South East London Integrated Care System

NHS South East London

Developing our SEL Integrated Care Strategy

Progressing the ICS strategy workshop: a focus on vision and strategic priorities – 14 September 2022

Briefing and supporting materials

Progressing the ICS strategy workshop: a focus on vision and priorities

South East London Integrated Care System

Wednesday 14 September, 14:15-17:00, The Assembly Room & Suite 16 at Lambeth Town Hall

This workshop will bring together Integrated Care Partnership and Board Members to progress SEL ICS strategy and move to the next stage of development in the autumn.

The workshop aims to:

- reflect on the engagement so far,
- seek guidance on the emerging vision and cross-cutting themes for how we should go about our work, and
- progress towards agreement on a focused number of strategic priorities for cross-system action, which will determine how the strategy develops in the coming months.

13:45	Lunch
14:15	**Welcome and introductions**
	Setting out the context and ambition for our strategy and our progress so far in the development process
14:25	**How will we be successful?**
	Lessons we can learn from other strategy processes in the NHS and further afield
14:30	**Progressing… Our vision and cross-cutting themes**
	Discussion on the progression of our vision and cross-cutting themes for our strategy
15:00	**Progressing… Our strategic priorities - Introduction**
	Plenary and breakout discussions on our strategic priorities and what would have the biggest impact progressed collectively
16:45	**Reflections and next steps**
17:00	**Close**

Our ambitions and objectives for our integrated care strategy*

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- Our ambition is to develop a strategy that is different to what has gone before.
- We are not trying to replicate what is happening in each borough or provider in our system.
- Instead, we want our strategy to home in on a small number of major opportunities for cross-system change and deliver real impact
- We want to build on broader engagement with staff and communities on strategic priorities, including engagement in 2019.
- Finally, we want to continue developing our strategy in close dialogue with local authority, VCSE partners and our staff and communities and ensure a joint strategy across bodies in our system.

Our strategy development process

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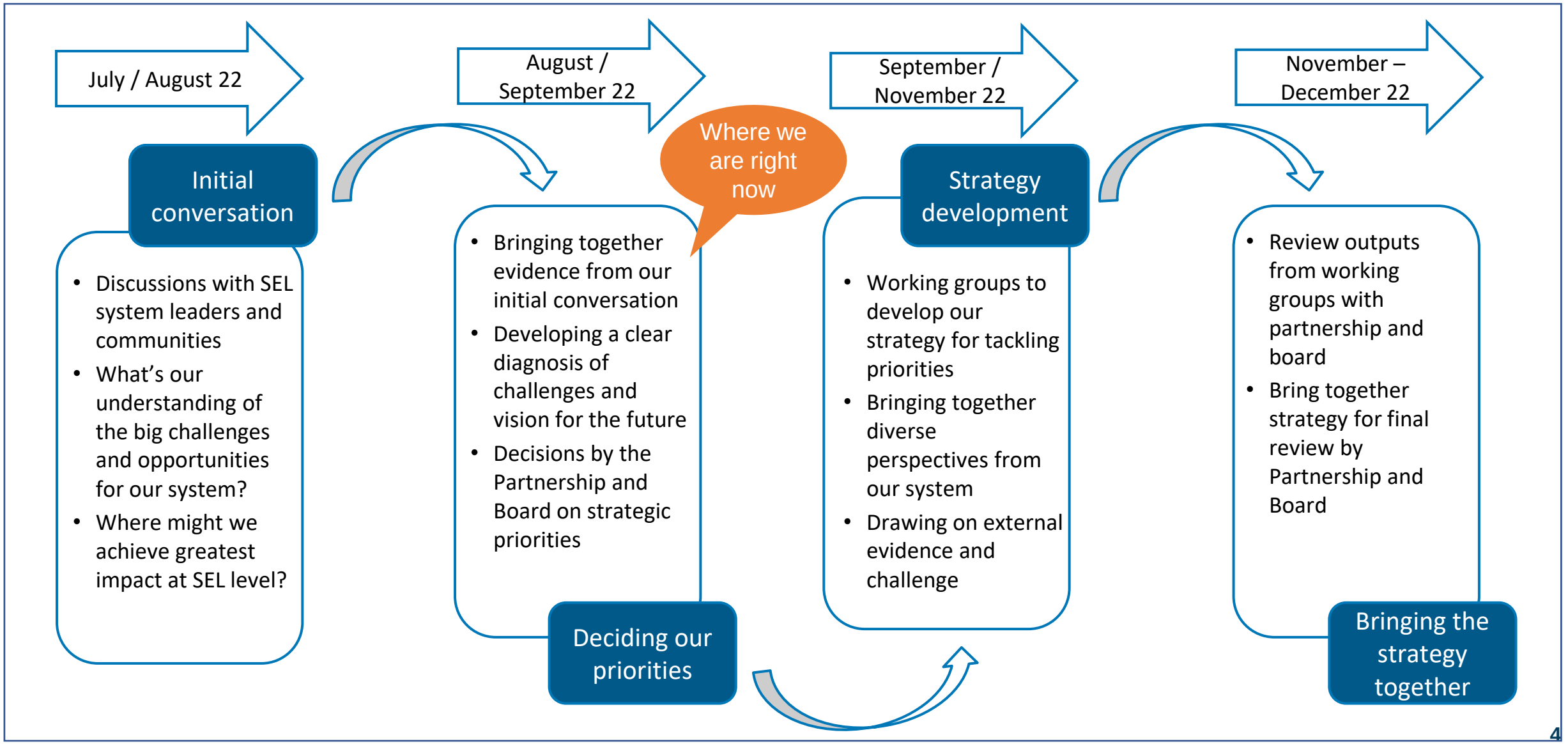

