by collaborative, pan provider approaches and models

- **Clinical strategy – introduce new mental health services at system-wide level:** identify new services that can be best delivered through collaboration and at scale, meeting local needs. Investment in new services and facilities (through efficiency and commissioning budget savings); identifying needs and gaps in provision; responding to national and local commissioning priorities.
- **Integration – vanguard of provider collaboration, help drive wider health and social care approaches with mental health at the forefront across south London:** collaborative, provider-led; collective responsibility for managing resources, delivering all mental health NHS standards, and improving the health of the population we serve.
- **Operational strategy – improve existing mental health services delivered by SLP trusts:** where a collaborative approach can improve service performance, quality, access and patient outcomes. Developing new clinical and operational approaches, adopting best practice and deploying rapidly. Utilise QI, data and informatics to look whole population issues and transform pathways through collaboration and innovation to improve outcomes and drive better value.
- **Workforce strategy – nursing development programme:** collaboration aiming to improve retention and develop flexible workforce across south London for future mental healthcare including increased community provision. Standardise quality, job competencies, development frameworks and sharing innovation, training and opportunities.
- **Productivity strategy – improve back-office efficiency:** identify best practice including via NHSE&I Model Hospital and NHS Benchmarking to reduce unwanted variation and improve spread; collaborate to deliver productivity and efficiency gains.

Commitment 4: Integrated care

We will test integrated care approaches through development of PCNs at the core of our delivery model for fully integrated community based care

Vision

Delivery of consistent and high quality integrated community based care for adults and older people with complex needs, which keeps people as healthy and independent as possible, in their homes.

At the heart of our community based care model is the “primary care network”: groups of practices coming together locally in partnership with community services, social care and other providers of health and care services around the needs of a geographically coherent population or “local neighbourhood” (typically covering 30,000 to 50,000 population*). If we are to deliver our vision of a genuinely multidisciplinary team at this level of the population, this will need to be a collective endeavour. Organisations will need to work together to deliver a core, proactive, innovative and integrated community based care provider offer, in partnership with local neighbourhood populations – a true test of ICS approaches and ways of working.

We have illustrated our vision in the diagram overleaf.

Objectives

- To develop our ways of working at borough and neighbourhood level so that we are delivering truly integrated and MDT care in the community for those who need it, with a consistent offer across our population.
- To support the sustainability and resilience of primary and community care services through enhanced collaboration and support across and within local systems.
- To shift to a system of community care delivery which is driven by a systematic approach to population health management, with a focus on optimising quality of life and reduce inequalities in health outcomes.
- To shift to a system of community care delivery which is proactive rather than reactive in focus, demonstrating a tangible impact on managing demand seen in the acute hospital setting.

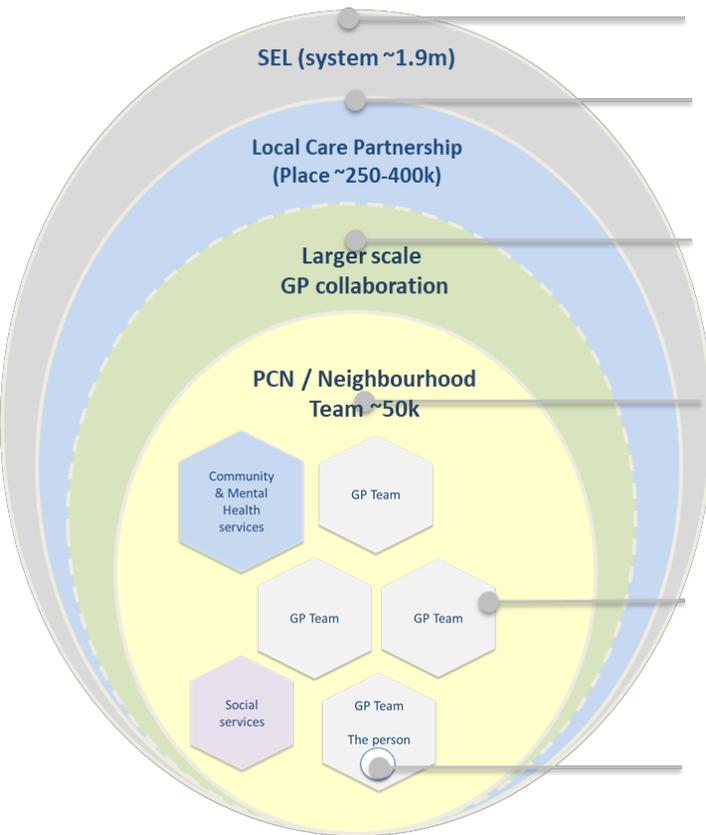
We will deliver our vision and objectives through the following priority actions

- Developing a systematic approach to addressing health inequalities within community services, as part of our wider system approach to population health management.
- Supporting the development of PCNs through a comprehensive PCN support and development strategy.
- Work across the SEL system to develop “a core community offer” which meets the needs of local populations and supports delivery of wider system ambitions, with an initial focus on improve the responsiveness of community health response service, via two-hour crisis and two-day reablement responses (as part of our national accelerator site application).

*Some partnerships in south east London have agreed PCN agreements covering patient populations larger than 50k; where this has been agreed this better meets local need.

Commitment 4: Integrated care (continued)

We will test integrated care approaches through development of PCNs at the core of our delivery model for fully integrated community based care



- **Primary care** has a seat at the table for **System level** leadership of services and strategy across SEL.
- **Primary care** interacts with **hospitals, mental health trusts, local authorities and community providers** in an alliance of **commissioners and providers** across health, social care and broader voluntary and community sector.
- Working with **PCNs** to deliver **fully integrated, community based care**.
- Operating through a common model to support the **development and delivery of PCNs**, including support for **PCNs to come together**.
- Delivering **efficiencies of scale, infrastructure, coordination, leadership support** to general practice and PCNs.
- **Interface with Local Care Partnership arrangements**
- **Practices and other health, social care and voluntary partners** collaborate as **primary care networks**.
- **Geographically contiguous** teams of practices caring for **30k+ people**.
- Delivery of **data driven** integrated MDT based services.
- **Key Scale** to deliver **integrated community services around patient needs**.
- GP team providing **resilient and sustainable core general practice**.
- Coordination and planning of **holistic, personalised accessible care**.
- **Small enough** for the benefits of **continuity of care** and a **personalised service**; **big enough** to **safely cover rotas** and provide a **balanced skill mix**.
- **Each person** can access **joined up, proactive and personalised care**, matched to **their needs**.
- Supported by **families and local communities**.
- **Enabled and empowered to access care** in a way which works for them.

Commitment 4: Integrated care (continued)

We have already agreed a set of principles for the organisational development of PCNs

- 1 Build on local arrangements:** Plans and business models will build on the progress already made locally and reflect the wider context of delivery of primary and community health care. Common delivery models will support the interface with wider Local Care Partnership arrangements at a borough level.
- 2 Maturity and organisational infrastructure:** The delivery model for PCNs will include providers with the right scale, maturity and infrastructure to maximise the value opportunities to be delivered by PCNs in respect of service delivery, recruitment of staff, financial management and governance.
- 3 Workforce:** Collaboration and integration will be core to the culture of the PCN workforce, enabling our local populations to access a wider range of services that meet their evidenced need and address the outcomes that are important to them. Providers will have the right scale and infrastructure to effectively support this diverse workforce in line with national guidance to support this system working (NHS Employers).
- 4 Patient and public involvement:** PCNs will embed a culture that welcomes authentic community and patient partnership. Involving People in Health and Care, the statutory guidance to CCGs on involving patients and the public, should be the starting place for primary care networks.
- 5 Quality improvement:** PCNs will maximise opportunities to identify and address quality issues, through a culture of continuous improvement, building on the contractual delivery expectations of the improved quality and outcomes framework.
- 6 Estates:** PCNs will maximise the opportunity of the collective estate. Estate and other community assets will be utilised appropriately, efficiently and to their full capacity, embedding a local delivery model that supports vibrant, empowered and sustainable local communities.
- 7 Digital:** Information and technology approaches will minimise the burden of data collection, bring together the data necessary for quality improvement, and create a single source of truth for decision making, and enable modelling and forecasting to enhance health and care planning.

Commitment 4: Integrated care (continued)

We have already made progress and will build on this through our future plan

Progress to date

- We have a strong history of partnership working in SEL. In line with the regional vision of the Next Steps to the Strategic Commissioning Framework, supported by the London wide LMC, we have invested in general practice to support greater collaboration across practices and with providers in the wider health, voluntary and social care sectors, building a strong and sustainable future for our populations and workforce.
- We have developed a vision and set of shared principles to support and guide the development of PCNs in SEL, and we have agreed 35 PCNs and their associated contracts across SEL. We have completed assurance on PCN delivery of Extended Hours Directed Enhanced Service provision.
- PCNs and their local systems have undertaken a shared self assessment of organisational maturity, and we will continue to work together to agree resourcing for PCN development at a neighbourhood, place and SEL level.
- Providers have configured many community services to align with PCN footprints and there are notable examples of integrated community, mental health and learning disability services (e.g. Bexley Care) for wider spread and adoption.
- We developed a shared set of commissioning intentions for community based care for 2019/20 and are further developing our ICS strategy for a core community based care offer for future years.
- We have agreed a principle that a key focus of primary care networks should be prevention and reducing health inequalities within the population; we have begun to review initial data on the drivers for health inequalities and to understand our geographies or neighbourhoods of greatest need. We are focusing on this as part of our LTP response through a SEL population health approach to addressing health inequalities, evidenced within and across our local neighbourhoods (PCN) areas.

High level milestones and plan

- To continue to build a collective clinical voice for primary and community care at every level of our ICS.
- Continue commissioner collaboration including aligned commissioning intentions for prevention, improvements to extended access, care coordination (etc.) and consideration of SEL commissioned services such as the Special Allocation Scheme.
- To develop a shared, standardised, primary care offer through new GP core and network contract and through broader alignment of local incentives and services at a neighbourhood and place level.
- To agree a roadmap for a workable alignment of all community services to PCN geography and to further embed shared models, integrated ways of working and system partnerships to support PCN and wider contractual alignment and delivery.
- To support the four community providers to move towards a more formal partnership as part of a collaborative approach to deliver of consistent service outcomes across SEL.
- To develop a system wide framework to support the recruitment and development of additional staff as part of PCNs via the national role reimbursement scheme and wider system approaches.
- Support PCNs with their agreement, to establish a QI approach that supports evidence based, data driven decision making and enables them to assess their impact on health inequalities.
- Support local systems to maximise the benefit of the SEL Enabler Board, sharing and embedding learning such as Lambeth Digital Accelerator and via agreement of SEL approaches to key programmes such as online consultation.

