Our Healthier South East London
Integrated Care System

NHS

Our Healthier South East London Recovery Plan

Working together to improve the health and wellbeing of our neighbourhoods and communities

October 2020

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Our Healthier South East London Recovery Plan

Our Healthier South East London
Integrated Care System

CONTENTS

Our Healthier South East London
Integrated Care System

NHS

Section 1

Overview and Context

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Who we are

The London boroughs of Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley are home to two million people, supported by:

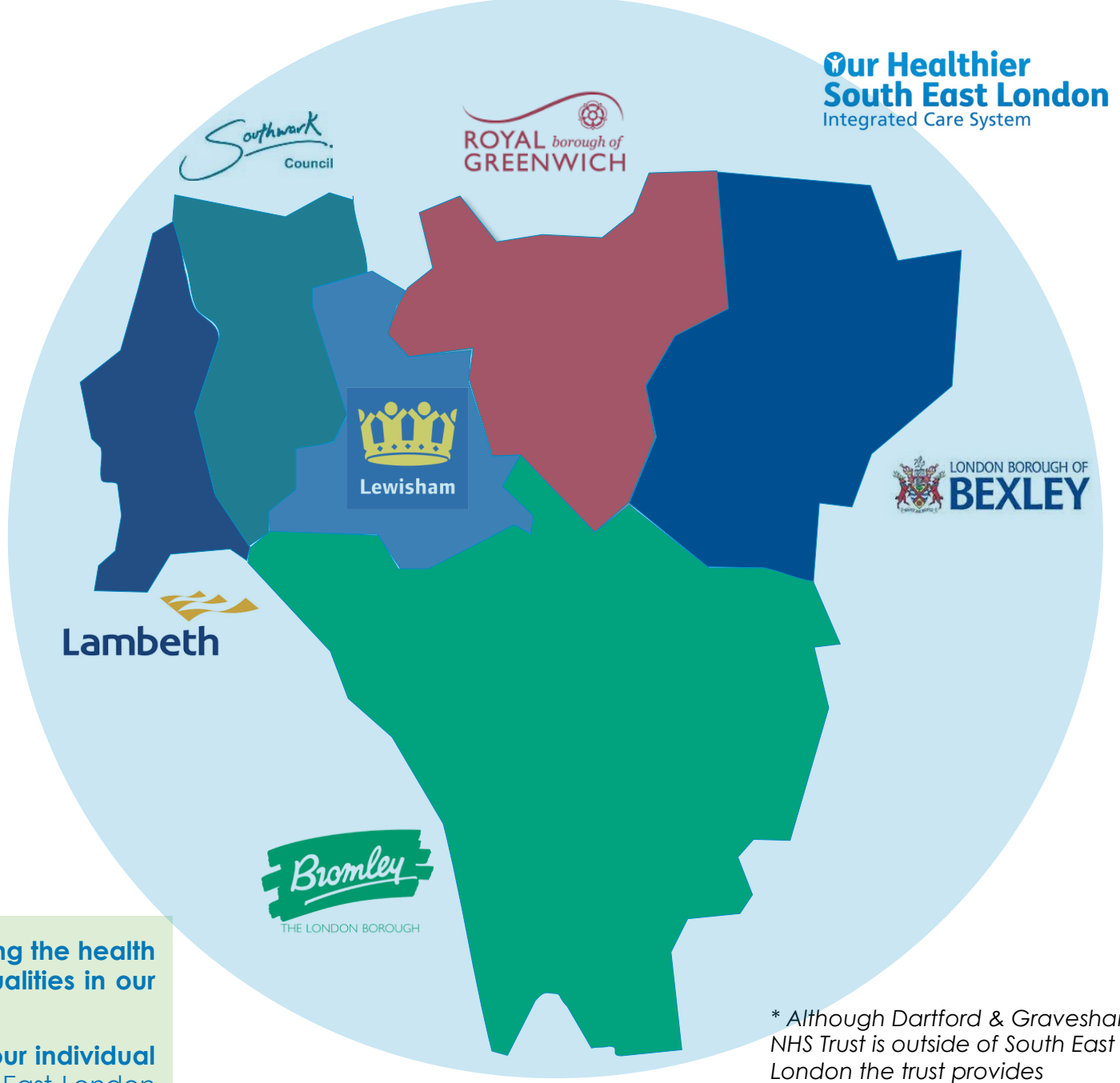
- The six South East London local authorities
- 212 individual GP Practices
- Guy's & St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Lewisham & Greenwich NHS Trust
- Oxleas NHS Foundation Trust
- South London & Maudsley NHS Foundation Trust
- Bromley Healthcare
- South East London Clinical Commissioning Group
- Dartford & Gravesham NHS Trust*
- Thousands of local voluntary & community organisations

This plan describes our work as a "system of systems" providing health and care support and services, including:

- our work as South East London Integrated Care System
- our three Provider Collaboratives
- our six Local Care Partnerships
- our 35 Primary Care Networks

The partners in Our Healthier South East London are central to improving the health and wellbeing of our population and to tackling long-standing inequalities in our communities. However, we recognise this is only one part of the story.

Our South East London recovery plan has been designed to support our individual borough plans for recovery including the wider work of the six South East London councils in supporting neighbourhoods and communities to "build back better".



** Although Dartford & Gravesham NHS Trust is outside of South East London the trust provides significant numbers of hospital services to Bexley residents*

Introduction to this plan

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Integrated Care System

COVID-19 has impacted every one of our communities, the social and economic life of our boroughs, our public services and our voluntary and community sector. Data shows the pandemic has already disproportionately affected older people, people living with one or more long-term conditions or disabilities, those from a black and/or minority ethnic background, people living in areas of existing deprivation and key workers.

We are proud of the way people across South East London have come together and our health, care and other vital local services have responded to the un-precedented pressures upon them since March 2020. However, we are also aware of the tragic cost to South East Londoners of the last six months.

In the aftermath of the first wave of COVID-19 we have been working together to support those impacted and the services upon which we all rely - recognising that what we mean by "recovery" in this context will need to be as broad and deep as the impact of the pandemic itself:

- **On an individual level** this means supporting those who are COVID positive or living with the ongoing effects of COVID-19 infection through their personal recovery.
- **On a borough level** it means ensuring that our health and care plans align with the broader wok of our six local authorities to enable social and economic regeneration in the aftermath of the first and any subsequent waves of COVID-19, addressing the underlying inequalities which have contributed to and been exacerbated by the effects of COVID-19.
- **On an organisational level** we will continue to support the restoration of the health, care and broader services to all parts of South East London – including our acute hospitals, mental health services, primary and community care teams and the vital role of the voluntary and community sector.

Even as we develop plans, engage with local individuals and communities, and take concrete steps towards this vision of recovery, we recognise the enormous uncertainty which surrounds all of our lives.

The success of our recovery will depend on our ability to develop and deepen joint-working and improve outcomes, whilst at the same time managing and mitigating the ongoing risks and impact of COVID-19.

Over the next year we will work within national and local policy and funding arrangements which are still developing. The journey will not be simple and we will not always be able to move in one direction: as we respond to the evolving situation, we will need to consider at each stage where we need re-implement local or organisational measures to safeguard staff and public which were stood-down after the first wave; and in relation to all aspects of this plan, we must be able as a partnership to flex our efforts to support immediate needs, and provide mutual aid, whilst remaining focussed on the long-term health and wellbeing of our populations.

In this context, ongoing engagement across South East London will be central to the success of this plan – across our six boroughs, with all our communities (including traditionally excluded groups) and with all those providing essential health, care and supporting services, to move forward from COVID-19 together.

Local and South East London recovery planning

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Integrated Care System

Lambeth	Southwark	Lewisham	Greenwich	Bexley	Bromley
Lambeth Together Recovery Plan	Partnership Southwark Recovery Plan	Lewisham Health & Care Partnership Recovery Plan	Healthier Greenwich Alliance Recovery Plan	Bexley Local Care Partnership Recovery Plan	One Bromley Recovery Plan

- In each of our six boroughs, we have been working as partnerships of local authorities, NHS and voluntary & community sector organisations with local people to shape our long-term aspirations and to apply the lessons of the last six months.
- Our six borough recovery plans translate these conversations into priorities and next steps for how we will protect individuals and services, tackle inequalities, and develop new ways of working which improve local health and wellbeing whilst strengthening our neighbourhoods and communities as a whole.

Our Healthier South East London Recovery Plan

Our Acute Provider Collaborative, Community Provider Collaborative, and South London (Mental Health) Partnership

- 95% of South East London residents get all of their care within our Integrated Care System area, alongside significant "in-flows" from other areas and our specialised portfolio of acute hospital-based services.
- Our Healthier South East London plan builds on our borough plans to set out the support for individuals and families across all of our communities and at all stages of their lives: to stay safe during the ongoing Covid-19 pandemic, and to enjoy improved life-long mental and physical health.
- Whilst our immediate priority is the safety of patients, service users, the staff that support them and the communities in which they live, we recognise the urgent need to restore services affected by Covid-19 in a way which continues to improve the way we work;
- and we recognise the need to establish as part of this plan a clear set of principles and roadmap for how we will develop and deliver our shared priorities, in partnership with local providers of local health and care services, and the communities we serve.

The context for our recovery

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In the autumn of 2019 we set out plans as South East London for how we would respond to the ambitions of the Long Term Plan for the NHS, the London Vision and the opportunities presented by being London's first Integrated Care System. These plans include how we are transforming and joining-up the experience and outcomes of care, supporting each other to improve our finances and performance, and reforming the way services are planned, commissioned and delivered. The associated priorities went on to form a core part of all of our operational plans for 2020/21.

The COVID-19 pandemic has necessitated radical changes in our plans and how we work. The aspirations that informed our plans for this year, including around the development of better person-centred, co-ordinated care for all of our population, remain as important today as ever. In parallel, we continue to work to a shared ambition to see London become the "healthiest global city", tackling not just the effects of ill-health amongst Londoners but the underlying causes. Nonetheless, we have had to adjust rapidly to respond to the new and immediate threats which have arisen since March 2020.

Since March we have worked together to control and respond to the spread of COVID-19, including rapidly increasing our critical care capacity and enhancing our joint work across health and care, whilst ensuring access to vital Personal Protective Equipment (PPE) and testing services. Alongside this our clinical teams and professionals have led a rapid transformation of our "pathways" of care – including enabling people to access advice and support virtually, enhancing our community-based response teams, and improving the support to people being discharged from hospital.

All of these developments build on existing foundations in each of our six boroughs and across South East London but also point to how we can work together to build a better future for our residents and those in need of long-term support and care. In each area we have reflected on the lessons of the past six months, including those arising from Black Lives Matter and the Public Health England analysis of the disproportionate impact of COVID-19 across different parts of our society.

We have recognised that whilst we continue to manage and respond to the threat of COVID-19, we also need to plan for "recovery" – addressing the impact on public health, on staff and voluntary & community sector partners, on the patients and service users of health and care services affected by restrictions and disruption during the pandemic: all whilst working with local communities to improve population health and wellbeing.

This plan includes both immediate next steps and a number of shared priorities which we will continue to develop over the next 18 months. We need to apply the learning from the first wave of the pandemic now, to address the impact on those most affected including our BAME communities, people living in areas of deprivation, older people and those with existing health conditions; as well as the broader effects of lockdown on the mental and physical health of children and young people, neighbourhoods and communities, our local economies, and all of us living through the pandemic.

This document sets out some of our engagement and planning work to-date; immediate priorities and actions; how we will respond jointly to issues as they arise; and how we will work to co-develop a better future with people across South East London. We will ensure change is appropriately phased, to enable us to move forwards together in a safe, inclusive and transparent way, evaluation and learning as we do: underpinned by a commitment to use this time to improve population health and tackle long-standing inequalities by empowering South East London's patients, service users, carers and staff.

Recovery planning and our "Phase 3" objectives

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Integrated Care System

Our Healthier South East London is working to ensure that the NHS services upon which all of our population rely are able to return as rapidly as possible to normal operation whilst we continue to respond to the challenges of COVID-19. At the end of July 2020 the NHS nationally in England set out priorities for Phase 3 of the response to COVID-19 (Phase 1 having started in February 2020 when a Level 4 National Incident was declared in response to the global spread of COVID-19; and Phase 2 in May 2020, when urgent services began to be re-started).

The objectives of the national NHS work around Phase 3 are:

- **Accelerating the return to near-normal levels of non-COVID health services**, making full use of the capacity available in the "window of opportunity" between now and winter.
- **Preparation for winter demand pressures**, alongside continuing vigilance in the light of further probable COVID spikes locally and possibly nationally.
- **Doing the above in a way that takes account of lessons learned during the first COVID peak**; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, and action on inequalities and prevention.

This plan forms a key part of our response to these national priorities, ensuring they are consistent with local plans whilst also providing detailed underlying activity and capacity forecasting, shared across South East London. Our current Phase 3 submission shows we have:

- **A positive overall aggregate position against national activity targets** – in most areas our plans meet or exceed national targets.
- **A positive overall position in performance on cancer, mental health, learning disabilities and autism** – although with specific challenges in relation to the pace of recovery around IAPT (access to psychological therapies) and Oxleas Out of Area Placements.
- **Our elective position, and specifically long waiting times, represents our largest area of challenge and concern**. We continue to work to identify further ways of reducing our 52 week forecast including a specific focus on dental services as the largest single driver of our year-end position.

Our Acute Provider Collaborative will play a key role in this process, working with our new Director of Elective Recovery; and we have further committed to establishing Clinical Networks to support all six high-volume, low-complexity specialties we provide plus dental services in order to maximise availability, productivity and efficiency in elective care to our communities.