How we think our IC strategy should be structured

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1

SEL ICS mission statement - 'Our purpose'

Building on the four statutory purposes of an ICS*, "our mission is to help people in south east London to live the healthiest possible lives. We will do this through: i) helping people to stay healthy and well; ii) providing the right treatment when people become ill; iii) caring for people throughout the course of their lives; iv) taking targeted action to address health inequalities; and v) supporting resilient, happy communities."

2

High level ambitions for the ICS strategy - 'Our strategic vision' [*in development: from engagement so far]*

How we want the nature of care to change, e.g.: Preventing ill-health, particularly by taking a holistic approach to health and care and focusing on wellbeing; integrating services to achieve the best outcomes; working in true partnership with local people

3

Cross-cutting themes for the strategy - 'To take forward across SEL programmes of work' [*in develop.*]

Themes to take forward across all of our work including flagship programmes and in our enabler strategies. For example: improve health and care outcomes, improve productivity, efficiency and ensure sustainable services, address health inequalities; develop our transformation capability and build enabling infrastructure.

4

What challenges or opportunities do we prioritise for system-level action over the next 5 years – 'Our strategic priorities' [*in development*]

A small no. of big opportunities to improve health and care as a system in the next 5 years - measurable and outcome oriented.

**1) Improve outcomes in population health and healthcare; 2) Tackle inequalities in outcomes, experience and access; 3) Enhance productivity and value for money; 4) Help the NHS support broader social and economic development*

Our approach to developing our vision

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What we mean by a vision …

- A high level description of the sort of health and care system we want to have in, say, a decade's time
- What will it look and feel like for our service users, staff and communities. What will be different?
- Providing clarity on the choices and trades-off we will make as a system, which objectives we will prioritize above others?

Why we need one …

- To ensure broad agreement on how we want to develop our system, where we want to focus, and how we want to develop care.
- And empower our staff to go out and improve things, without waiting for permission, but in ways that are consistent with the sort of system we want to create.

Examples of visions / guiding principles: Canterbury Health Board, NZ and Southcentral Foundation, Alaska

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The Canterbury Health Board's visual representation of its vision for transforming care (2010)

- Building services around the service user rather than institutions, with the main focus on care in the home
- Focus on building the primary and community services needed to minimise reliance on hospital services
- Joining up different primary, community and social services to deliver holistic care.
- Shifting focus to early intervention and proactive care
- Avoiding wasting patient time as key efficiency metric

Southcentral Foundation's Vision, Mission and Operating Principles (late 1990s)

Southcentral Foundation's Vision:

A Native Community that enjoys physical, mental, emotional, and spiritual wellness.

Southcentral Foundation's Mission:

Working together with the Native Community to achieve wellness through health and related services.

Relationships between the customer-owner, family and provider must be fostered and supported
Emphasis on wellness of the whole person, family and community including physical, mental, emotional and spiritual wellness
Locations that are convenient for the customer-owner and create minimal stops for the customer-owner
Access is optimized and waiting times are limited

Together with the customer-owner as an active partner
Intentional whole system design to maximize coordination and minimize duplication
Outcome and process measures to continuously evaluate and improve
Not complicated but simple and easy to use

Services are financially sustainable and viable

Hub of the system is the family

Interests of the customer-owner drive the system to determine what we do and how we do it
Population-based systems and services

Services and systems build on the strengths of Alaska Native cultures

- Focus on holistic care and wellbeing rather than treatment for individual health conditions
- Commitment to collaborative working and sharing of power with service users and communities
- Focus on building sustained relationships between core teams and service users
- Emphasis on redesign and simplification for convenient care, improving coordination, avoiding duplication.

Draft vision statement

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

If we are to deliver this mission, we know that we will need to make far reaching changes to our current system. These are our most important principles for developing our services:

1. Health and wellbeing

Like other local health and care systems, we have inherited a set of services focused primarily on treating people when sick rather than supporting health. We need to develop a system which is as good at protecting health and wellbeing as it is at treating illness. This will mean investing in more coherent and effective preventative health services, more proactive services that go out and find people and intervene earlier to avoid serious illness, working in partnership to create healthier environments, and harnessing the power of our voluntary sector and communities to support healthier living and happier lives.

Draft vision statement

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2. Convenient care

Local people continue to tell us how difficult it is to communicate with us, access our services and navigate our system. We need to make it as easy as possible for people to interact with our services, tackle the long waiting times for some services, and offer convenient care, including high quality online consultations for people who want them and care in or close to people's homes. We need to dismantle models of care that consumer service users' time and impose avoidable travel or other costs, while increasing carbon emissions. We will need to harness the power of technology and simplify our services so that they are easier for people to understand and navigate.