These commitments will be delivered and driven forward under the governance of the Community Based Care Programme.

Commitment 4: Integrated care (continued)

We have identified our key priorities for 2019/20

We will work at local and ICS level to continue to support the development of primary care networks, with these being at the heart of our approach to fully integrated community care delivery. We will continue to develop our primary care plan and strategy further in line with our 5 year plan response to the Long Term Plan.

At a borough level, we will:

- Support development, improved maturity and ICS readiness of our primary care networks, in line with our shared SEL principles for the agreement of PCNs.
- Progress local projects on General Practice Forward View, Strategic Commissioning Framework and community based care delivery.
- Further embed shared models, integrated ways of working and system partnerships to support PCN and wider contractual alignment and delivery.
- Support PCNs to embed a culture that welcomes authentic community and patient partnership and maximises the benefit from local community assets.

Across south east London, we will:

- Consider the development of SEL level support and leadership for the development of PCNs, such as that developed via the SEL pharmacy system change leadership programme, to support the effective transfer and establishment of clinical pharmacists within general practice.
- Monitor delivery and share learning from local transformation programmes, and any further projects and programmes.
- Continue commissioner collaboration including aligned commissioning intentions for prevention, improvements to extended access, care coordination (etc.) and consideration of SEL commissioned services such as the Special Allocation Scheme.
- Support and develop provider collaboration (such as supporting the recruitment and development of additional staff as part of PCNs via the national role reimbursement scheme) as well as wider partnership working.

- Drive ICS arrangements across each borough that align to our major system challenges and priorities – in particular a step change in shared system response on urgent and emergency care and the transformation of planned care.
- Expand the community based care programme to encompass more extensive scope around community services and adult social care.

To support these changes, we require:

- Continued opportunities to access funding to support development and projects which accelerate at-scale and integrated working.
- Access to individuals with practical best practice, lessons learnt and evaluation outputs from other areas (in addition to those identified in Strategic Commissioning Framework next steps).
- Support for new contracting or other approaches to enable at scale working across different provider types.
- Access and support to understand national and local data for secondary use for primary care to support us to understand how GP activity is changing.

Commitment 5: New model for specialised services

We will develop a new commissioning model for specialised services for the SEL ICS

The SEL ICS has been working with south west London and London colleagues to consider the future of specialised commissioning in the context of our developing integrated care system. Our work is at an early stage and is taking place as part of a wider London work programme, where we are working (as part of the ICS Wave 3) to test approaches to delegated specialised commissioning in a London context.

Vision

To shift from our current model to a **new model of commissioning and provision** in line with the broader development of the SEL ICS and national policy with regard to specialised commissioning.

Objectives

- Secure the **delivery of high quality, sustainable specialised services** across south London that serve both our south London and wider populations as required.
- Secure an agreed **service and site strategy for the provision of specialised services** in south London. This should set out an agreed contribution of these services to the delivery of a sustainable ICS and end-to-end pathway population health outcomes. It should also be underpinned by networked provision across the most appropriate population base to support high quality sustainable provision.

We will deliver our vision and objectives through the following priority actions

- **Move from our current position to our end state model** and determining the steps required to get there. We will need to ensure effective risk management and mitigation as we transition to new ways of working and delivery, ensuring effective leadership, governance, infrastructure and organisational development to support our new ICS models.
- **Develop and implement south east London potential test bed proposals** to support both SEL ICS and wide London development – this includes the consideration of:

- An end to end commissioning and contracting provider test bed.
- End to end pathway commissioning test beds.
- Understand, assess options and agree handling of the following:
 - **Population focus** – the current model is provider not population driven. Future models need appropriate population focus and must also be clear about commissioning arrangements for populations outside of the SEL footprint who receive their care in SEL providers.
 - **Funding and risk management** – management of risk associated with specialised services, including budget transfer approaches, future growth funding, risk management and incentive approaches that will best support effective risk mitigation and delivery of system savings.
 - **Agreement of a south London specialised commissioning model** – consideration and agreement of options to include devolution of commissioning or a direct move to a lead provider / provider network model. We will also need to consider the infrastructure required to support the effective delegation of commissioning functions and how this is resourced.

Commitment 5: New model for specialised services (continued)

Our ambition is to move towards a new model for commissioning and providing specialised services

Commissioning system:

- How our new system architecture will support more effective use of our collective resources and improved outcomes for the population in relation to specialised services.
- The governance and leadership arrangements required to support delegated specialised commissioning for the future.
- The levels at which the specialised commissioning function is best undertaken – to include testing south London wide and SEL / SWL models and approaches, including the delegation of commissioning responsibilities direct to providers as part of new models of care approaches.
- The appropriate utilisation of resource in terms of commissioning capacity and capability; as we shift our commissioning focus to one of strategic commissioning, system management and assurance that focuses on the what – ‘agreed outcomes’ – rather than the how.

Provision and delivery models:

In addition to the above work on the commissioning of specialised services it is recognised that we also need to consider specialised services provision and delivery models – we are also committing as part of this programme to working to **develop an agreed strategy for specialised services provision across SEL and south London, to include consideration of London and south east region** strategies and requirements in doing so.

Three key outputs / deliverables

Specialised services strategy

- Strategic outcomes focused commissioning intentions.
- Service and site strategy – driven by outcomes, demand and capacity, workforce and financial challenges, quality and critical mass considerations.
- Delivery architecture – ICS group models and new models of care approaches.

Commissioning architecture change

- Appraisal of options for the future planning and commissioning of specialised services, including:
 - Shift to strategic commissioning functions working as part of the two south London ICSs.
 - Further delegation to providers of funding and delivery responsibility, working as part of managed clinical networks.

Provider architecture change

- Development and formalising of provider led delivery vehicles, encompassing:
 - The South London Partnership for mental health.
 - Formalised provider collaboration agreement for acute services.
 - Underpinned by operational delivery networks, linked to vertically integrated networks where appropriate.
 - Governance and infrastructure to support management and delivery.

Underpinned by – Organisational development.

Shift from current to new ICS commissioning models and provider development to support new ways of working / new models of care approaches.

Commitment 5: New model for specialised services (continued)

We have agreed actions to progress our work around specialised commissioning

Testing and engagement

- We are in the process of testing our proposals as part of the London devolution programme, with regional colleagues, across the commissioning system and with south London providers.
- We have further work to do to secure a definitive agreement and underpinning development programme but would work towards this agreement being secured over the coming months.

Work plan development

- We will then agree a definitive system work plan that sets out how we will develop and appraise options to collectively agree our end point state.
- We will assess and appraise options to develop a preferred approach to population based commissioning, financial and risk management, local autonomy and infrastructure to support the delivery of delegated responsibilities.
- We will establish an acute specialised services strategy work programme that will form part of our wider ICS strategy development.

Test beds to inform proposals and end state assumptions

- We will agree test bed approaches for the short term, to be developed in 2019/20 and ideally tested in 2020/21.
- We will maximise the new models of care approach for mental health specialised services for 2020/21 with a potential shift to a fully delegated responsibility model.
- We will test end to end pathway commissioning approaches to secure a single set of commissioning intentions and outcomes and an approach that supports overall pathway improvements and efficiencies being delivered in line with new models of care approaches.
- We will test joint commissioning arrangements with particular providers to test the scope for securing benefit through an integrated acute / specialised commissioning and contracting model.

We will harness ICS approaches to enable us to deliver the NHS constitutional standards

SEL's performance and specifically the delivery of NHS constitution standards is extremely challenged – our challenges are long standing in nature and span A&E, RTT and cancer access targets in all three acute providers. We recognise that these acute challenges are symptomatic of wider systemic issues and that our solutions also need to be system focused.

Our objective is to harness ICS approaches to enable us to deliver the NHS constitutional standards. This is inclusive of robust governance and oversight to support: collective responsibility to be enacted; system approaches to and responsibility for recovery; a robust diagnostic to support the identification of sustainable solutions; and appropriate resourcing and infrastructure to support sustainable recovery.

Case example: cancer

We recognised in 2018/19 that our organisation specific approach to cancer recovery was sub optimal. Many of our pathways were shared across providers and our providers were facing and trying to grapple with common challenges.

For 2019/20 we shifted our focus from organisation specific to a system approach including:

- The development and agreement of a **system wide recovery plan**.
- The agreement of **common pathways and best practice expectations** with regards timed pathways, PTL management, patient tracking and data systems.
- The establishment of a **SEL wide expert cancer team** working as part of our Accountable Cancer Network, working alongside site / trust cancer teams to support our improvement work.
- **Revised governance and oversight**, including an emphasis on standardised and robust reporting on performance and recovery actions and a Chief Executive led Cancer Members Board.
- **Agreed system approaches to the utilisation of national transformation funds**, with investment prioritised to support 62 day recovery and a system approach to **addressing diagnostic capacity shortfalls**.

Our approach has been recognised as an exemplar, but we have yet to see the positive processes outlined above translate into performance recovery. We need to better understand why this is the case and to ensure we address identified issues, as well as applying the learning to other areas of performance challenge.



Planned ICS approach

- **Strengthened governance** – to underpin A&E, RTT and cancer recovery – we need to shift from a system that is committed to (and has positive examples of) collaborative working to one where we can genuinely hold ourselves and each other to account in relation to delivering the commitments we make.
- **System approaches to recovery** – for all performance recovery a shift from organisation to system approaches, commitments and deliverables.
- **Systematic and sustainable recovery** – a shift in focus from short term immediate recovery actions to an approach that addresses the underpinning drivers of our performance challenges; these include demand and capacity, workforce, delivery of optimised best practice pathways, system wide commitment and incentivising culture and behaviour.
- **Capacity and capability to drive recovery** – a system approach to ensuring that we have the infrastructure in place to drive and sustain the delivery of our agreed actions.

We will need to operate as a mature and thriving ICS to secure the improved outcomes to which we aspire and are committed. This is in the context of a 2019/20 position which remains challenged and within which we have not met the improvement commitments we made at the start of the year. Our ICS development commitments are designed to support sustainable improved performance – but, as for cancer, will take time to secure.

We will harness ICS approaches to support us in improving our financial position

SEL's financial position is very challenged, particularly across our provider sector, albeit with a differential level of challenge across our organisations. Securing financial improvement has and will continue to present a challenge over the next five years. We will need to focus as a system on securing a recurrent run rate improvement, to not overcommit available resource and to achieve financial sustainability at the pace defined by the control totals set.

Our objective is to harness ICS approaches to support us in securing this financial improvement – inclusive of robust governance and oversight that enables collective responsibility for: allocating and managing resource and associated risk; system approaches to and responsibility for delivery of financial savings plans; a robust diagnostic to support the identification of sustainable solutions; and appropriate resourcing and infrastructure to improve our financial position.