Our plans are underpinned by a number of vital workforce assumptions and enablers. Our workforce and ability to recruit and retain staff is key to our activity and service transformation plans. There are a number of uncertainties and risks that we will need to manage, such as winter pressures, further waves of COVID-19, finance and available capacity, including the need to make use of independent providers to support cancer and elective services.

We recognise nonetheless the key role of all three of these areas – restoring services, managing winter, and applying the lessons of the first wave of COVID – to the success of our plans and aspirations for South East London.

Our Healthier South East London
Integrated Care System

NHS

Section 2

Our shared priorities

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Our shared priorities

Our Healthier South East London
Integrated Care System

This plan provides detail around how we will support neighbourhoods and communities in South East London over the next 18 months building on progress and learning since March 2020. Each area represents our specific, shared ambitions, and each will be needed to support the others:

1. Working with our staff and communities to keep each other safe	2. Taking practical steps to address existing and new inequalities	3. Supporting people to stay healthy and well at all stages of life	4. Restoring services and "locking-in" beneficial changes
We have worked hard as systems and as communities to bring the spread Covid-19 under control. Many sacrifices have been made and lessons have been learnt. **Nonetheless, we recognise that the risks have not gone away** and that it is critical we continue to manage these risks, even as we plan for and work towards recovery. **As we plan to "build back", we will continue to work together to help keep patients, service users, staff and residents safe** and to enable them to manage the ongoing risks from Covid-19 infection whilst still being able to access services and live their lives.	**South East London is home to many diverse and vibrant communities** but the pandemic has further highlighted the inequalities which persist within our society. **This includes the disproportionate impact of Covid-19 within our Black, Asian and Minority Ethnic Communities (BAME)**, those living in deprived areas, older people, and those with existing long-term health conditions and disabilities. **We will support concrete action and allocation of resources to tackle inequalities and to address the broader determinants of health and wellbeing** for all of those living in South East London.	**Giving our children and young people the best possible start in life** means re-starting key services and safely keeping open our schools and colleges; as well as targeted action on physical and mental health and wellbeing. **We will work towards improved health for our population as a whole** through immunisations, health checks, early detection and screening, and greater involvement of voluntary and community sector partners. **And we will further join-up support to those living with one or more long-term conditions** including for older people to stay healthy, independent and well at home, and for those in residential care.	**We will ensure people can access acute hospital services** including urgent and emergency care and elective care throughout the winter and any subsequent waves of COVID-19. **We will support primary and community care** in partnership with our boroughs and local voluntary and community sector to improve the way we work, building on innovation and collaboration developed prior to and during our response to the pandemic. **We will respond to identified priorities within our communities** including mental health support and services, support for Adult and Children & Young People's Social Services and Learning Disabilities.

5. Developing high-quality, joined-up and sustainable health and care systems

- **Our Primary Care Networks, Local Care Partnerships, Provider Collaboratives and Integrated Care System** are all vital components to enabling the success of this plan.
- **This is about supporting each other and providing mutual aid within our neighbourhoods, as boroughs and places, and as South East London** as a whole.
- **It is about developing better co-ordinated support and care**, built around individuals and carers, families and communities.
- **It is about bringing together the NHS, local authority and voluntary & community sector** ensuring information, resources and funding flow to where they are needed.

Our Healthier South East London
Integrated Care System

Overview

We will support the work within each of our six boroughs; our neighbourhoods and communities; our primary, community, acute and social services; our hospitals, care homes, surgeries, schools and shared public spaces – all to minimise COVID-19 infection and to equip people to stay safe and well during the ongoing pandemic.

This commitment extends to the 49,000 shielded residents in South East London who are at high risk from COVID-19 to make sure they can access the care they need in the community, safely and effectively; and everyone with long-term physical and mental health conditions, making sure that all our services take into account the new risks but also the vital necessity of being able to deliver face-to-face care.

- **South East London ICS will work community providers to support Primary Care colleagues** including:
  - **COVID community pathways across all six boroughs for symptomatic patients** supported by rigorous testing and remote monitoring.
  - **Green non-COVID pathways with hospital-level Infection Prevention and Control** to provide care in a safe environment, including for vulnerable and previously shielding local people.
- **Continued development of Green (COVID negative), Blue (COVID positive) and Amber (pending areas)** to enable us to maintain health and care provision across South East London, keeping our doors open whilst safeguarding key workers, patients, service users and carers.
  - **We anticipate having the ability to handle Blue (COVID) patients** at all five of our sites hosting emergency departments.
  - **This means mapping and segregating our hospitals**, by floor / building, with separate entrances and staffing.
  - **We are working with King's Health Partners Academic Health Science Centre** to continue to develop and share best-practice in Infection Prevention and Control across South East London and with national partners.
  - **Green (non-COVID) "pathways" within sites will help us keep open facilities** for functions such as diagnostics through any future waves of COVID-19.
  - **We will continue to secure extra Green elective care capacity** to help clear backlogs from the first wave of COVID-19, including he specialist work normally be undertaken at GSTT and Denmark Hill (for example, through transferring cardiac work to London Bridge).
- **Addressing the key lessons of the pandemic in enhanced support to Social Care and Care Homes:**
  - **Ensuring local facilities are in place for patients being discharged to avoid transmission of infection** from hospitals to care homes.
  - **Supporting the homecare workforce to implement robust infection prevention and control processes** with access to appropriate Personal Protective Equipment.
- **Where it is not possible to separate fully our community-based workforce or sites, we will use a combination** of testing, PPE, maximising home-based and virtual activity, zoning and "cohorting" to minimise risks of transmission across South East London between patients / service users and staff:
  - **Undertaking COVID status checking and ensuring appropriate PPE** for home-based services, with separate staff where possible.
  - **Increased virtual or home-based outpatient support**.
  - **Testing of patients pre-admission to bed-based services** with zoning of rooms, cohorting of bays, and separation of workforce.
  - **Shared mental health capacity and approaches** to help us maximise Infection Prevention and Control, supported by timely testing.
  - **Telephone, video and home-based support options** for mental health patients in the community.
  - **An additional focus on supporting mental health and wellbeing** including managing expected demand for IAPT and CAMHS support.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Key areas of immediate focus (South East London wide) 1/2

As London's first integrated care system and as a partnership of NHS, local authority and voluntary & community sector organisations, we will work jointly to develop best-practice in infection prevention and control, to reduce the COVID-19 transmission risk to the lowest possible levels and to mitigate the risks to our staff, patients, frontline workers:

- **We will continue to support access to and effective use of Personal Protective Equipment (PPE)** across all care settings, in line with Public Health England guidance.
- **We will provide strong infection control support to services** to ensure that best-practice is understood and being consistently applied.
- **We will continue to develop alternative and innovative ways** to access services, including virtually, where it is appropriate to do so.
- **We will ensure that face-to-face services are available** for those who need them.

Through this period we will work to mitigate disruption to health and care services and to ensure that insofar as possible our doors stay open to those in need - including through any subsequent COVID-19 outbreaks in London.

- **We will work across our health and care providers to prioritise access for those in greatest need** recognising the challenges that operating in a COVID environment bring in terms of our capacity, flow through our system, and the need to respond to "pent-up" demand from the lockdown period.
- **We will work to enable physical separation and "cohorting" within and between care settings** recognising the need to support each other to achieve this, given some of the limitations of our existing estate and the challenges of staff segregation particularly in small, sub-specialty teams and where care workers are supporting multiple clients in different areas of South East London.
- **In community services we will undertake a systematic process of audit and review** differentiating home-based services, site-based (outpatient) services and bed-based facilities across each of our four community providers.
- **For all home-based services, we will implement staff separation for COVID/non-COVID workforce where possible**, noting this will not possible in all areas. Patient and household COVID status will be checked and PPE utilised, approaches which will be maintained as we ramp up broader activity.
- **Site-based (outpatient) services will enable face-to-face appointments for urgent & priority patients plus alongside increased virtual and home-based care.** Approaches where we are unable to physically segregate will include maximising home-based visits / virtual activity plus cohorting within and across sites.
- **Bed-based services are being supported by patient testing pre-admission**. This includes physical separating of COVID and non COVID patients where sites allows plus zoning of side rooms and cohorting within bays, alongside workforce separation. Admissions will be made only where appropriate isolation can be assured. A South-East London wide pathway 2 (super augmented and augmented beds) is being developed to meet expected demand, including a projected COVID/ non COVID split.
- **Mental health will be supported by systematic process to ensure adherence to infection prevention and control guidance** as we plan for recovery and to meet demand for IAPT and CAMHS services.
- **This includes building in COVID escalation approaches with designated pre-admission cohorting by ward / facility whilst patients await test results** for bed-based services and timely processing of tests to support flow; with shared bed capacity plans across South London to enable best-in-class infection prevention and control.
- **Other site-based and MH community services will work to maximise virtual approaches to reduce face-to-face contacts**, with the majority of patients being managed through telephone and video contact or, if required, home-based visits. Where face-to-face appointments are required, the patient status will be checked and PPE utilised to minimise transmission with workforce separation wherever possible.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Key areas of immediate focus (South East London wide) 2/2

Primary care will be critical both to managing future outbreaks of COVID and ensuring broader system recovery, including access to key services throughout this period:

- **As an ICS we are committed to supporting primary infection prevention and control (IPC) in partnership with our community providers, including hub arrangements across all six of our boroughs** for symptomatic patients, with testing and remote monitoring supported by a South East London Standard Operating Model.
- **Green non-COVID pathways will be established with an equivalent level of Infection Prevention and Control to our acute sites** to provide community-based care in a safe environment for both staff and patients, including the vulnerable/ shielding cohort, wherever they live in South East London.
- **We will ensure effective use of our buildings and estates to deliver primary care to COVID and non-COVID patients** alongside diagnostics to support community services.

We recognise a specific need for action to ensure that social care and care homes are safeguarded through this period, learning from the lessons of the pandemic to-date.

- **We recognise our lists of shielded patients were drawn up at short notice.** These will be subject to regular review and checks to ensure people get the support they need.
- **We will work to ensure safe discharge facilities are in place to support discharge of patients who are symptomatic or known COVID positive.** This will help to avoid transmission of infection from hospitals to care homes with resultant risk of onward spread of infection. We are undertaking further urgent work to identify appropriate facilities, undertake demand and modelling, optimise existing infection prevention and control measures and prevent such transmission.
- **Home care data shows that a relatively small number of people receiving home care have needed to self-isolate during the COVID pandemic (<3%).** High quality and robust infection control processes and appropriate use of PPE are considered to be most effective and realistic way to prevent transmission of infection between the home care workforce and people receiving home care.

Excellent critical care is key to delivering the best possible outcomes for the residents of South East London and the people we look after in our hospitals from other areas. Supporting COVID-19 patients has required considerable expansion of critical care and we are now committed to doubling capacity on a permanent basis, focussed on our tertiary hospital sites.

- **This will involve aligning our existing strategic priorities and plans to the "right-sizing" of capacity to projected demand** ensuring best-in-class patient safety.
- **There has been a rapid ramp-up of critical care capacity across our ICS footprint** with positive collaboration across providers and the establishment of a Critical Care Hub to coordinate and oversee the delivery of our critical care response
- **Mutual aid and support will continue to be provided as required** across all sites in South East London, as we work through subsequent phases of COVID-19.
- **New staffing models are being developed and plans are underway to develop new roles** with our trusts are working together to train more critical care nurses.
- **We have submitted plans to double the permanent ITU capacity within South East London** over the next 6-12 months including expansion at Guy's and St Thomas' and King's Denmark Hill site, as well as critical care capacity on all six acute sites to support elective activity, maternity and emergency departments; and Extracorporeal Membrane Oxygenation (ECMO) capacity at Guy's and St Thomas'.
- **In parallel we have submitted plans to secure short-term surge capacity** which will rely upon some use of recovery and theatre space but can be delivered within 48 hours in the event of a further peak in COVID-19; and will ensure robust segregation of COVID-negative and COVID-positive patients.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Bexley Local Care Partnership

In July 2020, Bexley had 10,185 shielded patients; 4% of the total population. At the point when the national Lockdown was announced we were able to respond by building on longstanding integrated working across Adult Social Care, Public Health, Oxleas NHS Foundation Trust and NHS Bexley Clinical Commissioning Group.

The Bexley and Greenwich core strategy is to support people to remain at home with neighbourhood support. We have agreed to prioritise a "Home First" / "Home as Priority" approach to discharge in advance of and during any second wave.

Our work to mitigate the risks of COVID-19 include:

1. **Personal Protective Equipment:** Our joint PPE Task & Finish Group was set up early in the crisis resulting in easy-read, setting and role-based PPE guidance and training for care homes and other providers, adopted across London.
2. **Care Homes:** Continue to develop a "multi-disciplinary" approach to supporting care homes, bringing together professional teams, and including use of virtual vital signs monitoring and targeted support to care home staff.
3. **Rehabilitation:** Enhanced, therapy-led, home-based reablement with medical support to ensure for those admitted from home, the default destination from hospital is home.
4. **Community Beds:** Recognising that a minority of people who have tested positive will need a period of bed-based care to recover from Covid–19 prior to returning to their care home. We will ensure this capacity is available within our current intermediate care and hospice (for end of life) beds across Bexley and Greenwich.
5. **Supporting Discharge:** We remain committed to ensuring that patients are not discharged to care homes until we are sure they are Covid-negative.
6. **Shielding:** Scaling-up home visiting and voluntary support to patients who may need to shield and re-mobilising our Covid-19 Community Managed Service (Primary Care Hot hubs) as soon as they are needed.
7. **Rapid Testing:** Ensuring regular testing is available resources in place including mobile testing units with swabbing arrangements for care homes as required.
8. **Mental Health:** Joint work to provide the right clinical support to learning disability and mental health supported living settings – including a dedicated clinical lead, additional support from Mencap and early access to testing.