3. Whole person care

In our system, people rely on separate, disconnected teams for support with different physical health, mental health and social needs, rather than joined up, responsive services that can address all the issues that matter to them at the right time. We need to continue the process of reorganising small, fragmented services for specific diseases or conditions into more coherent team-based care. Local people should be able to rely on a single small team of staff who they know and trust to provide most of their care. Wherever possible, those teams should draw in specialist expertise when needed, rather than automatically asking service users to go to separate services for aspects of their care. In making these changes, we will also lay the foundation for stronger relationships between service users and their core teams of care givers and more compassionate, trusting and person-centred care.

Draft vision statement

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4. Tailored services

In our health and care system, we have traditionally developed general services for the whole population rather than bespoke services for specific communities or social groups. We know that some minorities and people from deprived communities are less likely to be enrolled with a GP practice, find it harder to access services, suffer poorer overall health and have worse outcomes from care. We need to develop more tailored services to better meet the needs of women, minorities and the most disadvantaged people in our society, for example finding new ways to connect with these service users, focusing resources on those most in need, adapting our existing services and developing different services where required to deliver convenient and effective care.

5. Partnership with our service users

During the Covid 19 pandemic, we demonstrated the power of partnership working between health services, social services, the voluntary sector and our communities to improve people's health and care. We want to continue the shift to a model of genuine partnership working between health and care professionals, communities and service users, where professionals work with service users to understand what really matters to them and support them in managing their health and care. As in the pandemic, we want to harness the strengths of our service users and communities to improve health and wellbeing.

6. Empowering our staff

As in the pandemic, we will rely on the creativity and commitment of our brilliant, diverse staff to continue adapting and improving care. While we plan a small number of programmes of work across our system, we will depend on our 100,000 staff to deliver most of the changes. We want to encourage our staff to go out and improve services, without waiting for permission, but to do so in line with these principles: thinking in particular about how we can improve prevention, offer more convenient, whole person care, tailor services for deprived groups, and harness the power of service users and communities.

Cross-cutting themes: lenses to apply to our strategy

Cross-cutting themes can be used as a lens to help us identify and develop our strategic priorities and strategy, and to structure further engagement. Below are some examples of the themes that have been identified so far.

Cross-cutting themes could be adapted from the four statutory purposes of an ICS:

- Improving health and care outcomes
- Efficiency, productivity and system sustainability
- Addressing health inequalities
- Supporting the social and economic resilience of our communities

Other cross-cutting themes previously proposed or identified during engagement for consideration:

- Person-centred, integrated and joined-up services which are inclusive, accessible and trusted
- Transformation (of our workforce, our care, digital and data, estate, investment and funding mechanisms)
- Sustainable services, a green system, and support our communities as anchor organisations
- Effective allocation of resources (in the context of a medium term financial strategy)
- Trusted and inclusive services
- Culture (noting need to define this)
- Workforce capability and capacity
- Empowering local people to take control of their own health
- Co-production with local people

Our approach to identifying strategic priorities for cross system action

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- In discussions so far, our senior leaders have agreed we want to home in on a very small number of big opportunities to improve health and care through cross system action.
- We want to focus primarily on significant, concrete problems or opportunities which, if addressed, would deliver major improvements for our service users.
- This will help us ensure that our strategy stays focused on things that really matter to local people and that we can monitor progress against tangible goals
- We need to be as clear and specific as possible about the problem, challenge or opportunity – so we can think through strategic options for addressing it
- We would want to ensure that partners across our system support these priorities, reflect them where needed in their own strategies and plans.

What should it mean to be a selected as a priority for our strategy - a proposal for discussion

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- An intensive process to review our current approaches, the existing evidence and identify strategic options for cross-system action in the Autumn

- A commitment in principle to allocating dedicated resources to support cross system work on design and implementation of solutions, subject to continuing appraisal of value for money, and resource to apply good practice in collaborative improvement?

- A principle that the Board and Partnership should dedicate particular attention to overseeing progress in delivering our strategic priorities and monitoring impact, with dedicated time on Board and Partnership agendas and agreed reporting measures?

- Ongoing engagement with service users and the public on the design of solutions for selected priorities and active involvement of communities in monitoring impact?

Agreed criteria for selecting a good strategic priorities

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Test 1: **Size of the opportunity**	Would addressing this problem or pursuing this opportunity deliver substantial improvements in health and care for our communities?	For example could we significantly improve outcomes, efficiency and address inequalities?
Test 2: **Need for collaboration**	Is this a problem or opportunity where different parts of our system would really benefit from working together?	For example, are there substantial benefits in pooling knowledge and expertise and joint working? Do different parts of our system need to redesign care together? Do we need to build some shared infrastructure?
Test 3: Feasibility	Is it realistic to believe we could make tangible progress on this area within the next 3 to 5 years?	For example, can we envisage a strategic approach that would allow us to make significant progress? Could we find the will, capabilities and resources to implement it?
Test 4: Strategic coherence	Put together, do our selected priorities add up to coherent consistent, and coordinated approach?	For example, does one priority support another. Do they add up to more than the sum of their parts?

1) Prevention & wellbeing - How can we become better at preventing ill-health and helping people to live healthy lives?