2019/20 planning round example

We recognised in the 2019/20 planning round that our historic bilateral approaches to planning were not securing optimal outcomes. Building from our collaborative approaches to financial recovery and management that we undertook as part of the Aspirant ICS Programme, we agreed the following approach:

- The development and agreement of a set of principles to underpin the planning round.
- The collective agreement of all key ICS partners to the allocation of CCG growth for the year.
- A consistent approach to contract form with all key contract agreements shifting to an aligned incentive (block type) contract agreement.
- A consistent approach to contractual efficiency and pathway redesign impacts, to support assumed savings related to pathway redesign and transformation.
- A system approach to the management of in-year risk associated with our contractual agreements, to support collective discussion and agreement about the use of in year reserves and flexibilities to support the best possible financial outcome for SEL as a whole.

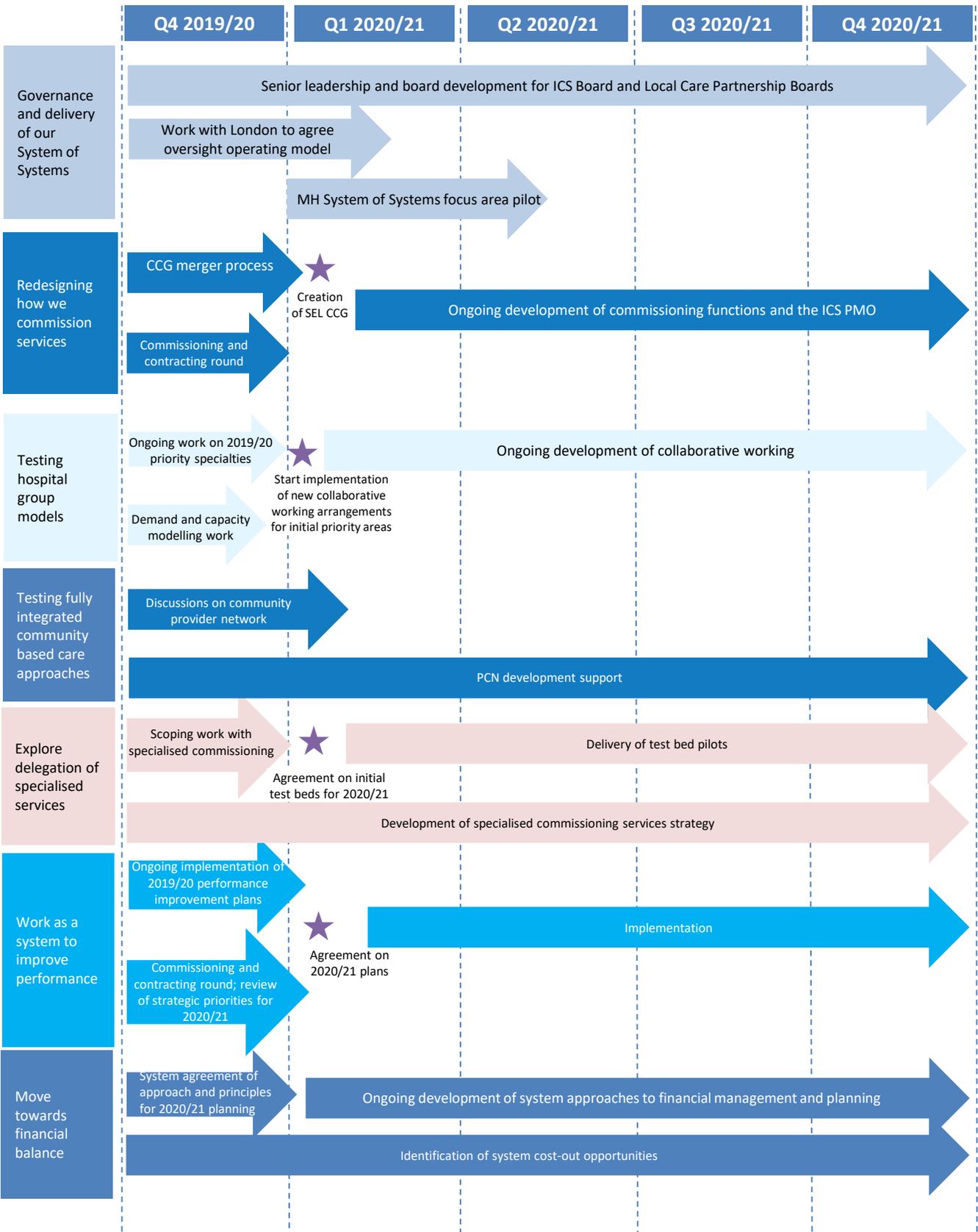
Our approach has been recognised as positive both internally and externally. However our key challenge remains to identify and secure cost out opportunities across our clinical and non-clinical cost base to ensure that our spend equals our available funding. Equally we need to move beyond our 2019/20 approaches to further develop new payment and risk share mechanisms that effectively incentivise change and financial control system wide.



Planned ICS approach

- **Strengthened governance** – to support more formalised collective financial planning, decision making and responsibility, and to oversee agreed actions and the operation of a system control total.
- **System planning** – we will agree a set of ICS principles to support future planning rounds, alongside collective agreements in relation to the allocation of resources and the management of risk. We plan to test some new approaches to risk management and incentives across providers in 2020/21, building from our 2019/20 planning approaches.
- **System approaches to improvement** – to enable the ICS to identify a number of priority cost out programmes that make explicit the relative contributions across the system, recognising that solutions for particular organisations may lie outside of that organisation.
- **Systematic and sustainable improvement** – a shift in focus from short term and non-recurrent financial improvement actions to an approach that addresses the underpinning drivers of our deficit: staffing, estates, demand and capacity, workforce, optimised best practice pathways, system wide incentives to manage patients in the most cost effective setting, culture and behaviour.
- **Capacity and capability to drive improvement** – a system approach to ensuring that we have the infrastructure in place to drive and sustain the delivery of our agreed actions.
- **New payment approaches** – to support a further shift from payment by results coupled with agreed approaches to demonstrating and securing a return on investment / productivity and efficiency across our CBC investment.

Year 1 and 2 milestone plan





Appendices to chapter 6: Enablers

Contents

- SEL ICS workforce programme plan 2019/20
- Primary care workforce trajectories



SEL ICS workforce programme plan 2019/20

LTP theme & requirement	SEL 19/20 Plan (and way of working)	SEL 19/20 Deliverable	Funding scale & source	Governance
1. Workforce implementation plan / Workforce planning:				
1.1 LWABs and Health Service and Social Care employers	1.1 Trusts are required by HEE to submit plans for workforce development funding investment to their LWAB for sign off (to ensure coordination & oversight of investment proposals). (Influencing and advising provision)	1.1 Overview of SEL trust workforce development investment intentions produced and used to inform additional investment requirements in line with SEL system priorities.	1.1 HEE workforce development funding 2019/20 – opening SEL trust allocations = £1.46million.	1.1 LWAB & WS&DO Group.
1.2 Funding for additional investment in workforce (in particular, primary and community settings)	1.2 Engage with training hubs to discuss 19/20 plans and priorities according to available resources, and scope opportunities for collaboration (for broader benefit and cost-efficiency). (Influencing and advising provision)	1.2 Further develop collaborative, at scale and cost-effective working arrangements and relationships.	1.2 HEE primary care funding £191k and £25k per hub for infrastructure (HEE “initial” payment).	1.2 LWAB & WS&DO Group.
2. Expanding the number of Nurses, Midwives, AHPs and other staff:				
2.1 Nurse supply & retention – reduce nurse vacancy rate to 5% by 2028	2.1 Provider trust nurse programme: Collaborative work across 4 workstreams – placement capacity, workforce development, widening participation & workforce data. (Influencing and advising provision)	2.1 Deliverables – expected to include increase in placements, delivery of key skills training to registered nurses, increase in numbers attaining standard for trainee nursing associate entry & an approach to defining SEL true demand.	2.1 Resources from 2018/19 positioned with GSTT for delivery. No additional requirements.	2.1 Provider collaboration with HEE coordination.
2.2 Nurse Associates - 7,500 new nursing associates to have enrolled in training nationally in 2019	2.2 Nurse associates: Work across the system to support / coordinate delivery. Approach will involve establishing a task and finish group to lead delivery across primary & community care and inclusion as a further workstream within 2.1 above. (Coordination across the system & system-wide support)	2.2 Deliverables – promotion of role (primary care, care homes, hospices and voluntary sector); generation of expressions of interest; engagement with GPN Delivery Group; enabling levy gifting; support HEE achievement of its target (SEL = 351).	2.2 GPFV SEL allocation (20k) £7.2k per trainee nursing associate to employer, offer of HEE B7 embedded resource and a practice facilitator for each cohort of 30 nursing associates (not yet received).	2.2 Provider Collaboration – to integrate into 2.1 above.
2.3 General Practice as a first destination for Nurses	2.3 General Practice Nurse programme: Progressing delivery of SEL GPN 10 Point plan, which includes support for: <ul style="list-style-type: none"> Recruitment and induction of GPNs. Supervision of GPNs and HCAs. Development of GPNs. (At scale and pan-SEL & influencing and advising)	2.3 Deliverables include – recruitment of practice educator and placement coordinator; increasing the number of pre-registration placements; coordinated training and education programmes for GPNs and HCAs; establishing an Educator / Preceptor network; GPN recruitment & retention.	2.3 Funding in place secured to Q2 2020/21.	2.3 GPN Delivery Group with WS&DO Group oversight.