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Our Healthier South East London
Integrated Care System

One Bromley

Supporting our vulnerable residents

- **1500 residents have received support through our volunteering programme** with an average satisfaction score for this support at 4.8 out of 5.
- **Over 12,000 residents have been shielding with 1,700 receiving support from government** in the form of a weekly food parcel or support with obtaining medicines.
- **Of those shielded, requiring urgent support, 400 required some form of additional support** from the council.
- **Community Links Bromley (who run the matching and allocation of volunteers) have surveyed 400 of the 1000 mobilised volunteers**, who have been pleased with the training and support they have received (4.5 out of 5 score)
- **Shielding residents requiring urgent support from the government have been written to by Bromley Council** before the support from government ceased on 31st July, to signpost them to an assistance line for supermarket slots, volunteers or food bank referrals as appropriate.
- **A newsletter has been distributed to all households to keep them informed of the COVID-19 response** and to advise all residents of how to seek support and access a range of services.
- **Communication with volunteers to retain this additional capacity in the voluntary sector** is ongoing.

Safeguarding vulnerable residents

In order to safeguard our must vulnerable residents, we have mobilised the following new ways of working:

- **Discharge from hospital:** A new single point of access (SPA) for discharge was set up to support timely and safe discharges from hospital for those people who need more community support once they get home. So far, almost 2,000 discharges have been co-ordinated using the SPA discharge.
- **The Bromley Covid-19 Community Management Service:** linking closely with the hospital, was set up to care for people with mild symptoms of Covid-19 who are high risk, and those who need a clinical assessment.
- **Care Homes:** Bromley has a high number of care homes, with residents at higher risk of Covid-19. Care homes are being well supported by a multi-agency professional network which is providing proactive and reactive support to ensure residents are managed safely and confidently.

Wave 2 Preparation & Response

Our recovery plan is a key part of our response to any second wave of the Covid-19 pandemic in Bromley. We are:

- **Working collaboratively** to gather more intelligence on local inequalities to strengthen our response to reducing inequalities in our Borough.
- **Developing a robust and flexible demand & capacity model** to support planning.
- **Continuing to build and deliver on our 'planning for recovery' priorities** learning lessons from our experience in the first wave.
- **Focusing on winter planning with urgent care providers** to ensure that the right services are in place for all our residents and patients.
- **Focusing on flexing the workforce to support the frail and elderly population** and all other vulnerable groups.
- **Retaining resilience in Primary Care and the Primary Care Networks** through any subsequent waves.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Healthier Greenwich Alliance

Our Community Hub will continue to identify and support those in most need:

- **Support for the transition of current hub arrangements** into a new permanent model – **Live Well Greenwich**.
- **Working with voluntary and community services** to develop "hub and spoke" model which locates support at the heart of local communities.
- **Responding to emerging needs** such as employment, digital inclusion and carer support.
- **Our financial inclusion group covering the financial impact of Covid-19** ensuring strong links with business and adult learning to support people into employment.

Maintaining access to local health services – through the pandemic we have worked to ensure people can continue to access local health services.

- **Initial contacts have been managed virtually / by telephone** followed by face-to-face assessment at a local surgery.
- **A central face-to-face Covid-19 "surge site"** operated by Lewisham and Greenwich Trust (LGT) has been supporting practices during the pandemic.
- **Across primary, community and acute sites, services have been redesigned** in line with infection prevention and control guidelines
- **Virtually, face-to-face and home visiting** through NHS 111 and Greenwich COVID Management Service (CMS) led by Greenbrook with the Urgent Treatment Centre at QEH.
- **The surge site ready to reopen** within 72 hours if required.

Supporting 'Shielded' residents – support for people who have been shielded to return to a new normal life and to plan in the event for further lockdowns:

- **Working with local community groups and volunteers**, with a new "walk and talk" service for those experiencing anxiety leaving their homes.
- **Access to psychological and other mental health support** through our mental health and wellbeing services.
- **Expanding money management support** to help prepare for when the national food box scheme stops.
- **Access to welfare support/community food response** for those with no means to pay for food.
- **Development of key messaging and communications plans** for those shielding.

The Greenwich Coronavirus Outbreak Control Plan sets out how we will work with NHS Test and Trace including:

- **Focusing on prevention of transmission** as well as the management of outbreaks.
- **Embedding best practice in mitigating and managing Covid-19** with partners and communities.
- **Ensuring a rapid flow of relevant information** between local and national organisations.
- **Work with communities to inform, build trust and protect**, recognising the impact on BAME communities and disadvantaged groups.
- **Further develop our local testing** to complement the national test and trace system, with local control measures when needed.

As part of the London Coronavirus Recovery Cell (LCRC) jointly managing outbreaks in "complex settings" and community clusters:

- **A co-ordinated approach to care homes**, extra care housing, supported housing, local hospitals, workplaces, prisons, primary care, schools, nurseries and homeless hostels.
- **Improved understanding and access to services**, reduce transmission, protect the vulnerable and prevent increased demand on healthcare services.
- **Shared outbreak information** to facilitate appropriate measures,
- **A Single Point of Contact (SPoC)** within Greenwich to facilitate data flow, communication and follow-up.

Planning for future waves of Covid-19, Greenwich Public Health has been given £2.2m to support local measures to:

- **Prevent, control and manage the spread of Covid-19** including responding to outbreaks and building local capacity.
- **Implement local policies to control and manage spread of infections** in the community, care homes and supported accommodation.
- **Arrangements include with Lewisham and Greenwich NHS Trust (LGT) laboratories to establish regular Covid-19 testing of staff and residents in care homes** and supported accommodation facilities; securing PPE; staff training, PCR swab testing, root cause analysis and quality improvement methods to prevent and reduce transmission.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Lambeth Together

Our Recovery Plan sets out how we will work together to prevent, predict and manage subsequent waves of Covid-19, including:

- **Use of surveillance and early-warning data and intelligence** to alert to spikes in demand; promoting the importance of Test and Trace to identify and track cases (Keep Lambeth Safe); and sharing data to provide rapid and joined-up care and support proactively.
- **Responding in the event of a surge:** with an Outbreak Control Plan in place, overseen through the new Health Protection Board; Covid Borough Response Group arrangements ready; enhanced public guidance and communications, and support to staff.
- **Regularly refreshed and updated plans** across all health and care services to support people through winter.

Lambeth Together health and care partners have worked ever more closely together during the pandemic period. The Lambeth Covid Borough Response Group (CBRG) meeting twice weekly and chaired by the Strategic Director for Integrated Health and Care, worked with the wider south east London NHS and Lambeth Council emergency response: including discharge planning, managing demand and capacity, Personal Protective Equipment (PPE) provision, infection control advice, testing, support to care homes, delivery of medicines, food and essential advice to vulnerable individuals, mental health, children's and primary care. Successful examples include:

- **Set up of a network of food delivery hubs** across the borough with community groups dispatching 23,500 food parcels to vulnerable residents, as well as a delivery service providing medicines to shielded and vulnerable groups.
- **Our Covid Response Unit** working across Lambeth's 41 GP Practices, 9 Primary Care Networks, the Local Medical Committee, GP Federation and the Clinical Commissioning Group; supporting remote working, including providing hundreds of laptops and remote access software tokens; creating dedicated Covid-19 'hot' clinics to provide services to patients with suspected Covid-19 symptoms; a transport service with local black taxis to help patients receive care; home-based phlebotomy services for shielding patients; support to GP practices to access PPE and other urgent supplies; antibody and antigen testing; clinical and health protection advice and guidance; and help with staff accommodation and illness cover.
- **A comprehensive package of support for social care providers** including care homes, with urgent access to PPE, infection control, advice and guidance, key worker testing, capacity and resourcing.
- **Continued mental health support** including to those who may be a risk to themselves or others, or in need due to isolation and / or self-neglect. Anyone who needs urgent and crisis support from our child and adolescent or adult mental health services can still be referred. We have extended our online professional counselling service Kooth working with 18-25 year olds to support all young residents.
- **Supporting hospital capacity through creating hubs at both Guy's & St Thomas' and King's** that act as a single point to facilitate and support discharges out of hospitals and secure additional community-based capacity.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Lewisham Health & Care Partners

A cross-sector COVID-19 Health Protection Board has been established to oversee our Local Outbreak Control Plan.

In Lewisham our partnership response to COVID-19 was swift with emergency structures put in place quickly, supported by coordinated communications across partners and with the local population.

In planning to mitigate and manage any subsequent waves, we will explicitly build on the accomplishments and the lessons of the first, including:

- **Continue with robust infection control practices** including support to our secondary school following reopening in September 2020.
- **Target services to those most in need quickly** using population health data. This information continues to be built on and refined.
- **Continue with collaboration between health and care providers** to ensure that those most in need receive relevant care and support.
- **Enable access to key services through use of digital for consultations and patient support and providing safe face-to-face services** supported by PPE, training and effective use of sites.
- **Consultant Connect provides access for GPs to specialist input** reducing the need for patients to be seen at the hospital.
- **Support for staff to work remotely where possible.** Laptops and telephone solutions are in place and continue to be supported.
- **Extra critical care capacity available as required** to support any second wave and winter plans.
- **The 2nd COVID Centre which was set up for the first wave of COVID** to be reinstated if needed.
- **The infrastructure to support shielded people will be maintained** to allow the service to restart in the event of a second peak. A shadow team of volunteers are "on call" for swift redeployment.
- **Ensure effective mental health services are available** including co-producing support on offer with local BAME groups.

Key aspects of Lewisham's response to Covid-19 to-date include:
Harnessing local knowledge and data: Lewisham population health data system was used to identify vulnerable people quickly and offer support via the shielding team and Lewisham Local.
Improving capacity in our hospitals: Working jointly to support people leaving hospital and improve A&E performance.
Supporting people at home: Ensuring Home care providers were able to flex care provision easily. Home-based swab tests and self-monitoring to avoid potentially risky contact during lockdown.
Volunteering: Over 2,000 people mobilised to support the most vulnerable in our community with practical and emotional support.
New technologies: Laptops were issued to GPs and other staff to enable remote working with a further 1,000 from DfE provided to children & young people.
Testing: Staff testing co-ordinated jointly by the Council and CCG, including key workers in primary care, pharmacies and care homes.
COVID Centres: 2 COVID Centres rapidly established in the north and south of Lewisham, to manage patients with suspected COVID.
Personal Protective Equipment: Distribution of PPE locally to GPs, council staff, Care Homes and Domiciliary Care agencies.
Infection Prevention & Control: providing advice and support to care homes, mental health settings and supported housing providers as well as schools and early years.
Mental Health: Triage in Emergency Department extended 24 / 7.
Service changes and additional support: delivery of food parcels to shielded and vulnerable families and provision of safe temporary accommodation.

1 Working with our staff and communities to keep each other safe

Our Healthier South East London
Integrated Care System

Partnership Southwark

Winter 2020/21 will bring a number of additional pressures on our health and social care systems including managing resurgences of COVID-19, knock-on effects of disruption to health and social care systems during COVID-19, and for an increase in respiratory infections and influenza. As a local care partnership, we are working to target support to the most vulnerable and protect our broader population, with:

- **Comprehensive Infection Prevention and Control** with the "track and trace" capacity to stop outbreaks before there is widespread community transmission, with support and training, including for all home care staff.
- **Being able to "stand-up" at short notice services and support** developed to respond to the crisis so far.
- **Joining up arrangements and plans with broader planning for winter and seasonal influenza** ensuring flu vaccine take-up.
- **Ensuring safe hospital discharge** including understanding the impact on other care settings and outcomes for service users and their families.
- **Using testing and quarantined "step-down" accommodation** to ensure that COVID-19 does not spread between care settings.
- **Working together to respond to national guidance** across health and care services and the voluntary and community sector.
- **Comprehensive Personal Protective Equipment (PPE) in place to ensure all people who need it, get it** – ensuring sufficient stock and a robust supply chain with a consistent Southwark approach.
- **If we need to pause services, ensuring we do so in a joined-up way** that reflects capacity and demand and learns from "wave one" of COVID-19.
- **A system-wide approach to supporting staff in all settings to be safe, resilient and healthy** recognising that a significant proportion of our staff are from a Black Asian and Minority Ethnic (BAME) background or have vulnerabilities that increase the risks associated with exposure to COVID-19.
- **Early and more accurate modelling to help predict and respond to any potential outbreaks / local community transmission** and inform our responses: updating and adapting these as the situation evolves.
- **Joint planning for implementing local lockdowns** wherever needed including how we will safeguard and support our communities.

Our care homes in particular have been majorly impacted by COVID-19. To respond to this challenge and Southwark health, care and wider Council services worked together in a whole system approach through the emergency period:

- **An integrated approach** to supporting older people's homes through joint working between primary care, GSTT and the Care Homes Intervention Team.
- **The work has provided an opportunity to strengthen our engagement with care homes** as we move forward, and for the team to work in the person's best interest.
- **Strong leadership with extended support** (e.g. 7 day support from primary care) and proactive services, underpinned by innovative and compassionate working.
- **The ease of communication/cooperation made a massive difference.** The use of technology enabled quick and decisive communications and a virtual support network (E.g. WhatsApp groups) for professionals.
- **We coordinated and delivered Infection Prevention Control (IPC) training** to care home staff with 17 CQC registered homes.
- **Regular contact** in the form of daily (now weekly) touch-points and check ins via the joint CCG and Council older people's and complex needs team, newsletters to provide information and key guidance, and fortnightly provider forums.
- **We are now resetting our approach based on this learning, harnessing new ways of working, and planning for any future surges** with a robust and consistent approach to testing, an expansion of our approach beyond older people's homes to all care and residential settings, whilst continuing to recognise successes – acknowledging that working across boundaries is difficult and requires relentless enthusiasm.