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Potential strategic priority		Our three main assessment criteria		
Ensuring that everyone in SEL receives convenient and effective primary and secondary prevention services	Many people in South East London (in particular those from deprived groups) do not receive the full range of proven primary and secondary health prevention services including vaccinations, health checks and screenings. We know that if we were to systematically deliver proven interventions to a high standard, this would have a significant impact on health outcomes and health inequalities. There is an opportunity for us to review our current approaches, test against approaches in other systems, potentially develop new delivery models for preventative care, and benchmark progress across SEL.	Size of opportunity	🟢	Strong potential to improve outcomes and address health inequalities
		Need for collaboration	🟢	Scope to accelerate progress through collaboration across our system.
		Feasibility	🟢	A clear evidence base on many interventions, scope for measurable improvement with clear targets, but need to focus the work.
Supporting people in South East London to live the healthiest possible lives.	Many people in South East London are living unhealthy lives, with poor diets, low levels of physical activity and high alcohol and drug use, alongside loneliness and other social factors that drive poor health. We know that achieving even modest changes in people's lifestyles, though difficult to achieve, would translate into better health outcomes, particularly for children and people from deprived groups. We also know it should in time help to reduce avoidable health and care costs. We might pool insight and expertise to develop a more coherent and effective approach to supporting healthy living across South East London with clear metrics for success.	Size of opportunity	🟢	We know even modest changes in lifestyles could significantly improve health outcomes.
		Need for collaboration	🟢	Scope for innovation and sharing of learning, including through VCSE and other partnerships.
		Feasibility	🟡	Lack of clarity on best overarching model. Could we deliver tangible improvement in 3-5 years?
Using our combined resources to improve the socio-economic conditions driving poor health in SEL.	People in our most deprived communities are struggling with poor housing and living environments, air pollution, access to affordable healthy food, poor jobs and unemployment, poverty, debt and other socio-economic factors that are driving poor health and wellbeing. As a collective, we are the largest employer in SEL and one of the largest purchasers, property owners and investors. We could harness our collective political economic power to influence poverty and inequality more directly, for example expanding current work on living wage and employment, investing in job creation and social enterprise or, like some health providers, investing in housing.	Size of opportunity	🟢	Huge potential opportunities for improvement, which should in theory translate to better outcomes and lower health and care costs.
		Need for collaboration	🟢	Only likely to make a tangible difference through coordinated collective action.
		Feasibility	🔴	Do we have the levers to effect tangible change in 3-5 years, beyond anchors work already in train?

2) Children & Young People: How can we ensure that children and young people in South East London get the best start in life?

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Potential strategic priority		Our three main assessment criteria		
Ensuring children and young people can access effective early intervention services for mental health challenges.	Children and young people in South East London are struggling with emotional wellbeing, anxiety, depression and eating disorders post pandemic, with long waiting times and a limited range of services. We could work together to break the cycle of overwhelming demand, rationing, delays, exacerbation of conditions, and subsequent pressures on more specialist services. For example we might explore new community-led support and new partnerships with the VCSE.	Size of opportunity	🟢	Huge opportunities to improve outcomes and reduce need for costly specialist services.
		Need for collaboration	🟢	Need for partnership working to develop innovative models, QI and benchmarking.
		Feasibility	🟢	Tested alternative models including peer support,
Ensuring that mothers, children and families receive effective pre-natal, postnatal and early years support.	Many babies, young children and their families in South East London do not receive effective pre and post-natal support, healthy eating and nutrition, mental health, and social support/parental interventions. We have the opportunity to review our range of services spanning primary, community, social care and the hospital system to develop a more coherent and effective model.	Size of opportunity	🟢	Evidence of longer term impact of early years support on health and life chances.
		Need for collaboration	🟢	Need for collaboration across health, care and VCSE services, potential for QI & benchmarking
		Feasibility	🟢	Effective models to draw inspiration from.
Ensuring that young people can access tailored primary and community services to meet their needs	Our traditional models of primary and community care are not designed to meet the needs of adolescents and young adults. There is some evidence that some struggle to access convenient and appropriate physical health, mental health and sexual health services and support for health and wellbeing. We could work together on tailored models of care for adolescents and young adults, harnessing digital tools or expanding the wellbeing hubs in some boroughs.	Size of opportunity	🟢	Some scope to improve outcomes and avoid more serious problems and costs.
		Need for collaboration	🟡	Potential benefits from joint learning, but progress already happening at borough level.
		Feasibility	🟢	Well established models such as young people's wellbeing hubs, including in SEL.
Ensuring that children with long term conditions in SEL can access proactive, joined up and effective care to manage their condition	Children with long term conditions such as asthma, epilepsy and sickle cell disease in SEL do not systematically receive proactive, joined-up care. There is scope to intervene earlier, support prevention, deliver more coherent packages of health care, social support and support, and develop team-based models that make better use of staff and resources, including hospital specialists.	Size of opportunity	🟡	A relatively small cohort, although significant impact on longer term health and life chances.
		Need for collaboration	🟢	Need for collaboration across primary care, hospital services and social are.
		Feasibility	🟢	Good models to draw from, including work in SEL on asthma and other LTCs.