SEL ICS workforce programme plan 2019/20 (continued)

LTP theme & requirement	SEL 19/20 Plan (and way of working)	SEL 19/20 Deliverable	Funding scale & source	Governance
2. Expanding the number of Nurses, Midwives, AHPs and other staff:				
2.4 Apprenticeships – widening participation / lead model / grow jobs	2.4 Apprenticeship programme: Collaboration between SWL and SEL to optimise levy utilisation across the health and social care system. (At scale and pan SEL)	2.4 Deliverables include: dashboards (spend and modelling) increase in cumulative provider levy spend; design of south London 'hub' to coordinate strategic approach to apprenticeships and levy spend coordination (to 'grow our own' and develop the pipeline); increase the total number of apprenticeships available / filled.	2.4 Project lead cost pressure of £22k. External support cost pressure of £40k.	2.4 System-wide therefore WS&DO Group
3. Growing the medical workforce:				
3.1 Increase the number of doctors working in GP: A net increase of 5,000.	3.1 Individual support to mid and late career GPs. (At scale and pan SEL)	3.1 Up to 15 GPs received 1:1 professional coaching / mentoring and trained as mentors (commissioned at scale). Evidence of enhanced job satisfaction in mid- to late career cohort with impact on retention. Mentoring capacity available to 'First Five' GPs. Total number of SEL GPs tracked via primary care workforce trajectories.	3.1 GPFV SEL Allocation (45k).	3.1 Primary care support - WS&DO Group oversight.
3.2 Increase the number of doctors working in GP: A net increase of 5,000.	3.2 GP first fives: portfolio careers. (At scale and pan SEL)	3.2 Simple, good practice 'first five portfolio working model' delivered. Deliver through collaborative working with practices and partners trailing fellowship and portfolio roles across SEL. Supports recruitment & retention. Total number of SEL GPs tracked via primary care workforce trajectories.	3.2 GPFV SEL Allocation (40k).	3.2 Primary care support - WS&DO Group oversight.
3.3 Increase the number of doctors working in GP: A net increase of 5,000.	3.3 Ongoing GP retention Fund projects (8 local projects – provide ongoing support and oversight and distil / disseminate learning to support adoption / spread. (Coordination across the system & influencing and advising provision)	3.3 Evaluation and SEL-wide shared learning event (to be held Q4 19/20). Outputs anticipated to support 3.2 and 3.4.	3.3 18/19 resources plus commissioned OD / workforce development support.	3.3 Primary care support - WS&DO Group oversight plus NHSE&I and Leadership Academy.

SEL ICS workforce programme plan 2019/20 (continued)

LTP theme & requirement	SEL 19/20 Plan (and way of working)	SEL 19/20 Deliverable	Funding scale & source	Governance
3. Growing the medical workforce:				
3.4 Working lives of doctors in training	<p>3.4 GP Trainees: Enable additional local interventions to retain GP trainees after training by:</p> <ul style="list-style-type: none"> • Hosting a T&F group & network event to distil & share learning and best practice from existing SEL initiatives. • Producing communication / materials highlighting most effective actions. • Encouraging collaboration and new interventions. (At scale and pan SEL) 	<p>3.4 Key learning identified and shared.</p> <p>Evidence of new actions to retain GP trainees identified.</p> <p>Total number of SEL GPs tracked via primary care workforce trajectories.</p>	3.4 GPFV SEL Allocation (10k).	3.4 Primary care support - WS&DO Group oversight.
3.5 Primary Care Networks: Expanded multi-professional team	<p>3.5 Physician associates: Support uptake in general practice (Reimbursable from 2021) through:</p> <ul style="list-style-type: none"> • Working with HEI to promote and identify placement and employment opportunities. • Longer-term recruitment pipeline and SEL as more attractive option. (At scale and pan SEL) 	<p>3.5 Target of 27 physician associates in SEL by end of 19/20.</p> <p>Total number of employed physician associates to be tracked via primary care workforce trajectories. Target re new physician associate student placements in SEL TBC locally.</p>	3.5 GPFV SEL Allocation (30k) plus 2018/19 resource of 14k with collaborating HEI.	3.5 Primary care support - WS&DO Group oversight (PCN development).
3.6 Primary Care Networks: Expanded multi-professional team	<p>3.6 First contact Physiotherapists: Support General Practice to engage First Contact Practitioner Physiotherapists by delivering quick reference pack re benefit and outcomes and support to engage additional new roles. (At scale and pan SEL)</p>	<p>3.6 All PCNs provided with distilled learning from pilot sites and existing roles.</p> <p>Evidence of expanding multi-professional teams tracked via 'other clinical' data in primary care workforce trajectories. Planning to undertake Q4.</p>	3.6 GPFV SEL Allocation (20k).	3.6 Primary care support - WS&DO Group oversight (PCN development).
* Primary Care Networks: Expanded multi-professional team	*See also 6.1 below: social prescribing link workers (reimbursable role in 2019/20).	* See 6.1 (Enabling one employed Link Worker per PCN from April 2020).	* See 6.1 below.	* See 6.1 below.

SEL ICS workforce programme plan 2019/20 (continued)

LTP theme & requirement	SEL 19/20 Plan (and way of working)	SEL 19/20 Deliverable	Funding scale & source	Governance
4. International Recruitment:				
4.1 GP recruitment	4.1 Continued SEL engagement in regional international GP recruitment programme. (Coordination across the system)	4.1 Revised target of 4 international GPs to SEL by end of 2019/20.	4.1 £96k confirmed for project manager & clinical lead input – fixed-term.	4.1 Primary care support - WS&DO Group oversight.
5. Supporting our current NHS Staff:				
5.1 Staff health and wellbeing	5.1 Delivery of mental health awareness and resilience training for primary care workforce (clinical and non-clinical) in collaboration with SEL training hubs. (At scale and pan SEL delivery)	5.1 All 12 courses (commissioned by the ICS at the end of 2018/19) to be delivered in 2019/20. The total number of people trained will be no fewer than 145 and a maximum 240.	5.1 Funded from 2018/19 resources for 2019/20.	5.1 Primary care support - WS&DO Group oversight.
5.2 Workforce Development	5.2 Nurse development: Design and implementation of a 2 year post graduate career pathway for Nurses new to UEC (delivery led by King's / King's College).	5.2 Target is for 60 SEL nurses to attain emergency nursing qualification.	5.2 2-year project funded from 2018/19 resources.	5.2 Clinical Programmes .
6. Enabling productive working:				
6.1 Making the most of staff skills and expertise	6.1 Non-clinical workforce: further development of competency framework through: - pilot and roll-out of online and ILM accredited training for level 2 staff (encompassing care navigation and social prescribing). - developing and testing a level 3, Medical Assistants, programme. - Consider adapted offer to support social prescribing link worker role. (At scale and pan SEL)	6.1 Summer pilot completed by 20 staff. Up to 85 additional staff trained by end of FY. Up to 105 staff awarded Certificate of Excellence in Supporting Healthcare. Pilot of Level 3 programme underway. Recruitment & retention (tracked through primary care workforce trajectories) reduced administrative burden on clinical staff, releasing 'time to care'.	6.1 GPFV SEL Allocation (75k).	6.1 Primary care support - WS&DO Group oversight.
7. Leadership and talent management:				
7.1 Leadership development offers available to support staff at all levels	7.1 PCN / Federation Practice Manager investment: Support access to level 7 diploma training via bursary style support. (At scale and pan SEL)	7.1 Contributes to retaining existing talent and establishing a recognised development path.	7.1 GPFV SEL Allocation (40k).	7.1 Primary Care Support (PCN development).
7.2 Develop and embed cultures of compassion, inclusion and collaboration across the NHS	7.2 Enable pan SEL workforce engagement on the key components of the interim NHS People Plan. (At scale and pan SEL)	7.2 Supports identification of additional SEL priorities and contributes to further development of collaborative cultures.	7.2 Funding TBC.	7.2 System-wide, WS&DO Group & LWAB.
8. Volunteers: to 'double' the number				
No planned delivery in 19/20.				

Primary care workforce trajectories: GPs

GPs	Actual	Planned Trajectory				
	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20
GPs FTE (excluding registrars)	866.0	883.4	888.3	891.8	896.6	911.3
Indicative 2020 STP target						1,108.9
Variance from Indicative 2020 STP target						-197.6

	Q2 to Q4 2018/19			Q1 to Q4 2019/20				Q1 & Q2 2020/21		Participation rate
	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	April 19 - Jun- 19	Jul 19 - Sep 19	Oct 19 - Dec 19	Jan 20 - Mar 20	Apr 20 - Jun 20	Jul 20 - Sep 20	
Headcount										
Inflow - New fully qualified GPs	9	61	9	9	24	9	9	9	24	0.82
Inflow - Induction & Refresher scheme				3	1	3	1	1	1	0.71
Inflow - International Recruitment	3		0		2			3		0.82
Inflow - GP retention scheme				1	1	1	1			0.32
Inflow - Other GP retention initiatives				3	3	3	3	2	2	0.82
Inflow - Other										
Outflow - Retirement	5	5	5	5	5	5	5	5	5	0.82
Outflow - Other	5	5	5	4	4	4	4	4	4	0.82
Net flow	2	51	-1	7	22	7	5	6	18	

FTE	Q2 to Q4 2018/19			Q1 to Q4 2019/20				Q1 & Q2 2020/21	
	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	April 19 - Jun- 19	Jul 19 - Sep 19	Oct 19 - Dec 19	Jan 20 - Mar 20	Apr 20 - Jun 20	Jul 20 - Sep 20
Inflow - New fully qualified GPs	7.4	50.0	7.4	7.4	19.7	7.4	7.4	7.4	19.7
Inflow - Induction & Refresher scheme	0.0	0.0	0.0	2.1	0.7	2.1	0.7	0.7	0.7
Inflow - International Recruitment	2.5	0.0	0.0	0.0	1.6	0.0	0.0	2.5	0.0
Inflow - GP retention scheme	0.0	0.0	0.0	0.3	0.3	0.3	0.3	0.0	0.0
Inflow - Other GP retention initiatives	0.0	0.0	0.0	2.5	2.5	2.5	2.5	1.6	1.6
Inflow - Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Outflow - Retirement	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1
Outflow - Other	4.1	4.1	4.1	3.3	3.3	3.3	3.3	3.3	3.3
Net flow	1.6	41.8	-0.8	4.9	17.4	4.9	3.5	4.8	14.7

Primary care workforce trajectories: wider workforce

Wider workforce	Actual	Planned Trajectory				
	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20
Wider workforce FTE	2661.0	2668.2	2697.8	2709.0	2738.6	2757.8

Clinical/Non-clinical breakdown	Actual	Planned Trajectory				
	Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20
Clinical Staff FTE	743.0	748.6	776.6	786.2	814.2	831.8
Nurses FTE	371.0	371.8	384.6	385.4	386.2	387.0
Non clinical FTE	1918.0	1954.6	1957.2	1959.8	1962.4	1965.0

	Q2 to Q4 2018/19			Q1 to Q4 2019/2020				Q1 to Q2 2020/21		Participation rate
	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sep 19	Oct 19 - Dec 19	Jan 20 - Mar 20	Apr 20 - Jun 20	Jul 20 - Sep 20	
Headcount										
Inflow - Nurses	2	14	2	2	3	18	3	3	3	0.8
Inflow - Direct Patient Care staff (excluding physician associates and pharmacists)	1	1	11	5	5	5	10	20	20	0.8
Inflow - Physician Associates	4	2	2	2	2	10	2	10	2	1
Inflow - Pharmacists	2	2	2	2	2	2	2	2	2	0.6
Inflow - Admin/non-clinical staff	9	9	10	3	3	3	3	3	3	0.8
Social Prescribing Link Workers					35	2	2	2	2	1
Outflow - Nurses	2	2	2	2	2	2	2	2	2	0.8
Outflow - Direct Patient Care staff (excluding physician associates and pharmacists)	1	1	1	0	1	0	1	0	1	0.8
Outflow - Physician Associates				0	1	0	1	0	1	1
Outflow - Pharmacists				0	1	0	1	0	1	0.6
Outflow - Admin/non-clinical staff	9	9	10	1	1	1	1	1	1	0.8
Outflow - social prescribing link workers				0	0	1	1	1	1	1
Net flow	6	16	14	11	44	36	15	36	25	