Our Healthier South East London
Integrated Care System

Overview

Reducing inequalities is an overarching priority and a "golden thread" that must underpin all of our work in South East London.

We know that South East London has some of the highest levels of deprivation and inequalities in health in the UK, where four of our six boroughs rank amongst the 15% most deprived local authority areas in England. The unequal impact of COVID-19 has further highlighted the health inequalities that persist across our population. Addressing inequality as we recover from the pandemic is a key priority and the pandemic has provided a galvanising moment: an opportunity to translate our ambition into clear and tangible plans for implementation across the whole South East London system.

- **Our recovery plans focus on reducing inequalities at both borough and system level**, including revisiting our Long Term Plan objectives and areas of focus alongside addressing risk factors and inequalities that have driven the differential impact of COVID on our populations.
- **Our vision is that every resident of South East London is enabled to live a happy and healthy life underpinned by principles of equity and equality** - post code, background, ethnicity and access should not drive health and health outcomes.
- **Our mission is to work together to ensure a clear understanding of population need and to work as a health and care system with our communities to ensure that we are systematically targeting our approaches**, **best practice and learning** to generate a demonstrable and positive step change in population health, equity and reduced inequalities.

We recognise that doing so will require system-wide leadership and commitment as well as the agreement and implementation of tangible actions and supporting infrastructure and resources.

We are committed to securing this whilst recognising that addressing inequalities represents a long-term investment, not a quick fix. Addressing inequalities will need to be everyone's responsibility and priority, and an integral part of the way Our Healthier South East London works. We will adopt a programme of cultural and behavioural change alongside appropriate governance, leadership, programme management and support to make this happen.

To support our inequalities work we will develop and implement the approach of 'Resilient Health Systems for the Life Course'. The aim is to turn the COVID-19 pandemic experience in to a 'transformative shock' by integrating what we learn from the experience into future ways of working; and by building resilience for the future. This will be underpinned by important changes to our governance and leadership, which will include an enhanced and dedicated focus on inequalities and equity.

Through all of this we will work with broader local authority colleagues to ensure co-ordinated approaches in areas such as housing and homelessness, such as identifying what aspects of the wrap-around support provided during the pandemic can be continued in order to secure shared priorities like "no return to the streets".

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Understanding the impact of inequalities on our population

The recent Public Health England review of disparities in risks and outcomes for COVID-19 looked into effects of age, sex, deprivation, region and ethnicity. Addressing the broader socio-economic determinants of health and wellbeing, including inequalities exacerbated by the effects of the COVID-19 outbreak, is a key priority in all of our plans as is continuing to improve the management of long-term conditions across South Easts London; working in partnership with local authority and VCSE colleagues.

	Age and Gender	Deprivation	Ethnicity	Occupation	Health and Co-morbidities
Risk Factors	• **Those 80 or over were seventy times more likely to die** than those under 40. • **Males had a statistically significantly higher rate of death** (9.9 deaths per 100,000) compared to females. • **Significant impact on mental health and wellbeing** of Children & Young People.	**COVID-19 has had a proportionally higher impact in the most deprived areas** when compared to all deaths, including on: • **Migrants** and those with "nil recourse" to public funds. • **Homeless people** and rough sleepers. • **Children and Young people** affected by school closures.	**The risk of dying is higher for those in Black, Asian and Minority Ethnic (BAME) groups** than in White ethnic groups.	• **Caring occupations** including social care and nursing auxiliaries and assistants. • **Those employed driving private and public vehicles** including taxi and minicab drivers and chauffeurs. • **Security guards** and related occupations. • **Those working in care homes**.	• **Hypertension** • **Cardiovascular diseases** • **Diabetes mellitus** • **Obesity** • **Smoking** • **COPD** • **Chronic kidney disease**
Areas to be reflected within recovery plans	• **Integrated support** to our vulnerable and frail population. • **Agreed risk stratification process** to identify the cohort of people who would respond most effectively to health checks, anticipatory care and integrated care following acute admission. • **Support to CYP and families** specifically around MH and emotional wellbeing.	• **Working with partners across South East London to address wider determinants of health and wellbeing** including housing, education, and employment.	• **Understanding and addressing health inequalities for BAME and other vulnerable residents across South East London** as exacerbated by COVID-19.	• **Shared programme to develop health and care workforce**, including support for BAME staff. • **Support for new partnership relationships** with local domiciliary care providers • **Dedicated Care Home support** with implementation of measures to mitigate future risks and enable ongoing recovery.	• **Continued investment in prevention** to support population health and wellbeing. • **Improved support for Long Term Conditions self-management** and care • **A continued focus** on improvement in Mental Health, Respiratory, Diabetes, and Frailty. • **Cross-borough work restoring and enhancing cancer services.**

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Key areas of immediate focus (South East London wide):

- **The establishment of an Inequalities Programme Board to oversee and drive implementation and delivery of our plans.** To support this, we have appointed a new ICS Population Health and Inequalities Director, who will work across the ICS and Kings Health Partners. Partner organisations will have a named executive board member responsible for tackling inequalities alongside a commitment to increase the diversity of senior leaders. The South East London Board is now meeting in shadow form.
- **A refreshed assessment of population health inequalities, which has formed the bedrock of our borough based recovery plans.** These assessment show:
  - **Commonalities between the four inner South East London Boroughs (Southwark, Lambeth, Lewisham & Greenwich):** younger, diverse and densely populated.
  - **Commonalities between the two outer south east London Boroughs (Bexley and Bromley):** older populations, less densely populated.
  - **All boroughs share inequalities in life expectancy and healthy life expectancy:** common themes include smoking; obesity; long-term and multiple health conditions; vulnerable younger people and children; poor mental health; communities with diverse ethnic heritage; housing and homeless; and across all factors, deprivation.
  - **A disproportionate impact on those with other underlying health conditions**, the obese, those from Black, Asian and Minority Ethnic groups and more deprived population groups. We also recognise that measures to reduce the spread have a negative impact on other aspects on our health and wellbeing.
  - **We will build on this work through further analysis**, including local risk assessment and stratification and targeted intervention.
- **Work to embed Population Health Management as the basis for planning and transforming services**, including work to address inequalities at both a strategic planning and an operational / delivery level. Our South East London Data Service provides the infrastructure to help deliver this key strategic objective. It will support a data-driven and needs-based approach to planning and provision alongside improving our overall availability of data, monitoring, management and evaluation metrics and data.
- **A population health and inequalities programme, focussed on securing an agreed approach to the implementation of evidence based interventions** in a systematic and targeted way, to support the maximum potential impact on reducing inequalities across our populations. We will seek to embed these interventions in our core service offers for patients, service users, carers and residents and ensure that an "inequalities lens" is an integral part of our health and care system.

In taking these forward our approach will seek to:

- **Engage our communities to co-produce approaches and interventions** with people with lived experience.
- **Mobilise our people to support the inequalities agenda** including health-as-an-asset and to ensure that improving population health is mainstreamed.
- **Maximise the opportunities to bolster local economies**, including opportunities to use "anchor institutions" to deliver change and broader improvement.
- **Develop the required technology and systems**, comprehensive data sets, and analytical capability.
- **Consider approaches to future investment** including though Making Every Contact Count, and targeted support for "high-impact" action on specific inequalities.
- **Implement action to improve health protection, manage risks and prevent ill-health**, including the "Vital 5" initiative with King's Health Partners to address the key risk factors driving mortality, morbidity and inequalities in our population: smoking, alcohol, obesity, hypertension and poor mental health.
- **Work with local people to improve screening and vaccination programme take-up**.
- **Ensure the system is able to support people from all backgrounds with wide ranging and differing needs** scaling up personalised care including for children and young people, those living with long term conditions, serious mental illness, or disability.
- **Ensure that we undertake equity impact assessments before we implement new pathways**, that we understand and seek to address inequity in access to services and that we evaluate changes made e.g. virtual by default to understand and address any differentiated impact on our populations.
- **Complete an audit of existing leadership arrangements, resources, activities and priorities** in respect of equality, diversity and inclusion.

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Bexley Local Care Partnership

COVID-19 had a disproportionate impact across our communities: we will build on local conversations to-date with the communities most impacted by COVID-19, to understand how we can improve support, and how we can best engage people in shaping the contents of these plans.

Health inequalities exposed and exacerbated by the pandemic have provided even greater impetus for our council's 'Connected Communities' strategy: to engage, empower and work in partnership with Bexley's communities, faith groups and community representatives in developing our Local Care Networks.

We will work together with local communities to co-develop:

- **strengthened, targeted programmes** to prevent chronic diseases.
- **enhanced health check programmes** to improve identification and management of long-term conditions with BAME groups, and with targeted messaging on smoking, obesity and common conditions including hypertension and diabetes.
- **support to residents** through digital means, including working with partners to promote digital inclusion and ensure no-one is left behind.
- **safely restored services for our most vulnerable adult residents, children and young people:** services temporarily stood-down or delivered differently because of COVID-19, including face-to-face assessment and protection work, re-opening of centres and access to short-break facilities, and support to schools and education establishments.
- **planning for those currently 'shielded'** to enable a return to full independence, recognising that there will be a people that may require ongoing assistance through our Prevention Strategy, Social Prescribing, Local Care Networks and partnership with the voluntary and community sector and local volunteers.
- **our proposals for Thamesmead** with some of the highest health inequalities and mental health need in the borough. As a place, it straddles the two London Boroughs of Bexley and Greenwich. The two boroughs, the CCG and Peabody Housing have been accepted on the national 'healthy towns' programme, which will provide the foundation for joint planning of health and care services between the partners and with the community.

One Bromley

Covid-19 has further exposed existing health and wider inequalities across our society. The virus has had a disproportionate impact on sections of our population, including those living in the most deprived neighbourhoods, people from Black, Asian and Minority Ethnic communities, older men, those suffering from obesity, who have long term health conditions, and work in specific occupations. It is essential that our recovery is planned in a way that is inclusive and supports those in greatest need. As an area with a diverse population and a diverse workforce, we recognise our shared responsibility in both our immediate and future plans. Our approach is summarised below:

Age and Gender	Deprivation	Ethnicity	Occupation	Health factors
• **Working together to support to those who have been shielding**, both through recovery and in the event of a second wave. • **Development of Covid-19 "protected" and "risk-managed" pathways**, co-ordinated through our local Primary Care Networks • **Improving the management of Long Term Conditions**, including enabling people to self- manage.	• **Addressing the wider socio-economic determinants** of health and wellbeing, including by improved housing, reducing overcrowding, and improving nutrition. • **Targeted investment in prevention** to support population health and wellbeing (including building on the use of social prescribing to provide non-medical support to people in need of assistance).	• **Working with our BAME communities** to co-ordinate improvements across mental and physical health services. • **Effective communication and engagement** with all of our neighbourhoods and communities to ensure that equal access to advice, guidance, services and support.	• **A joined up focus on staff mental and physical heath and wellbeing** across NHS, local authority and VCSE organisations. • **Ensuring ongoing availability of PPE and testing**, and effective "zoning" of areas for safe diagnosis and treatment, and management of patients and service users across all care settings in Bromley.	• **Providing support to smokers** to quit. • **Improving healthy weight** across our communities and ensuring everyone has access to good nutrition. • **Improving support for people living with multiple Long Term Conditions** at or close to their homes. • **Ensuring joined up support to those living our residential and care** homes.

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Healthier Greenwich Alliance

We have seen that Covid-19 has made worse existing health inequalities in Greenwich with a disproportionate impact including for our Black, Asian and Minority Ethnic Communities (BAME), those living in deprived areas, those with existing long-term health conditions, key workers and older people. Adults and children with disabilities have in many cases been particularly affected by the lockdown measures and mental health concerns and anxiety levels have risen across all communities.

At the same time, through the pandemic we have had to work differently with communities to develop new ways of providing support and delivering services.

We have strong agreement from all senior leaders and partners to work together as a system to improve the health and wellbeing of all our communities: to use our resources to address historic and new health inequalities, and to keep people safe and well.

Our outline recovery plan sets out set out how we will do this:

- **Listening to, understanding and acting on what our communities tell us**.
- **Developing neighbourhood working and delivery.**
- **Developing a 'Home First' approach (See policy link).**
- **Redirect resources to address health inequalities.**
- **Building community and staff resilience.**

Over the coming months, we will engage with all communities and all local stakeholders to make this a reality – including individuals, community groups, church and faith groups and businesses. We are committed to responding to the issues of racism highlighted by Black Lives Matter and to looking actively at our own policies and practice.

Lambeth Together

Covid-19 has further exposed existing health and wider inequalities across our society with a disproportionate impact on sections of our population, including those living in the most deprived neighbourhoods, people from Black, Asian and Minority Ethnic communities, older men, those suffering from obesity, who have long term health conditions, and work in specific occupations.

It is essential that our recovery is planned in a way that is inclusive and supports those in greatest need. As an area with a diverse population and a diverse workforce, we recognise our shared responsibility to address emerging disparities in risks and outcomes in both our immediate and future plans.