3) Adult mental health and people with learning disabilities: How can we ensure earlier intervention and more appropriate and effective support for people facing mental health challenges and people with learning disabilities?

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		Our three main assessment criteria		
Ensuring that adults across South East London can access effective support to maintain good mental health and wellbeing.	At present, adults in South East London have access to limited and variable support to maintain good mental health and wellbeing, with variable preventative support in primary care and a patchwork of voluntary sector services, more focused on people who already have significant needs rather than prevention. There might be scope for concerted cross-system action to raise awareness of opportunities to maintain good mental health and avoid problems developing, for example through supporting healthy lifestyles and social networks.	Size of opportunity	🟡	Unclear how great an impact concerted effort would have on prevalence of conditions.
		Need for collaboration	🟢	Need to pool expertise and learning across sectors including social care and VCSE.
		Feasibility	🟡	Unclear whether there is a coherent and evidenced model for us to build on.
Ensuring that adults in SEL have rapid access to a broad range of effective early intervention services for mental health challenges.	Adults in South East London are struggling to access timely and effective early support for mental health issues, emotional wellbeing and broader health, care and social challenges. This is leading to the development of more severe mental health problems, avoidable exacerbation (e.g. psychosis) and increasing demand for urgent care and more specialist mental health services at significant cost. There is scope for partnership and innovation to develop a broader range of early intervention services, working across health, social care and the VCSEE, to achieve the impact seen in other local systems.	Size of opportunity	🟢	Significant scope to improve outcomes and reduce avoidable healthcare costs.
		Need for collaboration	🟢	Need to pool expertise and coordinate change across primary, community, VCSE and urgent care. Need for benchmarking on impact.
		Feasibility	🟢	Well established models including joint health and care teams and peer-led crisis support.
Ensuring that people with learning disabilities in SEL receive proactive, holistic and tailored care to support them to protect their physical and mental health	Many people with learning disabilities have a complex set of physical health, mental health and social needs but do not receive sufficiently proactive, holistic and joined up care to protect their health and maximise their independence and quality of life. People with learning disabilities struggle to access preventative services and appropriate treatment services, with scope to improve quality of life and life expectancy. We could pool expertise and work together on a new model of joined-up, team based support for people with learning disabilities to deliver much more proactive, whole person care.	Size of opportunity	🟡	A small cohort. Could be addressed through larger programme for people with physical health, mental health and social needs.
		Need for collaboration	🟢	Need for collaboration across primary, hospital, social care and VCSE. Scope for sharing and benchmarking across boroughs.
		Feasibility	🟢	Would build on well established team based models for people with multiple needs.

4) Primary and community-based care and interface with the hospital system: access to primary care, LTCs, and people with multiple needs

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Potential strategic priority		Our three main assessment criteria		
Ensuring that people across SEL can access easily and conveniently appropriate primary care services	People are struggling to access primary care services conveniently and in the ways they would like, with frustration about waiting times, and ability to chose between online and face to face appointments. Potential for joint working to harness technology and make better use of the primary and urgent care workforce across our system.	Size of opportunity	🟡	Significant scope to address public concerns. Impact on outcomes less clear.
		Need for collaboration	🟢	Requires collaboration across primary care and broader urgent care system.
		Feasibility	🟡	Major workforce and other challenges
Ensuring that people with long term conditions receive high quality joined up and convenient care spanning the primary, community and hospital system.	People with long term conditions don't consistently receive joined-up care, reporting that their care is often from many disparate teams, with frequent travel to services on different sites. This fragmentation also leads to duplication between different teams and poor use of staff and resources across primary and secondary care. We could pool expertise to develop a more coherent team based model of care for these groups, based in the primary and community system, but also focusing on improving joint working and coordination with hospital specialists.	Size of opportunity	🟢	Significant opportunity to improve outcomes and make better use of resources.
		Need for collaboration	🟢	Need for team-based collaboration in primary and community system and with hospitals.
		Feasibility	🟢	Well established team based models to draw from. Political imperative and potential additional resourcing from the Fuller Review.
Ensuring that people with multiple physical health, mental health and social needs in SEL have access to joined-up, team-based care close to home.	Many people in South East London with multiple physical health, mental health and social needs do not receive sufficiently proactive health and social support to help them cope with challenges and live good lives in their communities. The result is poorer outcomes and also avoidable use of urgent care services, hospital stays and residential care, as well as pressures on other public services. We could pool resources to develop an effective model of intensive, wrap around care for these groups.	Size of opportunity	🟢	Major opportunity to improve outcomes and reduce costs and pressures across system.
		Need for collaboration	🟢	Requires cross system action, potential cross system services and infrastructure.
		Feasibility	🟢	Well-established models to build on, scope for rapid roll-out. Investment required.
Ensuring that people from the most deprived groups in SEL can easily access tailored and effective primary care services	People from the most deprived groups are less likely to be registered with a primary care practice and, even when they are, appear to face particular challenges in securing high quality preventative care, treatment for care, and support for long term conditions. We might pool expertise to develop more effective models of primary care for our most deprived neighbourhoods or groups of service users, drawing on established approaches such as those developed by the deep end network.	Size of opportunity	🟡	Smaller cohort, but significant scope to improve outcomes and address inequalities.
		Need for collaboration	🟢	Would require collaboration across services and scope to pool expertise on design.
		Feasibility	🟢	Established primary care models for deprived communities, homeless and asylum seekers.