FTE	Q2 to Q4 2018/19			Q1 to Q4 2019/2020				Q1 to Q2 2020/21	
	Jul 18 - Sep 18	Oct 18 - Dec 18	Jan 19 - Mar 19	Apr 19 - Jun 19	Jul 19 - Sep 19	Oct 19 - Dec 19	Jan 20 - Mar 20	Apr 20 - Jun 20	Jul 20 - Sep 20
Inflow - Nurses	1.6	11.2	1.6	1.6	2.4	14.4	2.4	2.4	2.4
Inflow - Direct Patient Care staff (excluding physician associates and pharmacists)	0.8	0.8	8.8	4.0	4.0	4.0	8.0	16.0	16.0
Inflow - Physician Associates	4.0	2.0	2.0	2.0	2.0	10.0	2.0	10.0	2.0
Inflow - Pharmacists	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Inflow - Admin staff	7.2	7.2	8.0	2.4	2.4	2.4	2.4	2.4	2.4
Inflow - Social Prescribing link workers				0.0	35.0	2.0	2.0	2.0	2.0
Outflow - Nurses	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6
Outflow - Direct Patient Care staff (excluding physician associates and pharmacists)	0.8	0.8	0.8	0.0	0.8	0.0	0.8	0.0	0.8
Outflow - Physician Associates	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0	1.0
Outflow - Pharmacists	0.0	0.0	0.0	0.0	0.6	0.0	0.6	0.0	0.6
Outflow - Admin staff	0.0	0.0	0.0	0.8	0.8	0.8	0.8	0.8	0.8
Outflow - social prescribing link workers				0.0	0.0	1.0	1.0	1.0	1.0
Net flow	12.4	20.0	19.2	8.8	7.2	29.6	11.2	29.6	19.2



Appendices: Long Term Plan headline metrics



Long Term Plan headline metrics

The NHS Long Term Plan requires that systems provide in their plans a description of how they will deliver improvement on a number of metrics. This section maps the metrics required to the relevant areas of our plan.

Agreed headline metric	Measure description	Our response
Primary and community services: annual implementation milestones for 5 year GP contract; new community services response times	GP contract / primary care network patient reported access measure – measure to be confirmed ¹	Integrated community based care
	Community rapid response 2 hour / 2 day measure to be confirmed ¹	N/A metric TBC
Emergency care: on agreed trajectory for same day emergency care	Percentage of non-elective activity treated as same day emergency care cases ¹	N/A metric TBC
Prevention: increase uptake of screening and immunisation	Population vaccination coverage – MMR for two doses (5 years old)	CYP; prevention
	Bowel screening coverage, aged 60-74, screened in last 30 months	Cancer
	Breast screening coverage, females aged 50-70, screened in last 36 months	Cancer
	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years)	Cancer
Inequalities: inequalities reduction trajectory	Measure that reflects the inequalities focus of local plans – measure to be confirmed ¹	Prevention
Prevention: Alcohol care teams (ACTs), tobacco treatment services, and diabetes prevention programme	Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place	Prevention
	Percentage of people admitted to hospital who smoke offered NHS funded tobacco treatment services	Prevention
Mental health: on track for locally agreed service expansion, and increase in investment for mental health services as a share of the NHS budget over the next five years, worth in real terms at least a further £2.3 billion, nationally, a year by 2023/24	Mental health access standards once agreed ¹	N/A metric TBC

¹ Metrics are still under development

Agreed headline metric (cont.)	Measure description	Our response
<p>Workforce metrics will be agreed through development of the NHS People Plan. Interim placeholder metrics to support development of local plans will be:</p>	Staff retention rate	Workforce
	Proportion of providers with an outstanding or good rating from the CQC for the “well led” domain	Workforce
	Workforce diversity measure to be agreed ¹	<i>N/A metric TBC</i>
	Number of GPs employed by NHS	Workforce
	Number of FTEs, above baseline, in the primary care network additional role reimbursement scheme	Workforce
	Nurse vacancy rate	Workforce
	Staff wellbeing measure to be agreed as part of the People Plan ¹	<i>N/A metric TBC</i>
<p>Outpatient reform: Avoidance of up to a third of outpatient appointments (including outpatient digital roll out)</p>	Percentage reduction in the number of face to face outpatient attendances ¹	<i>N/A metric TBC</i>
<p>Access to online / telephone consultations in primary care</p>	Access to general practice appointments	Digital First primary care
<p>The NHS will reduce variation in performance across the health system</p>	Measure on reduction in unwarranted variation achieved by the NHS	Referenced throughout the document
<p>The NHS will make better use of capital investment and its existing assets to drive transformation</p>	[Metrics to support this test to be confirmed following the Spending Review and the development of the new NHS capital regime] ¹	<i>N/A metric TBC</i>

¹ Metrics are still under development



Appendices:
Equality impact assessment



South East London Integrated Care System: Implementing the NHS Long Term Plan

How our plans may impact local communities – DRAFT

1. Our commitment to equality, diversity and involving local people

We are committed to reducing health inequalities, promoting equality of access to services and involving patients and the public in supporting us to make decisions about local health services. As part of developing our LTP implementation plan we've heard from over 1600 people, with the support of south east London Healthwatch organisations.

Our response to the Long Term Plan proposes service transformation priorities and outlines how these will be delivered and supported by our enabling workstreams. This document focuses on how the implementation of our plans may directly impact patients, reflecting on what local people have told us as well as how we intend to consider equality and health inequality impacts. By giving focused consideration to equality impacts and working in an ongoing partnership with local communities and the voluntary sector, we believe our plans will be able to better tackle health inequalities and the challenges people can face when trying to access services.

The ICS is a partnership of statutory organisations, each having responsibility for following statutory guidance around involving patients and the public in decision-making and giving thorough consideration to equalities issues. Although the ICS is not a statutory organisation itself, it follows the principles set out in this guidance. This does not replace the responsibilities that each individual organisation in the partnership has in respect of patient and public involvement and the consideration of equality impacts when making changes to services.

(a) Public Sector Equality Duty

The Public Sector Equality Duty requires, in the exercise of functions, to have 'due regard' to the need to:

- **Eliminate** discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- **Advance equality of opportunity** between people who share a relevant protected characteristics and people who do not share it.
- **Foster good relations** between people who share a relevant protected characteristic and those who do not share it.

We show 'due regard' by undertaking equality impact assessments on projects and policies to determine whether they will have an impact on communities with protected characteristics, outlined in the Equality Act 2010.

For the purposes of this document, when referring to the protected characteristics as stated under the Equality Act 2010 (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) we also scope in those who may be socio-economically deprived and carers, in line with our population, as identified in chapter 2 of our LTP response ([understanding our population's needs](#)).

b) Health and Social Care Act 2012

The Health and Social Care Act 2012 states that commissioning organisations must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) in:

- The planning of the commissioning arrangements by the group.
- The development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them.
- Decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

2. South east London context

South east London has a diverse population of 1.9 million. Some of the key population characteristics include:

- **Growing and ageing.** The population is growing and is predicted to increase by 9.5%, exceeding 2 million, over the next ten years to 2029. The expected growth in the older population far outstrips the overall population growth rate (by three times in 65-80 years and 80+); this is likely to lead to increasing demand for care across the system overall.
- **Highly diverse.** The number of people from black and ethnic minority groups ranges from 19% in Bromley to 46% in Lewisham. A higher than average proportion of residents identify as gay, lesbian or bisexual. Lambeth and Southwark have the 2nd and 3rd largest lesbian, gay and bisexual communities in England.
- **Significant levels of deprivation.** 1 in 5 children live in low-income homes. Four of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) rank amongst the 15% most deprived local authority areas in the country. The other two boroughs (Bexley and Bromley) are significantly less deprived but have pockets of deprivation.
- **Highly mobile.** In Southwark and Lambeth, roughly 9% and 10% respectively of the current population moved in and out over 12 month period. In Bexley the equivalent figure was around 5%, compared with approximately 3% in London as a whole.
- **Variation in life expectancy and healthy life expectancy.** Life expectancy and healthy life expectancy at birth remain below the national and London averages for many of the boroughs, especially for men. In recent years, inequalities in life expectancy have been increasing (Public Health (England) Outcomes Framework, 2018). This may be attributed to SEL having some of the highest levels of deprivation and inequalities in health in the United Kingdom.

Between boroughs life expectancy is similar, but healthy life expectancy does vary significantly. Men in one borough of SEL can expect to live on average almost 6 years longer in health than men in a neighbouring borough; for women, the difference is almost 10 years.

- **Several risk factors drive mortality and long term conditions across SEL.** Locally, cancer and cardiovascular disease are the highest causes of under-75 mortality.

- **Increasingly people are living with more long term conditions.** Increasingly more people are living with three or more long term conditions, reducing the number of years lived with good health for a significant proportion of the population. The most common of these are depression, diabetes, chronic kidney disease, coronary heart disease and chronic pain.
- **Unwarranted variation in care.** Some differences in the way care is delivered are not planned around the population's needs and can be due to differences in clinical practice or how services perform. This can lead to unwarranted variation in both patient outcomes and the cost of delivering care.

When considering the diversity of our population in south east London within the context of the 11 equality characteristics listed in section 1, it is important to recognise that there are both individuals and significant parts of the community who experience inequality in terms their access to care, outcomes and overall health and wellbeing.

In addition, these inequalities are not static. Throughout the course of life, people's needs and the impact of inequality will vary and may change quickly – at any point in time there will be a large number of south east London residents whose health is impacted as a result of the inequality they experience in one or more of the protected characteristics.

Therefore, in understanding the overall equalities impact of a wide-reaching plan such as the LTP across a large and diverse population, we will ensure that we are responsive to the needs of individuals and communities as they change. To do this we will ensure that our understanding of the population's needs and the range of equality impacts that exist is fully baselined prior to implementation of Long Term Plan initiatives and is constantly reviewed, and plans updated to reduce these inequalities throughout delivery.

3. Our approach to considering equalities issues and further engagement

As part of developing the national NHS Long Term Plan, NHSE&I has undertaken an equalities impact assessment of the service developments at a high level. This has informed our thinking when reviewing the proposals set out in our plan.