Age and Gender	Deprivation	Ethnicity	Occupation	Health Factors/Comorbidites
• Integrated support to our shielded population. • Development of Covid-19 protected and risk-managed pathways co-ordinated through our nine PCNs • Focus on improving LTC management	• Mitigating social determinants by improved housing, reducing overcrowding, improving nutrition • Targeted investment in prevention to support population health and wellbeing (social prescribing)	• A focus on BAME support co-ordinated across mental and physical health services. • Effective communication and engagement across all of our communities to ensure that equal access to advice, guidance, services and support.	• A rigorous and co-ordinated focus on staff mental and physical heath and wellbeing across NHS, local authority and VCSE organisations. • Ensuring ongoing availability of PPE and testing, and effective "zoning" and management of patients and service users across all care settings	• Reducing smoking prevalence, • Improving proportion with healthy weight and access to good nutrition, • Improved management of LTC • Focus on care home

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Lewisham Health & Care Partners

- **Birmingham City Council and Lewisham Council are launching ground-breaking work into the health inequalities of African & Caribbean communities.** The programme, which will conclude in December 2021, consists of a series of reviews which aim to explore in-depth the inequalities experienced by these ethnic groups and their drivers. The review topics include: children and young people, mental health and wellbeing and chronic health, amongst others. The aim is to find approaches to break the decades of inequality in sustainable ways that will lead to better futures for local citizens.
- **Continuing to improve the management of long-term conditions in Lewisham is a key priority for our partnership,** as (working with VCSE colleagues) is addressing the broader socio-economic determinants of health and wellbeing. These include inequalities exacerbated by the effects of the COVID-19 outbreak.
- **In March 2020, the Health and Wellbeing Board agreed to the development of a new strategy for the period 2021-26.** In developing a new strategy, Lewisham will consider the wider contributory factors to health and wellbeing such as housing, education and employment. It will also seek to encourage individuals to take greater control and responsibility for their own health and care and reflect the need to address health inequalities, particularly in Black, Asian and Minority Ethnic (BAME) groups.

A full communications and engagement plan is being developed with partners to support the borough's recovery plans. This includes:

- **Reflecting on what we know** from previous engagement work.
- **Understanding further what we have learned** from people's experiences of receiving care during the pandemic and the impact this has had on them.
- **Identifying and addressing gaps in our knowledge** and understanding.
- **Considering how this will shape our recovery planning** and delivery going forward.
- **Working collaboratively across our partnership** in a coordinated way for the good of all of our residents.

Given the disproportionate effect that COVID-19 has had on older people and those from the BAME community – alongside the disproportionate impact on men, lower paid workers, people with long term conditions, people with learning disability and/or autism and people with mental health needs – we will engage proactively and work with people from these communities and groups to understand the impact across our borough.

This information will inform how recovery planning can address these issues, as well as supporting how people can help shape our plans. It will build on pre-pandemic work to address health inequalities including the 2018 BAME Mental Health Summit and the BAME mental health insight co-production work which followed.

2 Taking practical steps to address new and existing inequalities

Our Healthier South East London
Integrated Care System

Partnership Southwark

Significant health inequalities remain within the borough, with over a fifth of residents living in communities ranked as the most deprived 20% in England. Estimates suggest around 21% of Southwark residents are at increased risk of severe illness if they contract COVID-19.

Southwark is an ethnically diverse borough, with over 120 languages spoken, with 36% of the population from a Black, Asian or Minority Ethnic group including the one of the largest Latin American communities in the country.

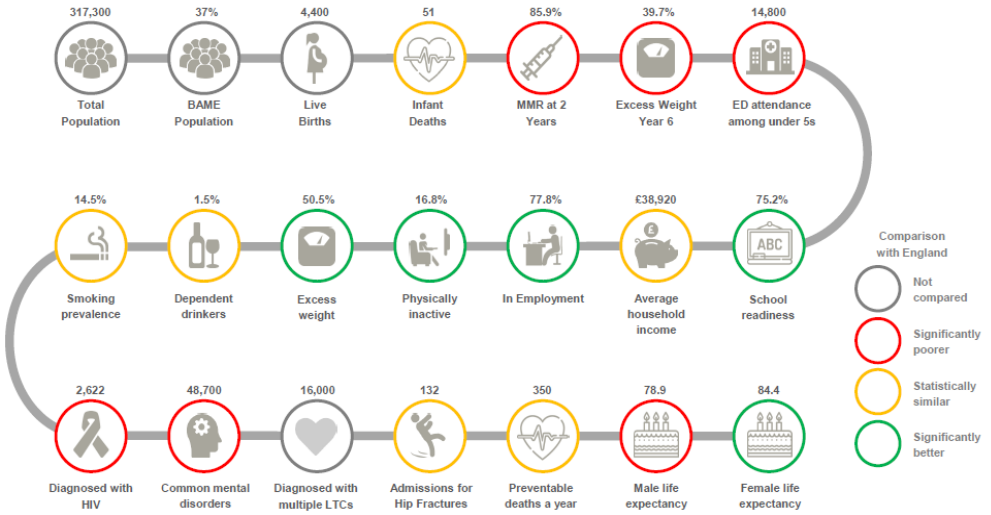
Partnership Southwark has committed to responding to the inequalities exposed by COVID-19 and Black Lives Matter holding a series of public listening events, roundtables and workshops over summer. Together with partners, an action plan is being developed to embed organisation wide approaches to tackle systemic discrimination, to improve the experiences of BAME patients in health and care and their health outcomes.

The Health and Wellbeing Board in July 2020 carried out a deep dive into the national and local data to better understand how our most deprived and vulnerable communities were disproportionately affected by the pandemic.

Southwark partners including local education and other public and voluntary community services have agreed to take forward the high level framework to address health inequalities which was considered at our Health and Wellbeing Board in September 2020.

This is underpinned by the 3 principles of life course, targeted approaches and community empowerment and will cover 5 key areas:

- **Ensure the best start in life for every child.**
- **Enable healthy lives through healthy environments and healthy behaviours.**
- **Ensure fair employment and healthy workplaces.**
- **Create and develop healthy and sustainable places and communities.**
- **Support early detection and management of common long-term conditions.**



Our Healthier South East London
Integrated Care System

Overview

Our response to the NHS Long Term Plan and London Vision set out our approach to helping people across South East London stay health and well. As we address the challenges and inequities highlighted by the COVID-19 pandemic, it is more important than ever that we deliver on these commitments to children and young people, adults and older people living in our six boroughs.

At the heart of this vision is the ability to deliver consistent, high-quality community-based care to keep people as healthy and independent as possible in their own neighbourhoods and homes. This means ensuring everyone in South East London is able to access a "core offer" of mental and physical health support, wherever they live, upon which our boroughs will continue to develop and build services tailored to local population needs.

It is critical in this period that we ensure availability of support to children and young people, adults and older people living with one or more long-term conditions and / or complex needs; as well investing in our communities to address the causes and consequences of health inequality, preventing ill-health and enabling people to pursue the things that matter most to them.

To ensure this happens, we are committed to enabling everyone in South East London to "Start Well, Live Well and Age Well":

- **A key shared objective across our boroughs is prevention** – including early detection, improved risk management and targeted intervention – supporting people proactively to stay independent and well with care that responds to their needs and their priorities; and care that is delivered as much as possible in, or close to, the place where they live.
- **We are accelerating plans to offer a single set of "community pathways" across South East London** to provide access to the best physical and mental healthcare - built around a clear set of commitments to service users and with a shared improvement methodology to reduce variation, improve outcomes and spread best practice.
- **And we are determined to work more closely with the voluntary sector and with public health colleagues** to make sure that people are supported to live better lives in the best way, with support provided by the most appropriate organisation, in the right place and at the right time.
- **During COVID wellbeing / shielding hubs set up by our Local Authorities, supported by primary care, community and mental health providers, have provided better co-ordinated support** to our population and provided us with the ability to develop new models of neighbourhood-based support.
- **New crisis access services have been developed for people living with mental health problems**, ensuring that they can access emergency care without being exposed to undue risk in acute hospital emergency departments; whilst psychological therapies (IAPT) services have moved increasingly to digital delivery.

In the immediate term, at a South East London level we will continue to build a safe and secure infrastructure to support improved population health management across all ages and communities: with enhanced advice, guidance and best-practice models to enable professionals and individuals to stay well and to better support those with complex and long-term needs, both remotely and in-person.

3 Supporting people to stay healthy and well at all stages of life

Our Healthier South East London
Integrated Care System

Key areas of immediate focus (South East London wide)

Supporting previously shielded patients, those vulnerable to COVID-19 and those living with one or more long-term mental or physical health conditions:

- **We will build on new operating models for shielded patients and wellbeing hubs**, with a major focus on prevention to support people to stay well in the place where they live, with the necessary multi-disciplinary support. We want to develop an integrated offer within which roles and responsibilities across primary, community and social care are founded on professional autonomy and close collaboration, reflecting the physical and mental health needs of our residents.
- **We will make the most of opportunities for improvement including expanding and integrating the primary and community care workforce**, supporting people to self-manage their conditions, and working with public health to promote prevention and health improvement across all ages.
- **We need to make sure our community services have strong links with other pathways that support our at-risk residents** including admission avoidance services, specialist teams caring for people with long-term conditions, care coordinators, frailty and primary care services – and work in an integrated way and with the extensive and expert support available from the voluntary sector.
- **We are rapidly reviewing and identifying patients who may have deteriorated or are at increased risk as a result of delayed review or treatment** to agree mitigating action, including implementing UCLP remote review templates in primary care.
- **Within the NHS and partners our focus on our existing long-term condition and frailty plans will continue**, bringing in the early accelerator ageing well initiative, our expanded "home first" offer, and our revised community bed base. This will be underpinned by accelerating our approaches to population health management across all of our health and care services and settings.
- **We recognise families and carers will have strong views about changes we need to make** to the care of some of our most vulnerable residents and we will ensure that we have appropriate processes in place at both a borough and South East London level to capture and respond to these.
- **We will work to ensure our new operating models are supported by the right infrastructure** including data sharing, digital technologies, and safe physical environments.

We will build stronger links between physical and mental health services:

- **This will include support for Post Traumatic Stress Disorder** for post-intensive care COVID patients.
- **People with learning disabilities, and with chronic mental illness, are at higher risk of losing out due to rapid changes in services** – we need to do more to understand this.
- **Many people under the long-term care of mental health trusts have frequent contact with community physical healthcare** – there is a South East London-wide opportunity to build care plans in a multidisciplinary way during this period of rapid change.
- **We will further develop crisis access for mental health** to improve triage, digital access, and integrate "mind and body" care.

And we will support our families, children and young people through the recovery process including:

- **Working with schools and colleges to ensure pupils and students can return to education safely** and that their healthcare needs are identified and met.
- **Restoring key services** including around learning disabilities and autism and children and adolescent mental health services.
- **Investing in prevention** including early years services, childhood immunisations and support to families through this period.
- **Ensuring Paediatric Intensive Care capacity (and surge plans) at Evelina London (and Variety Children's)** supporting the South Thames Paediatric Network.

Start Well

Our Healthier South East London
Integrated Care System

The long-term future of our health and care system depend on our ability to support the physical and mental wellbeing of our children and young people.

Since March 2020 we have seen our children and young people's education interrupted and their lives subject to significant disruption. There has been a drop in GP referrals and A&E attendance and resulting potential levels of un-met need, with increasing backlogs and waiting lists particularly for ASD / ADHD support.

We know that the experience of the pandemic and lockdown has exacerbated and been exacerbated by existing inequalities in our society.

This has reflected the broader, disproportionate impact on BAME communities and areas of deprivation. Parents, teachers and children and young people have expressed concern around the impact of closure of children's services, waiting times for those services being restored, the safety of schools and colleges, and the impact on children's mental health and wellbeing. There has been disruption to the continuity of individual care and challenges of managing within existing facilities and estates.

Across South East London we have seen nonetheless seen rapid adaptation of children and young people's services to online, virtual platforms.

We have strong physical assets in South East London including at the Evelina, South Lambeth and Maudsley, King's College Hospital and have received positive feedback on our primary care virtual offer. We have been able to maintain safe acute and maternity service, including recent changes to enable visitation in postnatal wards.

Our shared priority now across South East London is to ensure children and families are more visible, that their needs are identified earlier and safeguarded through this and any subsequent waves of COVID.

This includes:

- **Strengthened links between maternity services and health visiting**.
- **More children having access to immunisation** including take-up of MMR.
- **Improved access to mental and physical health and wellbeing support** continuing to develop our community and digital offers.
- **Networks that support for children and young people living with long-term conditions** based in our neighbourhoods and communities.
- **Enabling families with children & young people to access different forms of support** including through enhanced social prescribing.
- **Young people feeling more connected to their neighbourhood with voluntary & community sector support** to address local needs.
- **A smooth transition as children return to schools and colleges** with close joint-working to help early identification and management of specific needs.
- **A commitment to ensuring access to broader support and services** in any subsequent waves of COVID-19 across South East London.

Live Well

Our Healthier South East London
Integrated Care System

Our work on living well encompasses a range of support and services designed to prevent ill-health, support mental and physical wellbeing, and address the broader determinants of health across our communities.

We know that we can identify and support people to better manage many of the risk factors for COVID-19 through our Health Checks programme. We will ensure this programme is restarted and use the information and data gathered in the first wave of the pandemic to help us prioritise support for the immediate and longer term.

We will work through our borough partnerships to provide a range of support through a multi-agency hub and spoke approach including economic, employment and benefits advice, food delivery, peer support, onward referral to our voluntary and community, health and social care services.

A key element of this approach is to ensure "no wrong doors" across South East London, with effective communication to help identify opportunities and risks and engage our local communities in response.

We will work across our providers to ensure joined-up, proactive support to mental and physical health including targeted support for our broader work on addressing health inequalities and those with complex needs, such as those who are currently homeless or rough-sleeping.

Our neighbourhood approach to preventative services will involve working with our Primary Care Networks, Public Health, and our Voluntary & Community Sector, and other key local partners to help recover support to local people even as we manage ongoing challenges from COVID-19.

We will prioritise our initial focus on identifying and working with residents at high-risk of poor outcomes, wherever they live, and encouraging take-up of support in response to the findings of Public Health England from the first wave of infections.