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Annex

Engagement timeline and summary of outputs so far

Overview of engagement so far

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Public webinars and chat forums

The ICS hosted two online webinars aimed at local people and the VCSE. These sessions were joined by 140 people and aimed to share our ambitions and approach to developing a new strategy for our system and gain input on what we should focus on and what opportunities we should explore. Additionally, we hosted chat forums with local people, on the SEL engagement platform ‘Lets Talk Health and Care’.

100 leaders event

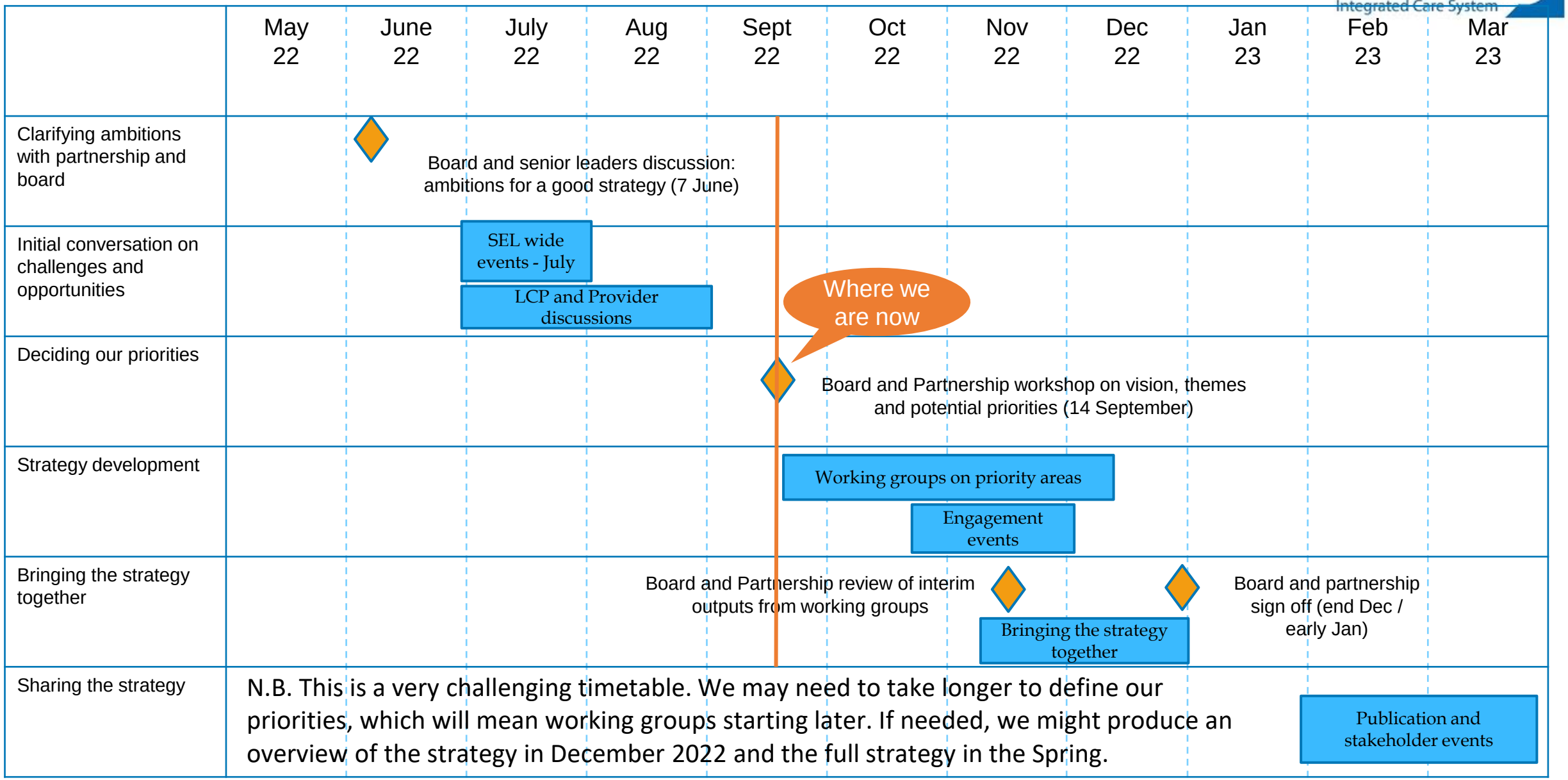
The ICS hosted a leaders event at The Oval bringing together 97 leaders from across the system to share our ambitions and approach to developing our integrated care strategy, shape our vision for our future health and care system, identify potential strategic priorities for SEL wide action and to start thinking about our options and approach to tackling these issues.