We have developed the following equalities and engagement framework to understand where our plans require further engagement or deeper consideration of equalities issues, in line with statutory guidance. This will support us to generate actions for next steps, focused on mitigating negative or enhancing positive impacts, as well as identifying opportunities for further engagement.

Individual equality impact assessments and engagement plans will be undertaken on a project by project basis, as we move into the implementation of the LTP changes. Table 3 provides information about areas where further work may be required. As a partnership, this work will happen at the most appropriate level within the system.

Table 1: Equalities and engagement framework

Key tests to apply to project / priority areas:
<p>1. Do the proposals relate to an area of commissioning such as:</p> <ul style="list-style-type: none"> • Planning (e.g. developing a strategy or policy)? • Proposals for change (e.g. developing options for delivery of a service or set of services, pathway redesign)? • The operation of existing services (e.g. closure of or location of a service)?
<p>1. If the plans and proposals are implemented, do you think there will be:</p> <ul style="list-style-type: none"> • A change to the range of services that are available? • A change to the way in which services are delivered?
<p>1. A) Does available data (for example: Joint Strategic Needs Assessment (JSNA), national data sets, national patient experience survey data and population health data) suggest there will be a negative / adverse impact to any of the protected characteristics?</p> <p>B) Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?</p> <ul style="list-style-type: none"> • Age • Disability • Gender reassignment • Marriage or civil partnership • Pregnancy and maternity • Race • Religion or belief • Sex • Sexual orientation <p>Other groups also being considered include those who may be socio-economically deprived and carers.</p>

If the response to any of the questions in the framework is 'yes', ICS partners will need to engage further with patients or the public to undertake an equalities impact assessment at the appropriate level. These will support the development and implementation of the project / priority area.

Key activities should include:

- Undertaking a mapping exercise to highlight gaps in knowledge.
- Reviewing previous engagement undertaken around the topic (either by the CCGs, providers, Healthwatch and voluntary and community organisations).
- Reviewing available local and national data including, for example, population health information.
- Reviewing existing arrangements for involvement – considering how we can reach the groups / communities highlighted.
- Developing a more detailed engagement plan.
- Undertaking an equalities impact assessment.

4. Reviewing our engagement to date

To support the development of our plans in response to the Long Term Plan, we undertook a programme of patient and public engagement between July and August 2019 to understand views on: how to get the best start in life, young people's mental health, daytime hospital appointments, access to services, social isolation, working with charities and services working together. Activity included:

- 12 face-to-face events across the six boroughs, in which almost 290 people participated.
- A series of conversations with 19 community groups (involving 200 participants), focusing on reaching communities we ordinarily wouldn't hear from in the NHS.
- An online survey, which 76 people responded to.

South east London Healthwatch organisations also ran their own survey and used focus groups to speak to those with mental health issues, learning disabilities and autism – reaching nearly 1000 people.

South east London is culturally diverse, with each of the six boroughs having unique populations. To evaluate the breadth of our engagement and ensure we have heard from a full range of people, we have reviewed engagement activity with a view to:

- Identifying any groups we haven't managed to hear from to ensure we can focus on these groups in future phases of engagement.
- Ensuring feedback relating to equality impacts has been considered as part of developing implementation plans.

Information used to undertake this exercise has included the Healthwatch engagement report and Kaleidoscope / Together Better engagement report and appendices. At this early stage, engagement was broad, focusing on the population of south east London. As we move towards implementation our engagement work will become more targeted and informed by the outcome of individual project equality impact assessments.

Table 2: Groups reached through engagement

Protected characteristic	Engagement activity	
	Our Healthier South East London (events, focus groups and survey)	Healthwatch (focus groups and survey)
Age	✓	✓
Disability	Some coverage (Further engagement considerations below)	Some coverage
Gender reassignment	Unclear (Further engagement considerations below)	X
Marriage and civil partnership	✓	✓
Pregnancy and maternity	✓ (Further engagement considerations below)	Unclear
Race	✓ (Further engagement considerations below)	✓
Religion or belief	Unclear (Further engagement considerations below)	✓
Sex	✓	✓
Sexual orientation	✓	✓
Carers	✓	✓
Socio-economic deprivation	✓ (Further engagement considerations below)	X

(a) Findings

Mapping our activity against the protected characteristics, it is clear engagement was broad and wide ranging. However, there are several groups we will aim to work more closely with in future phases of engagement, to ensure their views are integrated into our plans.

- **Disability.** Through focus groups run by OHSEL and Healthwatch, we have spoken to: people with mental health issues; learning disabilities and autism; people with hearing impairments; and people who are housebound. Other disability groups may have been missed, including those with visual impairments, neurological impairments or other physical disabilities.
- **Gender reassignment.** Through focus groups we reached out to an LGBTQ+ group. However, it is unclear whether the views of anyone currently undergoing or who has undergone gender reassignment were spoken to.
- **Pregnancy and maternity.** There is no clear evidence that new or expectant mothers were reached through this period of engagement to discuss either pregnancy or maternity issues or wider health concerns. However, engagement work has been undertaken in Bromley to

- understand new and expectant mothers' experiences of services, which should be reviewed and incorporated into future plans and assessments as part of implementing plans in this area.

The Better Births plan, which was refreshed recently, was co-produced with Maternity Voices Partnerships in SEL. That plan forms the basis of our response to the LTP in respect of maternity services. Supporting the six Maternity Voices Partnerships across SEL to bring the views of new and expectant mothers into the work of the Local Maternity System and to pursue their own local initiatives to co-design services for this group is a key workstream in OHSEL's maternity programme.

- **Race.** Although specific communities were sought out (Polish, Portuguese, Latin American and BAME) there are opportunities to engage more widely to ensure the diversity of south east London is reflected.
- **Religion or belief.** There is limited evidence that those from different faiths have been involved at this stage. The Healthwatch survey highlights that the majority of respondents to their survey were Christian.
- **Socio-economic deprivation.** Through focus groups we spoke to several organisations supporting those who are socio-economically deprived, including those working with refugees and asylum seekers. Future engagement activity should focus on reaching the range of people who are socio-economically deprived alongside targeting specific affected communities and individuals such as the homeless and people with substance misuse issues.

5. Considering how our plan may impact local communities

Using the equalities and engagement framework introduced in section 3, we have carried out a review of the priorities and proposals within our LTP response. This has supported us to consider whether any service change is required, if what is proposed is business as usual activity which will not directly impact patient services, and if further work is required to understand equality impacts.

We anticipate that all elements of the plan will positively impact local communities by reducing health inequalities, improving access to services and addressing differential impacts across all protected characteristics. This will be confirmed as and when more detailed equality impact assessments are undertaken on individual initiatives.

There is awareness that demographic data is not captured at service level to support the impact assessment process. Where it is captured, it is often not detailed enough. Individual CCGs are working to ensure that, during the contracting process, this is a requirement to support evidence based decision making.

Many of the plans we have set out are not new initiatives. All priorities align to what is set out in the national LTP and the needs of our system.

The [national Long Term Plan equality impact assessment](#) (EIA) provides an overarching assessment of the equality impacts on which much of this initial review has been based. In addition, this initial review has been informed by the LTP public engagement activities across SEL as described in section 4 above and the development of our partnership's LTP response. This draft EIA has been reviewed by all south east London CCG engagement and equalities leads, to allow

for insight of local populations, equalities data and engagement feedback to be included. The draft has also been shared with members of our patient and public advisory group.

Moving forward we plan to undertake further public engagement to allow us to develop our understanding of equalities impacts of the LTP in more detail ahead of and during implementation.