Key outcomes include:

- **Improved preventative services and support** across all of South East London, for those with existing conditions and those at-risk.
- **People knowing how to access and being in receipt of good quality care** at home and in the community.
- **More people receive good quality, personalised support** with rapid and effective shared decision making.
- **A shared plan, proactive care and support** for people at most risk of poor physical or mental health.
- **Lowering of health risks and increased numbers of people** living independently and well in our communities.

We will work to expand access to and take-up weight management, stop smoking, health checks and support for substance misuse.

Age Well

Our Healthier South East London
Integrated Care System

Between our boroughs, life expectancy is similar, but healthy life expectancy varies significantly. Men in one borough can expect to live on average almost six years longer, in good health, than men in a neighbouring borough; for women, the difference is almost 10 years.

Older people tell us consistently that they value their independence and want to be cared for in their neighbourhoods, at or as close as possible to home.

We will continue to build up the commitments of our Long Term Plan to improving support and services to our older population. This includes developing and implementing more personalised care, coordinated or delivered by one of our community based multi-disciplinary neighbourhood teams, which brings together a range of professionals integrated with our 35 Primary Care Networks. The focus of this work is to ensure that across all six boroughs, we have the right skills, capacity and resources in place to provide wrap-around support including to the vulnerable and those at greatest risk, in order 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 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 development of Enhanced Health in Care Homes; (iv) build capacity and workforce to do these three things.

The pandemic has re-emphasised the value of care co-ordination in improving support and quality of life of older people. This includes those living with one or more long-term physical or mental health conditions.

We will build on existing integrated working at a South East London, borough and neighbourhood level and the developments in response to the pandemic, including the experience of supporting those shielding through Community Hubs. Our priorities now include enabling our Primary Care Networks and Local Care Partnerships to develop and share best-practice in the delivery of person-centred, community-based care, with:

- **A single care plan that takes a "strengths-based" approach** with input from carers and the voluntary & community sector.
- **Integrated, neighbourhood-based networks of services and support** that keep people as healthy, safe and independent as possible, in their home.
- **Elderly residents feeling more connected to their local voluntary & community sector** via joined-up "Hubs".
- **Integrated care available at convenient times** with equipment, mental health input and out-of-hours provision.
- **Social care reablement beds** to enable people to return home.
- **Emergency department frailty "pathways"** to support people to return home safely and quickly.
- **Proactive support to shielded and vulnerable people** living with one or more long-term conditions.
- **Prioritised focus on immunisations programmes** to encourage take-up this winter.

Our Healthier South East London
Integrated Care System

Overview

A core focus of our recovery plan is the full restoration of health and care services, across all parts of South East London.

In doing so we are committed not only to ensuring people an access the support they need, where and when they need it, and to tackling backlogs where services were impacted during the pandemic; but also to responding to the learning, and incorporating the positives changes, that have come about as part of our joint work over the last six months.

We know that pre-COVID we needed to improve elements of our urgent and emergency care and we remain committed to doing so.

This included a focus on managing demand out of hospital wherever possible, underpinned by investment in our services to help keep people safe and well and to avoid the need for hospital admission, alongside improvements in the way in which people are supported through stays in hospital and wherever possible back into their own homes and communities.

Winter is a time when our health and care services face annual pressures and this year this will be compounded by the ongoing fight against COVID-19.

We will be seeking to secure and maintain positive performance over the winter, including continuing and further developing a number of changes to support flow and patients being seen and treated in the most appropriate setting. There are risks, related to demand, workforce, primary and community care capacity, care homes and home care provision in the pandemic and the flow into and out of hospital that we will need to manage: with key areas include how long people have to wait for handover from the London Ambulance Service, to be seen in hospital when needed, and around the growing demands on our mental health services. This plan will help inform our response as South East London to managing these pressures through the winter, and through any subsequent phases of COVID-19.

We will continue to build on our COVID responses to maximise referral, triage, booking, virtual and "Talk Before you Walk" approaches.

We will seek to optimise the role of the South East London 111 Integrated Urgent Care service to minimise face to face Emergency Department attendance including alternative services where appropriate.

The recent approval of capital funding will help to support improvements to our emergency departments with the creation of additional assessment, treatment and waiting capacity along with work to support Infection Prevention Control and social distancing measures.

We are jointly committed to reducing delays in transferring people between care settings and in getting them home once they are medically fit for discharge. We are working to develop enhanced Mental Health Crisis pathways to reduce pressure on emergency teams. As an ICS Living Well Accelerator site, we will drive our enhanced admission avoidance and supported discharge approach (as detailed further in this section).

And we will reflect our investment in our hospitals with our investment in community services and in supporting Adult's and Children's Social Care:

Protecting the vulnerable and ensuring that we are supporting all of those in need, with a particular focus on groups such as those with learning disabilities who have been particularly impacted during the pandemic by the disruption to key local services, will be critical to the success of this plan.

Our Healthier South East London
Integrated Care System

Emergency and Urgent Care

Emergency and Urgent Care over the past 6 months

We have witnessed over recent months both reduced A&E demand and periods of challenging performance. As we enter the winter period, ensuring the resilience and sustainability of our emergency and urgent care services remains a priority, both to provide safe and effective treatment to those most impacted by any future waves of COVID, and to continue to provide an accessible, safe and effective service for non-COVID patients in times of critical need.

We will be seeking to secure and maintain positive performance through the winter, including continuing and further developing a number of pathway changes to support flow and patients being seen and treated in the most appropriate setting.

Emergency and Urgent Care recovery priorities

We will continue to build on our pre-COVID plans and our COVID responses to maximise referral, triage, booking, virtual and 'Talk Before you Walk' approaches. We are optimising the role of the SEL 111 IUC service to minimise avoidable face-to-face Emergency Department (ED) attendance by ensuring patients are diverted to alternative services where appropriate, for example Same Day Emergency Care (SDEC), 2-hour rapid response and other community services.

We will continue to transform Urgent and Emergency Care with a focus on further development of SDEC services and strengthening discharge processes and support across South East London, to reduce delays in getting patients home and overall length of stay in hospital. We are working to develop enhanced Mental Health Crisis pathways to reduce pressure on EDs and, as an ICS Living Well Accelerator site, we will drive our aim of admission avoidance and supported discharge (based on a 2-hour rapid response, and 2-day reablement, to enhance home-based care throughout South East London).

Emergency and Urgent Care next steps

The South East London Community Provider Network has established a Keeping People At Home programme which includes measures to help admission avoidance, and the Accelerator Programme work in South East London. The work stream has identified key priorities as follows:

- **Urgent Community Response (UCR)** - 2 hour urgent care response and up to 2 day rehabilitation and reablement response.
- **Current refinement** – of demand, capacity and service delivery models.
- **Future planning** – a "gap analysis" and action to address identified gaps in our future urgent and emergency care across South East London.
- **Communication** - establishment of a learning and discussion forum.
- **Engagement** - staff and citizens engagement to help shape all of the above.

Our Healthier South East London
Integrated Care System

Elective Care

Elective Care over the past 6 months

Elective care covers all of our treatment and support planned in advance. It is one of the areas that was most impacted in the initial response to COVID. The profile of the waiting list at our providers has changed significantly since March 2020 and is now heavily skewed towards patients waiting over 18 weeks, alongside a large growth in long waiters (>52 weeks). We faced challenges in the form of theatre capacity due to maintenance, implementing infection prevention and control measures, and the ability of patients to meet pre-admission criteria and/or reluctance of patients to attend hospital sites.

Over recent months we have worked together to re-shape our elective pathways at pace, including a shift to virtual models of care where applicable, as well as taking a joined-up approach to managing our urgent and complex surgery workload across South East London to meet demand and keep people safe. We are committed to applying the learning to elective recovery going forward.

Elective Care recovery priorities

The scale of our challenges mean we need to increase the pace and scale of our elective transformation work to ensure we explore all available opportunities to restore access and improve performance. Since 1st September 2020 we have worked as a system to assess and confirm the mitigating actions that will be taken forward over the reminder of this year, to ensure that we are doing everything possible to reduce our unmitigated long waiter position and forecast.

The challenges we have set ourselves are:

- **To eliminate all non-admitted very long waiters** (with the exception of dental) by the end of the year.
- **To commit to equity of access for all** of those on South East London waiting lists.
- **To ensure a system-approach to managing available capacity** and associated waiting lists, providing each other with mutual-aid wherever possible.
- **To establish Clinical Networks to drive our elective recovery**, including improvements to the way people access care and the efficiency of services.

Elective Care recovery next steps

- **Robust waiting list management** and validation of long waiters.
- **Increasing outpatient capacity** to address all non-admitted breaches (except dental) by March.
- **Weekend working** to increase on-site capacity.
- **Maximising the use of all available capacity**, including that of the independent providers in South East London.
- **Review of wait and capacity by site** to enable the utilisation of capacity on a system basis.
- **Review of the position in relation to dental services** as an identified challenge in South East London and significant driver of our overall position.

Our Healthier South East London
Integrated Care System

Mental Health

Mental Health over the past 6 months

Mental Health Services, including Learning Disability and Autism services, have been significantly impacted across South East London during the pandemic. Mental health providers and commissioners across health and care have worked together over this period to try to ensure that patient needs continue to be met. Significant changes to service delivery have been introduced, including an increased digital offer and in particular Increased Access to Psychological Treatment (IAPT) services.

Mental Health recovery priorities

We are working to retain and build on the positive innovations made during the response to the pandemic that have been shown to be of benefit to service users at the same time as we safely restart services and increase activity.

We are committed to delivering the Mental Health Investment Standard along with the ambitions set out in the Long-Term Plan for 2020/21, including achieving positive performance against the mental health national standards. We continue to work across South East London to ensure that access standards for IAPT, Children and Young People and Perinatal services are met.

Our plans reflect increasing demand for services, including pent-up demand for support for those presenting with Severe Mental Illness, and we continue to work together to ensure services can respond flexibly to that demand. A key area of focus is work on the development of crisis pathways, to enhance the support offered to residents and reduce pressure on emergency departments.

Mental Health next steps

- **To create a mental health "prevention taskforce" that will have representatives from across organisations and boroughs** that will oversee a twelve-month prevention programme.
- **To develop a programme of mental health community capacity building across South East London** working with schools, faith and community groups to help people stay well.
- **Making sure we reach out and listen to as many communities as possible across our boroughs**, including those for whom English is not a first language, to ensure we are able to appropriately shape and develop this work.
- **To create a package of digital mental wellbeing courses for all residents** including young people across South London through the Recovery College .
- **To support and share the South East London CCG "Free Your Mind" mental health campaign** with all our residents and communities .
- **To work together on tracking and addressing the levels of psychological distress** in our communities as a result of COVID-19.
- **To host a mental health prevention follow-up summit** to report back on progress and further challenges as a result of COVID-19: using the priorities shared with us already, and our listening campaign with local communities, to publish our shared action and implementation plan in full.
- **To ensure we are have in place adequate arrangements through the winter for those experiencing existing and new Severe Mental Illness** for whom virtual channels are not always appropriate to provide the support they need.

Our Healthier South East London
Integrated Care System

Community Services

Community care over the past 6 months

Our community services have seen increased demand compared to previous years, including in key areas such as district nursing, and a continuation of this demand represents a risk in terms of meeting need and supporting flow through our health and care systems across South East London over winter. This area is a good example of where our ability to proceed with our planned out-of-hospital investment plans will help mitigate risks across our communities and provide people with the best possible access to the care they need, close to or at home.

Community care recovery priorities

In our approach to recovery we have prioritised building on our pre-COVID Long Term Plan response and associated care offer, whilst also reflecting lessons learnt from COVID and the new requirements of providing community services in the pandemic. We want our community recovery plan to:

- **Learn from COVID and informed by discussions with the four community providers, six social services, hospices, primary care and borough colleagues**.
- **Align with broader London expectations and planning**.
- **Build on our Healthier South East London work** and our national exemplar Accelerator programme for an Urgent Community response.
- **Take a population health approach** built upon multi-disciplinary and partnership working.
- **Anticipate potential future peaks** in infection and be able to respond accordingly.

Community care next steps

- **Responding to differential impact of COVID** – targeted service offer to maintain the health of shielded or vulnerable patients.
- **Keeping people at home though enhanced admission avoidance services** – including progressing our early accelerator bid for two hour rapid response.
- **Supporting quick and safe discharge home** - supported discharge once people are medically fit, including aftercare of COVID patients.
- **"Last year of life" support** – compassionate care that improves quality and reduces need for hospital admission.

All of the above priorities have an agreed set of priority actions that will be progressed in each of our six borough partnerships – with a focus on consistent outcomes, supported by a delivery model that meets local needs.

In parallel, we are reviewing learning from COVID and identifying good practice to support learning, evaluation and spread of improvements across South East London's community providers. As an example, our community health services (particularly district nursing) and hospices provide vital support to End of Life Care at home for people choosing not to go into hospital, and we will support and develop these services through second wave/winter.

Our Healthier South East London
Integrated Care System

Social Care

Social care over the past six months

We have faced a number of severe challenges arising from COVID in protecting and sustaining core services, in providing social care support for adults and children at home, in the community, and in care homes. We have seen a reduction in referrals and placements, but we know there is a likelihood this will reverse as recovery proceeds. And all of our boroughs have seen unacceptably high levels of deaths in care homes, although mostly below the London average of 26%.

Coupled with a reduction in those funding their own care opting for residential care, and a reduction in admissions, this means there are high vacancy levels in our care homes, putting at risk their viability and those who need this level of support and care, now and in the future. We have worked hard to learn from the challenges faced by both staff and service users in this period.

Our broader communities are facing significant, ongoing pressures including high levels of food insecurity, along with high levels of local residents who have been furloughed and a rise in benefits claimants. All of this impacts on deprivation and existing health inequalities, with the potential for a high level of un-met need for support going forward. We are working in a time of severe pressures and financial challenges, including in meeting the long-term costs of enhanced care needs.