LCP and provider stakeholders and staff

Currently ongoing

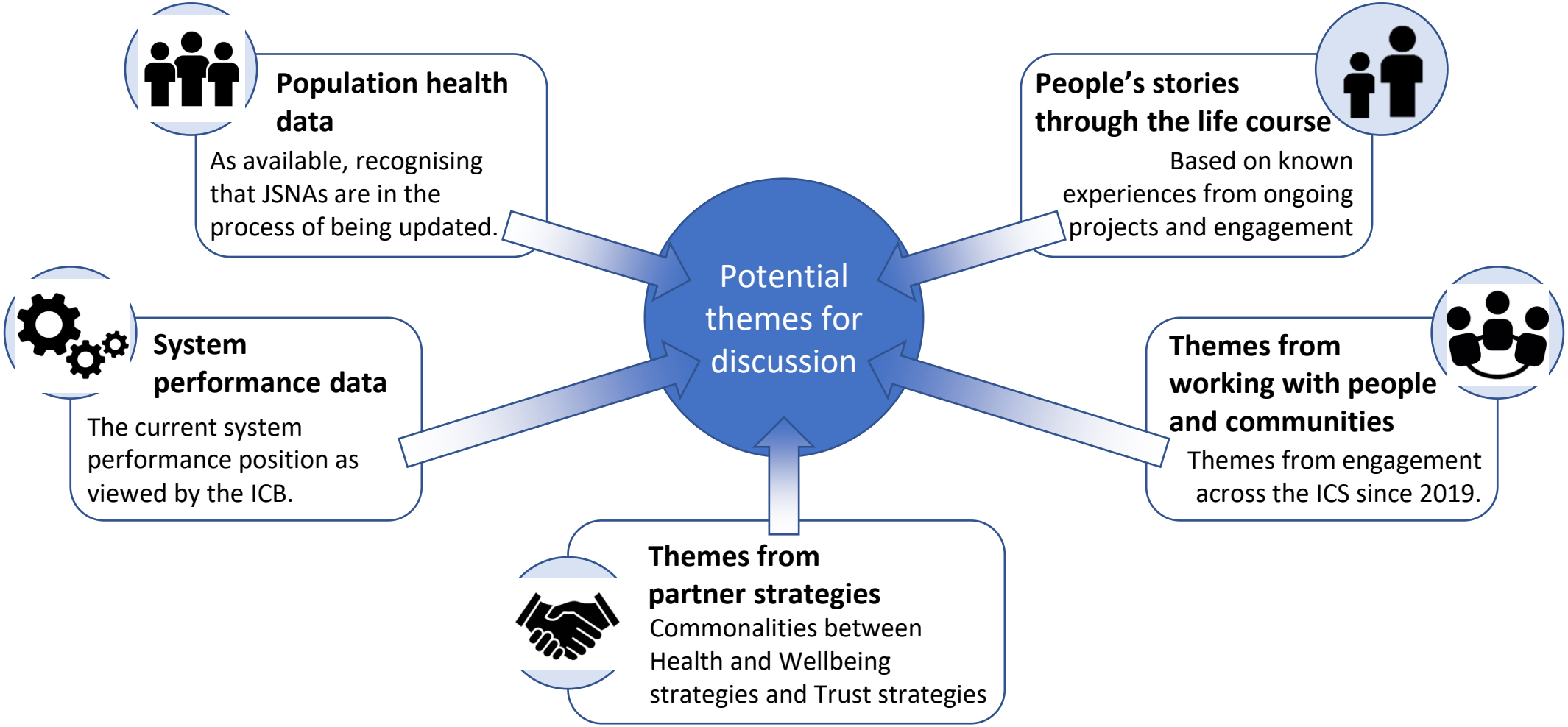
Providers and local partnership are currently engaging with staff and key stakeholders on the challenges we face as a system, the biggest opportunities for the system to work together and the “golden thread” that flows through our system, place and organisation strategies.

High-level timeline



Our starting point – where we are as a system

Five sources of information were initially collated and reviewed:



Our starting point – where we are as a system

Source of information	Overview
People's stories along the life course	People's experiences differ; whilst many receive excellent care, there is room for improvement, particularly regarding addressing known inequalities around protected characteristics including race. Pockets of patient-centred excellent care are evident, including examples of holistic approaches which bridge healthcare, social care and support from the Voluntary, Community and Social Enterprise (VCSE) sector. These provide evidence of the opportunity for improvement.
Population health data	South east London faces significant health inequalities. There is significant variation across the six Boroughs, although all contain areas of high deprivation which is linked to poorer health; life expectancy and healthy life expectancy differ both between and within Boroughs. The five highest risk factors are smoking, high systolic blood pressure, high fasting plasma glucose, high body-mass index and high LDL cholesterol.
System performance data	Our system is facing continued pressure across all areas, which is impacting on key performance indicators (e.g., A&E waiting times, elective RTT). COVID-19 continues to have an ongoing impact as the system looks to manage the backlog. However, opportunities for improvement have been identified and a number of key programmes are underway at system, place and organisational levels.
Themes from working with people and communities	Over the past three years there has been significant work with our people and communities at system, place and organisation levels. A review of outputs from selected processes suggests our people and communities want to see a more joined-up and patient-centred approach to care. There is a push to increase the role of the VCSE and communities in shaping care, and to recognise their contributions to care delivery. Trust and inequalities in access and outcome are critical issues.
Themes from partner strategies	The Borough Health and Wellbeing Strategies and Trust strategies highlight a commitment from across the system to partnership working. Common themes can be seen (for example, four Boroughs have specific priorities around obesity or ensuring a healthy weight). It is noted that many of the Health and Wellbeing Strategies are under review, and remain part of an ongoing process of development, including with our people and communities.