DRAFT

Table 3: Review of priority areas against equalities and engagement framework

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
<p>Integrated community based care</p> <ul style="list-style-type: none"> Establish a systematic approach to addressing health inequalities within community services. Deliver a comprehensive PCN support and organisational development strategy across SEL and within our local borough based systems. Deliver anticipatory pathways in conjunction with PCNs and local authorities. Improve the responsiveness of community health response services: provision of 2 hour crisis / 2 day reablement response. System wide and local priorities to deliver Enhanced Health in Care Homes. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>Particular groups who may be impacted by developments in integrated community care, as identified in the national EIA, include: older people, those with disabilities, those experiencing social isolation and / or socio-economic deprivation, those living with long-term conditions, and carers.</p> <p>As part of future equality impact assessments, there should also be consideration of intersectional equality issues that may need to be addressed for this particular group.</p> <p>Opportunities to involve local people</p> <p>Existing insights from CCG engagement leads should be utilised as a baseline when developing further plans for engagement.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
<p>Reduce pressure on urgent and emergency care</p> <ul style="list-style-type: none"> • Deliver an integrated and consistent community based urgent and emergency care offer across SEL. • Hospital front-door services and streaming models to direct people to the least intensive setting for their UEC needs. • Improve in-hospital processes and enhance community offer to minimise the time patients spend in hospital. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>Particular groups to pay attention to, as identified in the national EIA, include older people and those with disabilities.</p> <p>Opportunities to involve local people</p> <p>Plans in this area propose delivering improvements to non-patient facing services that will not directly impact how services to patients are delivered.</p> <p>This should be constantly reviewed to ensure patients and the public are involved as and when there are opportunities to influence plans.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
<p>Improve planned care outcomes and performance</p> <ul style="list-style-type: none"> Implement access to telephone and video services alongside face-to-face appointments. Implement access to virtual services. Offer better support to primary care. Provide appointments closer to home through community services. Cut long waits and reduce waiting lists by introducing clinical triage across a wide range of specialties. Cut long waits and reduce waiting lists by developing clinical networks in some specialty areas to ensure safe and sustainable services and by taking action to make the best collaborative use of available capacity to treat patients. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>Plans focus on introducing digital and virtual appointments. From an equalities perspective, particular groups to pay attention to may include: those with sensory or learning disabilities (particularly those who are hard of hearing), different ethnic groups (especially those for whom English is not a first language or for those who speak no English), and those who may be socio-economically deprived who are unable to access or afford the technology required.</p> <p>Some groups, who do not have, or do not want to have, the skills to use digital technology may also be disadvantaged. For example, older people and those with reduced dexterity or with additional communication needs.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Improve planned care outcomes and performance (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	<p>Feedback from engagement highlighted that, for those with learning disabilities, accessing outpatient services can be quite challenging. Often information is not in easy read format and doctors do not explain procedures and results in a way that is understandable. This should be considered when planning to introduce digital appointments.</p> <p>Opportunities to involve local people</p> <p>Existing insights from CCG engagement leads should be utilised as a baseline when developing further plans for engagement. For example, feedback from a Bromley patient survey supports points above and, additionally, indicates some people are not as confident when talking over the phone so may not get all their points across.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Cancer <ul style="list-style-type: none"> Work with national and regional teams to improve uptake and coverage of bowel, breast and cervical screening in London. Implement early diagnosis intervention bundles. Deliver the national specification on rapid diagnostic centres in south east London. Implement a comprehensive SEL clinical programme across all tumour sites supported by cross-cutting groups to drive improvements in cancer performance, outcomes and experience and deliver the cancer five year plan. Reduce “primary care interval” (time from first consultation to specialist referral). 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs, screening uptake and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	Equalities considerations <p>Equality impacts are currently unclear. However, as suggested in the national EIA, lung and cervical cancers impact disproportionately on deprived communities and there are significantly higher rates of prostate cancer in black males.</p> <p>With lung cancers, smoking rates are often higher in certain communities or groups, for example LGBTQ+ communities, Gypsy, Roma and Traveller communities, eastern European migrants, homeless people and those who may be socio-economically deprived.</p> <p>Feedback from engagement highlighted that, for those with learning disabilities, screening processes can present a challenge. Those we spoke to highlighted that they were not routinely offered screening, there was often not enough time given for screening appointments,</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
<p>Cancer (continued)</p> <ul style="list-style-type: none"> Implement a range of high quality treatment interventions across the Alliance. This will ensure patients receive the most effective, precise and safe treatments, with fewer side effects, shorter treatment times and reduce variation in access and outcomes. Work with NHSE&I and our London South Genomic Laboratory Hub partners to increase genetic and genomic testing coverage and ensure equitable access to all tests covered by the National Genomic Test Directory. Ensure that all patients diagnosed with cancer have access to high quality personalised care. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs, screening uptake and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>there is a lack of clear easy read information in advance about what will happen or who will undertake the screening (is it a male or female), and lack of awareness about the purpose of screening.</p> <p>Bowel screening is particularly problematic for people with learning disabilities because of lack of understanding of the different samples required and sometimes requiring support to acquire the samples. MENCAP currently offer training around these issues which could provide support for staff in better supporting those with a learning disability.</p> <p>It will be important to review any equality data available on the uptake of various screening programmes to consider what barriers there may be for certain groups in accessing screening.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Cancer (continued) <ul style="list-style-type: none"> Implement stratified follow up pathways at end of treatment for the agreed cohort of breast, colorectal and prostate cancer patients and other tumour specific pathways as appropriate. Enable development, resilience and productivity of the cancer workforce in south east London. Involve patients and carers in our patient experience and service transformation work. 	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs, screening uptake and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Opportunities to involve local people Plans already reflect the need for further engagement with service users and carers – in particular, this should focus on personalisation of care and pathway redesign. Further work is required to understand barriers to taking up various screening programmes in order to make improvements.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Adult mental health <ul style="list-style-type: none"> Implement new integrated community mental health models of care wrapped around primary care networks. Implement increased capacity to support more people in IAPT services including people with physical health long term conditions. Embed annual PHC, EIP and IPS services for people with SMI within core community mental health service offer. Implement a consistent core offer of specialist community perinatal services across SEL with links to maternity community clinics. Implement alternative crisis support working jointly with police, LAS and voluntary sector, and improve the quality of psychiatric liaison services. 	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Equalities considerations It appears plans may positively impact older people and those who are homeless, as well as those with common and severe mental health problems more generally. Early feedback from patients indicated those with mental health issues experience barriers to accessing services, particularly crisis support, and are often subject to long waits and thresholds when attempting to access services. Those experiencing financial challenges, who may be reliant on a carer, have learning disabilities, or who may be from different cultural backgrounds may be disproportionately impacted by any changes to mental health services. It was also recognised that men often do not seek help for mental health issues.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
<p>Adult mental health (continued)</p> <ul style="list-style-type: none"> Implement pathways with specific focus for people diagnosed with personality disorder, older adults and eating disorders. Implement increased provision for suicide bereavement, problem gambling and rough sleeping. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Those with a learning disability mentioned that having difficulties expressing themselves and not having information in easy read formats often made accessing mental health issues even more challenging. Carers commented that they often felt left out or not recognised in the decision-making process.</p> <p>The way in which care is accessed, for example using telephone assessments, can present a barrier. Symptoms, body language and appearance can all be masked over the phone.</p> <p>It is important that services are accessible this includes a range of factors, such as:</p> <ul style="list-style-type: none"> Being accessible outside of the traditional 9-5 – supporting those who are of working age. Providing information in accessible formats to help awareness of services, thresholds and other information.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Adult mental health (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	<ul style="list-style-type: none"> The physical environment of crisis services. Providing services in a culturally appropriate way. <p>Opportunities to involve local people</p> <p>Existing insights from CCG engagement leads should be utilised as a baseline when developing further plans for engagement.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
Cardiovascular disease <ul style="list-style-type: none"> • Deliver enhanced support for prevention. • Intensify effort for case finding and early intervention. • Reduce variation in care quality and inequalities in health outcomes throughout SEL. 	X	X	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Equalities considerations As suggested in the national EIA, those more commonly affected by CVD include those who are socio-economically deprived, women, South Asian and African and Caribbean communities and other black and minority ethnic communities. Opportunities to involve local people Ongoing engagement will be required with patients and the public to ensure design, delivery, promotion and services are culturally appropriate.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
Respiratory disease <ul style="list-style-type: none"> • Ensure accurate diagnosis of COPD and increase case finding. • Medicines optimisation for inhaler use in asthma and COPD. • Improve access to pulmonary rehabilitation services. • Deliver enhanced support for prevention. 	X	X	To be confirmed – assessment to be made when scope defined.	To be confirmed – assessment to be made when scope defined.	<p>Plans largely focus on implementing back office improvements which will improve patient experience without changing the way in which services are delivered.</p> <p>The scope of this priority area should be reviewed as plans are developed to ensure further engagement and consideration of equality impacts is not required.</p>
Heart disease and stroke care <ul style="list-style-type: none"> • Improve detection and treatment of people with heart failure and valve disease. • Improve stroke care, rehabilitation and outcomes for stroke patients. • Build upon the work of existing networks and expertise in SEL. 	Unknown.	Unknown.	To be confirmed.	To be confirmed.	<p>Assessment of equality impacts and areas where patients and the public can influence this work need further consideration once the programme has further developed.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
<p>Diabetes</p> <ul style="list-style-type: none"> Expand our Type 2 diabetes prevention. Innovative technology projects and structured education to support patients in making their own decisions on managing their health. Integrated, efficient services that provide a standard, high level of treatment and care. 	✓	X	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>Plans suggest that expanding diabetes prevention and introducing innovative technology projects and structured education will positively impact working age adults, BAME groups, those with a learning disability and serious mental health issues, and new mothers.</p> <p>It is well known that there is prevalence of diabetes within different sections of the community – this will need consideration.</p> <p>Opportunities to involve local people</p> <p>Further work is needed to properly explore equality impacts and opportunities for patients and the public to inform the design and delivery of suggested interventions, making use of existing insights.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
Learning disabilities and autism <ul style="list-style-type: none"> • Early intervention and admission prevention. • Deliver coordinated care for people with learning disabilities and / or autism. • Commissioning to improve community capacity. 	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Equalities considerations Feedback from our engagement work indicates particular barriers to accessing care due to the ways in which appointments need to be booked and the lack of training and awareness of staff in supporting those with a learning disability. Digital technology can help those with autism overcome social difficulties, e.g. sitting in waiting rooms. However, this may only be appropriate for certain types of treatment. Through ongoing programme planning, there should be the identification of intersectional equality issues that may need to be addressed for this particular group, when considering equality impacts.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
Learning disabilities and autism (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Opportunities to involve local people Plans already reflect the need for further engagement with service users and carers – in particular, this should focus on pathway redesign and development including pilot projects.

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Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
<p>Children and young people (including mental health)</p> <ul style="list-style-type: none"> Expand children and young people’s mental health services. Developing networked services to support children with LTCs (epilepsy, diabetes and asthma) and integrating multidisciplinary community health services around these children. Meet the needs of children and young people with learning disabilities and autism. Meet the needs of children and young people with cancer. Work with Public Health to improve prevention. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>As part of future equality impact assessments, there should be consideration of intersectional equality issues that may need to be addressed for this particular group.</p> <p>Through our engagement activity, staff communication was highlighted as a barrier in accessing care. Often things are not explained to the child / in a way that they can understand.</p> <p>Children from different socio-economic backgrounds will need varying levels of support. The assumption should not be made that those from more deprived communities will require more support than those from more affluent areas, as there are multifaceted issues at all levels.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
Children and young people (including mental health) (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Opportunities to involve local people Plans already reflect the need for further engagement with children, young people, and families to develop this programme of work.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics ?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics ?	
<p>Maternity services</p> <ul style="list-style-type: none"> Expand provision of continuity of carer. Deliver the Halve It ambition and improve newborn care. Provide integrated and personalised maternity care across the whole pathway. Enhance prevention support working closely with Public Health. Build a resilient workforce across SEL through networking and partnership. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>As suggested in the national EIA, particular groups such as mothers from BAME backgrounds, those who might be carers, those from socio-economically deprived areas and those with mental health problems need to be properly considered during the development of maternity services.</p> <p>Getting services right can also reduce long term disabilities and conditions for children and mothers.</p> <p>Opportunities to involve local people</p> <p>The plan already recognised the continued need for co-production and stakeholder with our established Maternity Voice Partnerships to explore opportunities for engagement. MVPs are one of the ways in which engagement takes place and efforts should be made to ensure engagement work with this group is representative.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
<p>Going further on prevention and reducing health inequalities</p> <ul style="list-style-type: none"> • Deliver a system-wide population health management programme, which will inform our prevention activities. • Go further on our primary prevention agenda, focusing on the areas prioritised in the LTP Implementation Framework. • When people do develop long term conditions, improve early detection, intervention and management so that people can stay as health and independent for as long as possible in their own homes. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include further analysis and use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	<p>Equalities considerations</p> <p>Plans for this priority area consolidate actions across several workstreams, particularly supporting those with long term conditions. It is important to have a view of equality issues across all priority areas which fall under prevention and reducing health inequalities.</p> <p>Feedback from our engagement work highlighted that access to GP and other health services, as well as the approach of staff and communication, was a concern and presented barriers to accessing support to stay healthy.</p> <p>Groups such as those with learning disabilities found being healthy and active particularly challenging. They are often reliant on carers or support workers to undertake exercise and outdoor activities. Having limited finances to buy healthy foods and pay for activities was also a factor in staying well.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Going further on prevention and reducing health inequalities (continued)	✓	✓	To be confirmed. Assessment to include further analysis and use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Opportunities to involve local people Existing insights from CCG engagement leads and other partners should be utilised as a baseline when developing further plans for engagement.