Nonetheless, there are successes we can build on including in the speed of decision-making and joint action in response to COVID; the development of "community hubs"; our improved understanding of our most vulnerable residents; improved hospital discharge arrangements; the co-ordinated support that has been mobilised around care homes; using technology to enable our workforce to continue to deliver support; and increased pan-borough working.

Social care recovery priorities

- **Addressing inequalities** including those exacerbated by COVID, across all of our communities, as part of broader council recovery plans.
- **Restoring key support services impacted by the pandemic** including for adults and children and young people.
- **Supporting previously shielded and at-risk residents** to stay safe whilst regaining their independence.
- **Building on our existing work with the voluntary and community sector** to support each other through recovery.
- **Supporting care homes** in both responding to COVID and in ensuring long-term market and financial stability.

Social care next steps

- **Maintaining the supply of Personal Protective Equipment** to the care sector as we step down the emergency arrangements.
- **Continuing to develop improved discharge processes** whilst addressing the corresponding financial and resourcing challenges in a sustainable way.
- **Building on community resilience and new and creative forms of support** including around day care, learning disabilities and dementia services.

4 Restoring services and "locking-in" beneficial changes

Our Healthier South East London
Integrated Care System

Primary Care

Primary care over the past 6 months

Primary care has played a critical role in our response to Covid-19. Rapid innovation has enabled us to maintain safe access, supported maximum continuity of service, and broader efforts with partners to support the shielded and those living with one or more long-term conditions. This includes dedicated Covid-19 hubs, virtual models of triage / consultation, remote care for both COVID and shielded patients, home visiting services and home-based phlebotomy; as well as accessing advice and guidance from secondary care to avoid unnecessary referrals and admissions, transport services provided in partnership with local black taxis, and support to practices to access PPE, urgent supplies, antibody and antigen testing. We have offered clinical and health protection advice and guidance, with help for staff accommodation and illness cover, but the pandemic has nonetheless put strain on all services.

Primary care recovery priorities

Our focus is on building safe and agile services that incorporate new models of access, partnership working and delivery, whilst supporting colleagues to respond with new ways of delivering services to meet to current pressures, the coming winter, and any surges in demand.

Key priorities include taking forward work with Healthwatch and local Voluntary & Community Sector partners to support of our BAME communities; Children & Young People; those living with Learning Disabilities, enduring mental health conditions, in care homes, and with long-term conditions; and those at the of their end of life.

We will invest in and support our workforce including listening to their ideas and concerns, maintaining an entrepreneurial ethos and fostering new ways of working in response to the pandemic, with strong communication, sharing of ideas, and a "test and learn" culture.

Primary care next steps

- **Restart and expand health checks**, prevention, screening and self-management, immunisation.
- **Embed neighbourhood / community-based care and local hubs** including support for "step-up" and "step-down" care as needed.
- **A focus on mental wellbeing** of both our staff and our patients, ensuring access to support.
- **Optimise our estate and support infection prevention and control** including a continued review of our primary care estate appropriateness and utilisation.
- **Continued antigen and antibody testing** to enable us to maintain safe services and support.
- **Work with colleagues** in the re-design of outpatient services and the review of urgent care.
- **Review nursing pathways and shared lists** to ensure that we are maximising capacity and mutual support across South East London.
- **Continue to invest in our Primary Care Networks** work with GP Federations and recruitment into new roles to support their work.
- **Develop our technology and digital infrastructure** with a continued focus on digital access wherever appropriate, whilst promoting digital inclusion.
- **Proactive use of population health management data to address health and wellbeing inequalities** and to reduce variation in outcomes and quality.
- **Establish delivery & governance processes** that support progressive working whilst providing appropriate assurance of performance and safety.
- **Communicate, engage with and listen to our communities** including communication across communities to ensure clear and equitable access.
- **Enabling finance and contracting arrangements** including accessing existing and new funds to enable innovation.

Our Healthier South East London
Integrated Care System

Learning Disabilities and Autism

Learning Disabilities and Autism services over the past 6 months

During Covid-19 the Learning Disabilities and Autism (LDA) programme focused on activities to reduce admission to hospital and on Care, Education and Treatment Reviews (CETRs) to support discharge from hospital. However, as a result of an increased mortality rate of people with a learning disability due to COVID-19 there is now increased focus on Learning Disability Mortality Reviews (LeDeR) taking place to learn from and prevent these deaths in the future.

Learning Disabilities and Autism recovery priorities

We have worked to identify actions and resources needed to restore services post-COVID both in the event subsequent waves and in support of our shared objectives; including reducing reliance on inpatient care and completing Annual Health Checks (AHCs). While the South East London LDA Programme continues to lead on improving community capacity, our place-based boards and alliances between health, local authority and providers play a key role in shaping and implementation, including of Dynamic Support Registers (DSRs) for all ages and support to community CETRS.

The Learning Disability and Autism priority actions across South East London are:

- **Early Intervention and admission prevention**
- **Delivering co-ordinated care for people with Learning Disability and Autism**
- **Commissioning to improve community capacity**

Learning Disabilities and Autism next steps

- **Reliance on inpatient care for people with a learning disability and/or autism:** The LDA programme is maintaining a consistently high discharge rate, facilitated by increased case management and programme management support, despite continuing pressure from admissions impacting net change.
- **Discharge improvements across South East London** include dedicated case managers, regular case management, monthly inpatient surgeries, escalation channels to South East London ICS Leadership and NHS England nationally, and Positive Behaviour Support (PBS) to support discharge.
- **Admission prevention steps** include introduction of compulsory admissions root-cause analysis, borough level review of risk register processes, Positive Behaviour Support (PBS) to prevent admission and PBS training to family carers and professional workforce, as well as autism awareness training to professional workforce.
- **We are building capacity** with extension of SLaM & Oxleas Autism support pilots to March 2021 and agreement to fund a service on a recurrent basis and BBG Intensive Community Support service piloted with agreement between Oxleas and the CCG to fund when pilot ends; and Training and engagement with workforce delivered by professionals (e.g. CLDT, pharmacists) and experts by experience.
- **Commissioning of Lewisham Intensive Community Support service** has been completed and mobilisation is in progress.
- **We will use the DHSC Community Discharge Grant** to support the community discharges.
- **Each of our local areas have been working with community LD teams, primary care and wider stakeholders to meet the 2020-21 target for Annual Health Checks for those on the LD register** sharing resources and practice, with initiatives including virtual Big Health Week and Influenza vaccine campaigns.

Our Healthier South East London
Integrated Care System

NHS

Section 3

Enabling the change

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Workforce

Our Healthier South East London
Integrated Care System

Our workforce in South East London is our greatest asset.

We are committed to ensuring that we progress new and refreshed activities to balance the demands on our staff and to support people into and through their careers, developing and embed new ways of integrated working and our volunteer strategy as a core part of our plans.

Our priorities around valuing and investing in our people and working collaboratively to improve working lives, workloads and wellbeing are more critical than ever. Similarly, our focus on workforce retention and growth programmes, particularly for nursing and care workers, remain vital as we move forward. Ongoing work to expand multi-professional teams, develop our non-clinical workforce, optimise apprenticeships and drive innovative and integrated workforce models will continue in order to enable the new, clinically and financially-sustainable models of care that sit at the heart of this plan.

Covid-19 has fostered greater collaboration and flexibility in how we work within and across organisations. Our workforce plans include a focus on:

- **Staff health and wellbeing** as we recover from the pandemic, with a specific focus on the psychological impact and ensuring safety and learning cultures.
- **Co-ordinating further system-wide discussions and planning of workforce needs** in relation to recovery: including plans to support vulnerable and at-risk members of staff, with a specific focus on our BAME workforce.
- **An agreed approach to embedding and further developing workforce-related elements of our new models of care,** multi-disciplinary team working, integrated workforce development and volunteer models alongside a review of all of our workforce planning assumptions.
- **Support to our Training Hubs,** working with our Primary Care Networks and with enhanced consideration of fellowship and employer models to enable integrated working in our communities.
- **Delivering a refreshed workforce strategy that incorporates learning from COVID and the workforce implications of our recovery plans.** This will include consideration and alignment with the London People Board priorities.
- **Continuing collaborative work on retention, sharing best-practice and skilled personnel for staff health and wellbeing** with an inclusive safety cultures across all of our organisations and partners.
- **Successful mobilisation of volunteers, social prescribing and care navigator link workers** to build further capacity and resilience. Examples include Greenwich volunteers who are supporting shielding patients to return to a "new normal" and Lewisham "on-call" volunteers ready for redeployment.
- **Increased strength of local collaborations** e.g. across care and residential homes. Greater cross boundary, multi-disciplinary and multi-agency working.
- **Our commitment to develop and embed health and care career opportunities for local people**, ensure student support models help secure a robust supply of qualified people to meet demand, and new roles are expanded to optimise the breadth of our teams and what they can offer.

Digital

Our Healthier South East London
Integrated Care System

The Covid-19 pandemic has seen a rapid digitalisation of many aspects of our lives. We are committed to building on this progress to provide ubiquitous access to people living in South East London to digital care services, whilst also ensuring that no-one is digitally excluded from being able to obtain the information, advice, help and support they need as a result.

Our objective is a digital strategy helps us to deliver improved population health and wellbeing and "pathways" through our healthcare systems. To achieve this we will continue to support primary care and outpatient services across South East London to enable virtual appointments and consultations wherever appropriate, to build digitally-augmented and integrated primary and un-scheduled care pathways, and to extend digital access to a wider range of care services, including mental health, diagnostics, care home support and empowering people to manage their own long-term health conditions.

The Digital Response and Recovery across South East London is underpinned by work across a range of areas in order to:

- **Secure collaboration and system leadership** for digital transformation and accelerating digital maturity .
- **Enhance capacity and capability to support system transformation**, agreed long term funding, interoperability, and secure access to records .
- **Implement Population Health Management** to identify the areas of greatest health need in South East London and match services to meet them.

Key priorities include:

- **The ability for GPs to conduct appointments virtually** where possible and appropriate for patient care.
- **Outpatient appointments delivered virtually wherever possible**, underpinned by embedding Referral Assessment Services (RAS) to ensure that referrals are clinically-triaged prior to booking.
- **Consolidation of Consultant Connect, RAS Triage and "Attend Anywhere" clinics** across all providers with clear and consistent protocols and procedures.
- **Consolidation of rotas for Consultant Connect across providers** to maximise coverage and improve answer rates / help avoid unnecessary referrals.
- **Clear system wide programme to secure and embed our virtual model in three phases:** (i) Baselining to quantify progress, lessons learnt and any unintended consequences; (ii) Stabilisation (0-3 months) to agree what changes to preserve / amend / avoid, underpinned by evidence-based evaluation; and (iii) Rollout and Recovery, embedding changes over the longer term whilst also supporting targeted intervention to manage the longer term consequences and public health implications of the pandemic and ensure compliance with access standards.
- **Develop a clear road map that secures senior leadership, clinical and digital leadership, enhanced capacity and capability to support system transformation**, identifying long-term funding via "Digital First" and other related national schemes, alignment with other digital enablers to support interoperability, secure and managed access to patient records, and the data services needed to enable effective population health management.

Care Homes sector support

Our Healthier South East London
Integrated Care System

The care home sector has been particularly badly affected by COVID-19 due to the early and rapid spread of virus amongst high risk and vulnerable residents and the nature of the demands on the care workforce.

Despite this, a success from our first wave response has been the strategic and co-ordinated support provided to care homes and care providers, as a platform for future collaborative working. All areas have developed Strategic Care Home Groups to coordinate support and identify issues within care homes sector, bringing together partners from across the system to find effective solutions. We now have clear mechanisms to escalate issues and are working to ensure all care homes in South East London are, and feel, supported and valued.

Local Authority leadership has been key, underpinned by an aligned approach across health and care to support the sector and residents. There are opportunities now to strengthen further relationships between the NHS, local authority social care and public health teams, and care providers around how we best support the care homes market as we respond to ongoing challenges of COVID-19.

Our response now involves multiple partners focusing on Care Homes to protect the service users and staff. Key examples include:

- **Bringing together leads from each borough, including infection prevention control and public health,** to support borough arrangements, identify solutions, share learning, pick up areas of concern and coordinate our response to national guidance.
- **Coordination and delivery of Infection Prevention Control (IPC) training** with 224/240 CQC registered care homes in receipt of training covering swabbing, IPC and PPE by early in July 2020, and a 'train the trainer' model in place to support ongoing training.
- **Maintaining an overview of the testing programmes for care homes and their workforce:** ensuring care homes can access testing; securing feedback on effectiveness of testing regimes and associated infection control; and supporting routine testing across all different types of homes.
- **Facilitating medication supply** – including rapid access to end-of-life medication, delivering medication reviews for existing and new residents, providing more accessible support to care homes with medication queries, and regular liaison between lead pharmacists and care home teams.
- **Seeking to implement responsive multi-agency support to residents within care homes and care home staff** including regular proactive reviews, virtual ward rounds, access to support and advice from a range of health and care professionals.
- **Building our relationships between our individual practices and Primary Care Networks and the care homes in their local areas** to ensure that there is effective understanding and continuity of support for residents' healthcare needs, and comprehensive services in place to respond to those needs.
- **Safe management of discharge from hospital to care homes** during subsequent waves of the pandemic, learning from the lessons of the first wave.
- **Working with care home providers to ensure capacity and demand are being effectively managed** and the care home market is supported through this period of instability.
- **A focus on last year of life with the aim of ensuring people are comfortable and well-looked after** in the setting that is most appropriate for them.