Our seven initial themes for engagement with leaders, staff and communities (July and August 2022)

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1	**Prevention & wellbeing**		How can we become better at preventing ill-health and helping people to live healthy lives?
2	**Children and Young People**		How can we ensure that children and young people in South East London get the best possible start in life?
3	**Access to good primary care**		How can we ensure access to convenient, high quality primary care with our available staff and resources?
4	**People with complex needs**		How can we deliver well-coordinated, joined up and whole person care for people with long term conditions and complex health and social needs?
5	**Adult mental health**		How can we ensure earlier intervention and more appropriate and effective support for adults facing mental health challenges?
6	**A sustainable system**		What big things could we do across our system to make better use of our resources so we can meet demand and invest in better care?
7	**Health Inequalities**		What targeted action should we consider across our system to improve access, quality and outcomes of care for specific social groups?

N.B. These themes are our 'starting point for discussion' – not our proposed priorities for the strategy!

Feedback on engagement so far: what do you want the health and care system to look like in 10 years?

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Care and treatment is provided in the most suitable environment, close to where people live

We focus on wellbeing and the wider determinants of health – responding to poverty and deprivation

Joined-up/coordinated, integrated, responsive services, underpinned by integrated digital infrastructure

Local people feel heard, and we focus on great outcomes that matter to local people

A greater focus on the whole person and a 'whole family' approach to health (person centred services)

Staff morale is high, turnover is low, and staff are well trained/capable

We empower local people, and treat them as equal partners

Equitable services, that are easy to access - no one gets left behind

Staff are empowered and we achieve local determination

Children are thriving, and living healthier, happier lives

High standard of care for everyone: technically competent and compassionate

Funding and resources are transparent, and there is a shift to sustainable funding for prevention

There is a focus on prevention and early intervention, which has resulted in reduced pressure and demand for acute and emergency services

Challenges and opportunities identified for each engagement topic, and common themes across all seven

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Addressing health inequalities

- **Institutional and medical mistrust in statutory orgs**: i) we need to develop a cross-system 'currency' so we can measure, compare and improve how we rate on this; ii) we need to change how we work with communities by championing **co-production**, **working with community orgs**, and addressing cultural issues
- **We don't know where to focus our efforts because we don't have access to the data we need**: i) we need to reinvigorate work to standardise the collection and **sharing of data** within the ICS; ii) develop a central IG function to provide support to (smaller) orgs within the ICS to share data

Ensuring a sustainable system

- **Workforce capacity and transparency around capabilities, noting the anchor agenda is a key opportunity to address this. In particular:** i) developing a sustainable VCSE workforce; ii) supporting workforce education iii) system approach to supporting **carers**.
- **Increasing funding and resource in the community for social prescribing and prevention activities**
- **Co-producing proactive and responsive services so these work for local people and they will want to access them e.g. neighbourhood-based teams**

Prevention, health and wellbeing

- **Poverty, social conditions and environment** (need to target certain areas)**:** i) make every contact count, working with private services who enter people's homes; ii) developing jobs in local communities; iii) social prescribing
- **Supporting people to be healthy and age well:** i) what matters to people and how create behaviour change?; ii)develop **trauma-informed approach**; iii) advocacy and **empowerment** key

Children and young people

- **Children's mental health and emotional wellbeing:** i) address waits; ii) provide services CYP and families want, that are **culturally sensitive** and trauma informed; iii) provide services close to home; iv) partner with schools, FE and HE; v) improve services for ASD & ADHD
- **Phases of childhood and transitions to adult services:** i) providing CYP services up to 25yrs; ii) develop 'core offer' across SEL for key stages

Adult mental health

- **Access to early support and responsive services:** i) co-produce solutions; ii) introduce no-wrong door policy (currently ridged criteria for access) iii) more neighbourhood based services iv) review crisis/psychosis services
- **Trust and experience of care:** i) diverse workforce; ii) more culturally sensitive services, iii) improve transition between services
- **We don't provide holistic person-centred care**

Primary care

- **Current primary care offer doesn't meet/suit needs of people, and they are struggling to access services, particularly deprived groups:** i) social prescribing and prevention to reduce demand; ii) share data; iii) review access (111) and build flexible offer around needs
- **Workforce:** i) New models; ii) Consistency of GP contract delivery; iii) sensitivity training; iv) cross-system recruitment campaigns

People with complex needs

- **Lack of proactive care, or access to additional support in community:** i) from risk averse to trust culture; ii) asset-based community develop (spread best practice) iii) **support carers**
- **Our system is complex and difficult to navigate:** i) review access to social prescribing; ii) holistic approach at point of access
- **Empower people to take responsibility for own health**

What's missing…

- Maternity services and/or women's services
- End of life care
- Social care integration/children's social care
- Providing more services in the community
- Cultures and behaviours, and changing incentives in the system
- Working differently: Harnessing our collective power to lobby for national change
- Systemic racism and racial disparities

South East London Integrated Care System

NHS South East London