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Delivering digital transformation in primary care <ul style="list-style-type: none"> Deliver an online consultation offer in each GP practice by April 2020. Deliver a video consultation offer in each GP practice by April 2021. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	Equalities considerations <p>Our plans focus on introducing digital and virtual appointments. There is a commitment to support those patients who cannot, or prefer not to, use these digital options. This offers them choice and comparable access to services, avoiding negative impacts on particular protected characteristic groups, which was something that came through strongly in feedback from patients. Further work is required to fully explore equality impacts.</p> <p>Although people would like a choice about how they can book GP appointments; digital booking would positively impact working age adults and those with autism.</p> <p>Other groups impacted may include those with sensory or learning disabilities (particularly those who may be hard of hearing), different ethnic groups (especially those for whom English is not a first language or for those who speak no English), and those who</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Delivering digital transformation in primary care (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	<p>may be socio-economically deprived and unable to access or afford the technology required.</p> <p>Some groups who do not have, or do not want to have, the skills to use digital technology may also be disadvantaged. This may impact older people, those with reduced dexterity, or with additional communication needs. Feedback from engagement highlighted that, for those with learning disabilities, using technology to access appointments can be challenging. This should be considered when planning to introduce digital appointments.</p> <p>Opportunities to involve local people</p> <p>Existing insights from CCG engagement leads should be utilised as a baseline when developing further plans for engagement.</p>

Priority area	Review against equalities and engagement framework				Equalities considerations and opportunities for further engagement with local people
	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Personalised care <ul style="list-style-type: none"> We will develop a plan to implement the NHS Comprehensive Model of Personalised Care in SEL. Implement the further roll-out of personal health budgets. Implement clear and effective pathways for social prescribing. Implement a personalised approach to care to improve end of life care. 	✓	✓	<p>To be confirmed.</p> <p>Assessment to include use of local data sources, including JSNAs and analysis of health inequality.</p>	<p>To be confirmed.</p> <p>Further local engagement to explore impact within identified groups.</p>	Equalities considerations <p>Feedback from patients and the public has highlighted that social isolation is a key issue of concern for all ages, particularly affecting the elderly and chronically ill. This may impact on their ability to engage fully in the personalised care agenda.</p> <p>Many groups do not feel listened to when discussing health and care options with health professionals and, as a result, treatment is not always tailored. This should be factored into the design of any personalised care approaches.</p> Opportunities to involve local people <p>Learning from engagement activities with our voluntary and community sector, there are huge opportunities for us to work in genuine partnership with small and developing organisations, to collaborate on improving how health and care services are delivered.</p>

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	1. Do the proposals relate to an area of commissioning such as planning, proposals for change or the operation of existing services?	2. If the plans and proposals are implemented, do you think there will be a change to the range of services or the way in which they are delivered?	3a. Does available data suggest there will be a negative / adverse impact to any of the protected characteristics?	3b. Does previous engagement work suggest there will be a negative / adverse impact to any of the protected characteristics?	
Personalised care (continued)	✓	✓	To be confirmed. Assessment to include use of local data sources, including JSNAs and analysis of health inequality.	To be confirmed. Further local engagement to explore impact within identified groups.	Assessment of equality impacts and areas where patients and the public can influence this work need further consideration, once the programme has further developed.
Leveraging research, innovation and genomics <ul style="list-style-type: none"> Support research and innovation to improve outcomes and efficiency in the NHS. Drive innovation in genomics, to expand access to genomic testing and the translation of testing into clinical practice. 	Unknown.	Unknown.	To be confirmed.	To be confirmed.	In supporting research and innovation to improve outcomes and efficiency in the NHS, assurances should be sought that in undertaking research, bodies are proactively seeking the views of service users, their families and carers and giving thorough consideration to equality issues. The outcomes of research, innovation and genomics will impact how services are planned and delivered by the Our Healthier South East London programme in future.

6. Our learning and next steps

Through undertaking a process of reviewing our engagement to date and considering the proposals within our plan, we have developed a greater understanding of the further work required to involve local people and consider equality impacts as we look to implement what we have set out.

Implementing our plan will be supported by:

- Increased partnership working with our voluntary and community sector to understand how to build capacity and support small organisations to provide elements of care.
- Undertaking a process of reviewing available data (to understand who is accessing our services and whether there are any gaps or differences in outcomes) and outputs from engagement activities, both locally and across south east London.
- Undertaking further engagement to develop implementation plans, working towards a culture of co-production.
- Continuing to work with providers to collect service level demographic data to support impact assessment processes.
- Agreeing the mechanisms by which the findings in this document will be taken forward and monitored on an ongoing basis as plans are implemented.
- Consideration of where the equalities and health inequalities portfolio sits within the SEL ICS, and how local activity drives, feeds into and supports consideration of equality impacts across the SEL system.
- Feeding back to those who have shared their views with us.



Appendices:
Abbreviations list



A&E	Accident and emergency
ACT	Alcohol care team
AF	Atrial fibrillation
AHP	Allied health professional
ARMS	At risk of mental state
ASCOF	Adult social care outcomes framework
ATAIN	Avoiding term admissions into neonatal units
BAME	Black, Asian and minority ethnic
BCF	Better Care Fund
BME	Black and minority ethnic
C(E)TR	Care (education) and treatment review
CACT	Charlton Athletic Community Trust
CAMHS	Child and adolescent mental health services
CBC	Community based care
CCG	Clinical commissioning group
CCT	Certificate of completion of training
CNS	Clinical nurse specialist
CoCarer	Continuity of carer
COPD	Chronic obstructive pulmonary disease
COSD	Cancer outcomes and services dataset
CPCS	Community pharmacist consultation service
CPMH	Community perinatal mental health
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CVD	Cardiovascular disease
CYP	Children and young people
DGT	Dartford and Gravesham NHS Trust
DISN	Diabetes inpatient specialist nurse
DMIRS	Digital minor illness referral service
DNA	Deoxyribonucleic acid
DNA	Did not attend
DToC	Delayed transfer of care
EBUS	Endobronchial ultrasound
ECDS	Emergency care data set
ECG	Electrocardiogram
ED	Emergency department
EEA	European Economic Area
EHCH	Enhanced health in care homes
EHR	Electronic health record
EIA	Equality impact assessment
EIP	Early intervention in psychosis
e-RS	e-referral service
ETTF	Estates and Technology Transformation Fund
FCP	First contact practitioner
FDS	Faster diagnosis standard
FH	Familial hypercholesterolaemia
FIT	Faecal immunochemical test
FTE	Full time equivalent
FY	Financial year
GIRFT	Getting It Right First Time

GLA	Greater London Authority
GP	General practice / general practitioner
GPFV	GP Forward View
GPN	General practice nurse
GSTT	Guy's and St. Thomas' NHS Foundation Trust
GTAB	Genomic Tumour Advisory Board
HCA	Healthcare assistant
HCHS	Hospital and community health service
HEAL-D	Healthy eating & active lifestyles for diabetes
HEE	Health Education England
HEI	Higher education institute
HGA	Healthier Greenwich Alliance
HIN	Health Innovation Network
HIV	Human immunodeficiency virus
HNA	Holistic needs assessment
HPV	Human papillomavirus
HRD	Human Resources Director
HSLI	Health System Led Investment
HTN	Hypertension
HWBE	Health and wellbeing event
IAPT	Improving access to psychological therapies
IBD	Inflammatory bowel disease
ICS	Integrated care system
inc.	Including
INN	Integrated neighbourhood networks
IPS	Individual placement and support
IT	Information technology
ITT	Inter-trust transfer
IUC	Integrated urgent care
JD	Job description
JSNA	Joint Strategic Needs Assessment
KCH	King's College Hospital (NHS Foundation Trust)
KHP	King's Health Partners
King's	King's College Hospital (NHS Foundation Trust)
KPI	Key performance indicator
LA(s)	Local authority / local authorities
LAS	London Ambulance Service (NHS Trust)
LCP	Local Care Partnership
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex +
LGT	Lewisham and Greenwich NHS Trust
LHCRE	Local Health and Care Record Exemplar
LMC	Local Medical Committee
LMS	Local Maternity System
LTC	Long term condition
Ltd	Limited
LTP	NHS Long Term Plan
LWAB	Local Workforce Action Board
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

MDM	Multidisciplinary meeting
MDT	Multidisciplinary team
MH	Mental health
MLU	Midwifery led unit
MMR	Measles, mumps, and rubella
MRI	Magnetic resonance imaging
MSK	Musculoskeletal
MVP	Maternity Voices Partnership
N/A	Not applicable
NDPP	NHS Diabetes Prevention Programme
NG	NICE guideline
NHS	National Health Service
NHSE&I	NHS England & NHS Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NO₂	Nitrogen dioxide
NUMSAS	NHS urgent medicine supply advanced service
NWL	North west London
OD	Organisational development
OG	Oesophago-gastric
OHSEL	Our Healthier South East London
ONS	Office for National Statistics
Oxleas	Oxleas NHS Foundation Trust
PCN	Primary care network
PCP	Personalised care plan
PFI	Private finance initiative
Pg	Page
PH	Public health
PHB	Personal health budget
PHC	Physical health check
PHE	Public Health England
PHM	Population health management
PICU	Psychiatric intensive care unit
PMO	Programme management office
PReCePT	Prevention of cerebral palsy in pre-term labour
PROMs	Patient reported outcome measures
PRUH	Princess Royal University Hospital
PTL	Patient tracking list
QOL	Quality of life
RAS	Referral assessment service
RTT	Referral to treatment
SACT	Systemic anti-cancer therapy dataset
SAFER	Senior review; all patients; flow; early discharge; review
SALT	Short and long term support
SBLCB	Saving Babies' Lives Care Bundle
SDEC	Same day emergency care
SE	South east
SEL	South east London

SELCA	South East London Cancer Alliance
SHRINE	Sexual and Reproductive Health Rights, Inclusion and Empowerment
SLaM	South London and Maudsley NHS Foundation Trust
SLP	South London Partnership
SMI	Serious mental illness
SPoA	Single point of access
SSNAP	Sentinel Stroke National Audit Programme
St. Thomas'	St. Thomas' Hospital
STI	Sexually transmitted infection
STP	Sustainability and transformation partnership
SWL	South west London
T&F	Task and finish
TBC	To be confirmed
TCST	Transforming cancer services team
TfL	Transport for London
TOR	Terms of Reference
TSA	Trust Special Administration
TYA	Teenagers and young adults
UEC	Urgent and emergency care
UHL	University Hospital Lewisham
UK	United Kingdom
UNICEF	United Nations Children's Fund
UTC	Urgent treatment centre
VCSE	Voluntary, community and social enterprise
WGS	Whole genome sequencing
WHO	World Health Organization
WS&DO Group	Workforce Strategy and Delivery Oversight Group

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