Buildings and estates

Our Healthier South East London
Integrated Care System

South East London's vision for the physical environment in which our heath and care services are delivered is to have a flexible, high quality property base that provides the right capacity, in the right place and at the right time - responding to the needs of our patients by improving access and ensuring safety of staff and service users.

We are working to ensure that the infrastructure is in place, at the pace and scale required, to underpin our recovery plans working with new care pathways, the needs of our workforce and local communities.

We will review and refine our estates strategy to take account of service and workforce impacts, in particular:

- **Maximise the benefit from existing Primary Care schemes** in various stages of development and delivery, reviewing in the light of COVID experience and aligning with broader capacity and demand planning and best-practice across London.
- **Review and ensure our estates are resilient**, **adaptable and better able to meet the needs of local people** including our ability to provide "Hot" and "Cold" COVID Secure sites and provide broader support to our changing workforce, with the growth of new roles such as those of the social prescribers and multi-disciplinary team working in our neighbourhoods and communities.
- **Align opportunities to deliver Health and Wellbeing Hubs** including our work with our 35 Primary Care Networks to enable prevention and deliver long-term health improvement.
- **Develop estates to be better accessible to local people** supporting both physical access and the delivery of digital services by professionals and teams, where appropriate to do so.
- **Ensure estates and digital developments are aligned** to best use available space safely, economically and effectively. This will include reducing "void" space and ensure more effective booking arrangements for the utilisation of shared spaces.
- **Re-invigorate the Local Estates Forum** where partners across boroughs come together to ensure maximum benefit from and alignment between the use of existing and new estate in support of recovery plans, including our re-design of South East London outpatient services.
- **Maximise opportunities through One Public Estate** to ensure we co-ordinate NHS and local authority investment and development across our six boroughs.

Improving capacity and managing future demand

Our Healthier South East London
Integrated Care System

We recognise that many of our services were already under severe pressure before the pandemic. And that there are huge opportunities to build on the experience of working together in responding to these challenges, to ensure we can support each other in South East London.

Across primary, community and acute services, in our care homes, domiciliary care and voluntary & community sector, and both physical and mental health services we are facing simultaneous challenges of restricted capacity due to the need to continue to safeguard against resurgence of COVID-19, potential backlogs of demand and new levels of need resulting from the first wave of the pandemic and associated lockdown, all at the start of annual winter-related pressures.

We know that during the COVID-19 pandemic we have been able to work increasingly collaboratively to understand and plan for expected demand and to provide each other with "mutual aid" where needed to keep people safe and well.

We are now building from this work to develop a South East London demand and capacity model, that will support both scenario planning related to recovery and a potential second wave, plus future strategic and operational planning across our system.

Our demand and capacity modelling will be utilised to underpin our service strategies and plans and will help us identify, understand and address capacity gaps in a consistent and systematic way.

This will include approaches to maximising productivity and efficiency and opportunities to transform the way we work by collaborating together to focus available resources as a "system of systems", rather than simply within historic boundaries. This will be key to supporting each other in meeting our objectives of equity of access and outcomes for all.

New tools will enable us to measure progress with a multiagency dashboard at a local and South East London level to provide transparency as to how resources are deployed, and to allow us to respond proactively as and when opportunities, risks and issues arise.

Finance (1/3)

Our Healthier South East London
Integrated Care System

Financial context – pre COVID-19

Prior to the pandemic, across South East London, NHS and Council colleagues had been working to establish agreed financial plans for 2020/21.

- These plans included significant savings programmes for the year, with the assumed impact of our transformation and productivity improvement programmes, to support the delivery of 2020/21 budgets and financial targets.
- The plans also included a number of agreed investments, including targeted NHS investment in our out-of-hospital care system across primary care, community and mental health services, alongside investment in acute services to support underlying demand and improvements in access. For local authorities, plans reflected the very significant pressure that social care and other budgets have been under for a number of years.
- Our plans included a continued commitment to pooling and delegating budgets across health and care to support integrated out-of-hospital service provision and to incentivise the development of integrated models of care, risk and gain share approaches.

NHS Financial context – COVID-19

The pandemic resulted in significant changes to the funding and payments regime for months 1 to 4 (April to July 2020) of our Financial Year 2020/21.

- Block payments to cover core costs were implemented nationally, alongside mechanisms to recover additional Covid-19 related costs. As part of these new arrangements discharge costs were borne by the NHS on behalf of the system.
- As a system we will work to implement the national guidance with a key priority of providing financial certainty and stability across the system and to ensuring shared approaches to the management of risks or any funding shortfalls. This enabled us to make best use of available resources and develop a funding approach that put the needs and care of our residents at its centre.

NHS 2020/21 in year issues and implications

While some of the overall implications of the funding regime remain unclear, we face a very challenging financial position in health and care:

- We have experienced an Increased year-to-date expenditure associated with managing the pandemic – this means that in underlying terms we are spending more money than we expect to have available to us on a recurrent basis.
- Our 2020/21 plans are on hold or delayed – resulting in efficiency programmes and the expected return on investment also being delayed during this year, with a bigger resulting financial challenge to address going forward.
- Recovery will require investment in some areas and/or result in increased in-efficiencies to meet national/regional requirements (critical care, infection prevention and control); increased demand (mental health, waiting list backlogs); or to support ongoing delivery of positive changes due to the pandemic response (discharge, hubs for vulnerable people). All of these requirements need to be reflected in our revised financial plans.

Finance (2/3)

Our Healthier South East London
Integrated Care System

1. Principles

Whilst recognising current financial uncertainty we are committed to the following principles in addressing financial challenges and future investments:

- Commitment to our existing strategic investment plan – supporting agreed strategic priorities and the development of community-based care.
- A commitment to local oversight of allocation of resources, including community and mental health services.
- Recognition that there will be additional recovery priorities that we will need to fund.
- A commitment to work collaboratively and with collective responsibility across system partners to ensure that we make ends meet over this period.
- Securing demonstrable best value and maximising available resources to secure the best outcome at organisation and system level.
- Ensuring that the recovery commitments we make are cost-neutral overall e.g. they can be managed within the total resource available to the system, whilst recognising that this will require stringent prioritisation and redistribution of funding where appropriate.
- Ensuring that there are no adverse consequences of our recovery (and wider) actions – where there is an intended or unintended consequence, we will collectively work to mitigate the risk for that organisation

2. Funding recovery

We will need to review our recovery commitments for the reminder of 2020/21 in the context of the national funding approach and the above principles, with a focus on ensuring that we can fund prioritised recovery commitments whilst also seeking to reduce our run rate wherever possible:

- For 2021/22 we will need to adopt a systematic approach to our financial planning that also reflects our principles, takes due account of our pre COVID-19 strategic investment plans and our identified recovery priorities. We are developing a planned approach for doing so and will develop this further as national guidance and our own implementation plans provide greater certainty in terms of the "ask" and our available resources.
- Our work will include a collective review of:
  - The investments and savings that we had planned for 2020/21 - to determine those that remain important (strategically or as a vital component of our planned recovery) and those that we would deprioritise as not feasible / no longer a priority in the current circumstances: this will give us a "carry-forward" proposition as a first step.
  - Our original 2021/22 commitments, our recovery commitments and requirements and the scope for new savings for 2021/22: this will give us a "new requirement" proposition as a second step.
  - An assessment of the carry-forward and new funding requirements against available resource and in the context of our pre COVID-19 investment strategy.
  - The development of options for managing the expected gap between aspiration and available resource to support an agreed within borough and system-wide prioritisation that will enable us to set plans that match available resources.

Finance (3/3)

Our Healthier South East London
Integrated Care System

3. Ensuring our financial planning and investment approaches support integrated delivery and optimised utilisation of available resource

If we want to tackle health inequalities as a system we need to disproportionately invest and shift our resources to address these.

We need to move away from the pre-pandemic funding regime to support our objectives of developing better prevention and community based-care, integrated service delivery underpinned by genuinely pooled budgets, and system approaches to risk and gain-share to incentivise innovation and financial sustainability. This includes through agreeing collective responsibility for managing our finances.

There are a number of key pathways or service areas that we will need to work through to determine approaches that best meet these objectives:

- We will move away from the NHS "Payment by Results" funding model.
- We will demonstrate that we can move forward on the basis of these principles and build a collective agreement in key areas that embeds the benefits seen during the pandemic, whilst also providing a sustainable approach for recovery and for our longer-term future.
- Potential areas that we are considering are: discharge, continuing health care, community services 2 hour rapid response/48 hour discharge models, shielding/vulnerable hubs, urgent and emergency new access models and digital by default.
- All will require agreed resourcing, and potential resourcing shifts, alongside appropriate incentives and risk / gain share approaches, to ensure they can be sustained financially.

We have now received confirmation of NHS sector funding for months 7 to 12 (October 2020 – March 2021) and will be working to ensure this is allocated in line with this plan, and to support all parts of our system to live within our means.

Through this we will work together to ensure we have a sustainable system which supports all our vital local providers, including health and social care.

Our Healthier South East London
Integrated Care System

NHS

Section 4

Delivering on our plans

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Overview of our Integrated Care System

Our Healthier South East London
Integrated Care System

Lambeth	Southwark	Lewisham	Greenwich	Bexley	Bromley
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Primary Care Networks (PCNs) bring together local groups of GP practices with other professionals working in primary and community services and social care, and the local voluntary and community sector, to provide proactive and practical day-to-day support to individuals, families, neighbourhoods and communities to stay well.

Lambeth Together	Partnership Southwark	Lewisham Health & Care Partnership	Healthier Greenwich Alliance	Bexley Local Care Partnership	One Bromley

PCNs in turn form part of our borough-based Local Care Partnerships. These partnerships bring together all of those responsible for planning and delivering health and care services within each of the six boroughs, together with local voluntary and community sector partners and local patient and service user representatives. They include physical and mental health services, adult's & children's social care, public health, and specialist care and support provided at home and in the community.

Guy's & St Thomas' NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Lewisham & Greenwich NHS Trust

Darent Valley

Princess Royal

Bromley Healthcare

South London & Maudsley (SLAM) NHS Foundation Trust

Oxleas NHS Foundation Trust

Acute, Community and Mental Health Provider Collaboratives

South East London Clinical Commissioning Group

Our South East London Integrated Care System supports and enables local integrated care through co-ordinating planning, capacity and demand across the major providers of health and care services for South East London, including through our provider collaboratives; developing best-practice approaches, in areas such as cancer care and learning disabilities; and joint investment in "enablers" such as workforce, technology and estates.

Our Healthier South East London
Integrated Care System

Our shared principles

This plan outlines a "journey" to a new health and care system for South East London, one which will support all of our neighbourhoods and communities through deepening integrated ways of working together with the culture and behaviours required to deliver joined up, person-centred care.

This will required shared leadership across traditionally separate organisations, services and boundaries; including those between those receiving services and those planning and delivering them. Our proposed approach will be build upon:

A "whole system" approach

1. **A focus upon the population and communities of South East London and our six boroughs.**
2. **Being clear about what is needed** from, and the requirements across, primary care, community care, social care, mental health and acute care to deliver integrated models of care and support.
3. **Using our collective capacity to deliver care in the most efficient and effective way for our whole population**, ensuring we provide effective support to both mental and physical health needs.

Safely addressing local needs and inequalities

4. **Taking action to address both the inequalities in health and care access and outcomes** and the public health challenges exacerbated through the pandemic.
5. **Ensuring that the way we deliver services gives our population the confidence to access the care they need**, whatever the coming months bring.
6. **Building and caring for our workforce**, now and in the future.

Future-facing

7. **Building on our wider strategic plans** – taking our original integrated care system plan and London Vision as "touchstones" for our work.
8. **Ensuring long term changes to models of care based on best-practice and sustainable investment.**
9. **Identifying and adopting innovation to help overcome workforce pressures**, support staff and ensure effective infection prevention and control.

A "learning" partnership

10. **Focussed upon and driven at the right scale for delivery** – empowering patients, service users, carers and front line professionals.
11. **Transparent about our objectives, our actions and their impact** – engaging local people and traditionally excluded groups.
12. **Using data and intelligence to inform plans and decision-making**, evaluate, adapt and improve as we learn.

Our provider collaboratives

Our Healthier South East London
Integrated Care System

Our provider collaboratives are focussed on improving standards and services across acute and community settings, and physical and mental health, working with local partners, providing "mutual aid" and collaboration in areas such as workforce and management. This includes developing our "core offer" for care pathways across South East London, and collaborating on their implementation.

South London Partnership

Oxleas NHS Foundation Trust, South London & Maudsley NHS Foundation Trust are working together in South East London to spearhead better mental health services as part of South London Mental Health and Community Partnership.

Together we work on a range of focussed, specialist programmes to improve patient care, experience and outcomes for mental health patients across the population. We bring shared clinical expertise, knowledge and best practice together, working at scale and providing best use of resources where we can make a difference.

Our aims include delivering care closer to home, with increased local community services and evidence-driven specialist support and clinical interventions.

Current areas of focus include improving access to mental health services for both the immediate and longer-term, and addressing the challenges of "out of area" placements for female psychiatric care, as a partnership.

Our Community Provider Collaborative

Oxleas NHS Foundation Trust, Guy's & St Thomas' Hospital NHS Foundation Trust, Lewisham & Greenwich NHS Trust and Bromley Healthcare all deliver community services across South East London. We work alongside the 212 local GP Practices and thousands of individual local voluntary & community organisations to provide services in our communities.

Our community services have seen significantly increased demand including as we address pent-up demand from the lockdown period and respond to new and exacerbated healthcare needs, as close as possible to people's home. Services such as district nursing have been under specific pressure including due to limitations of capacity required by the ongoing need to safeguard staff and patients.

Community services play a key role in the recovery of our health and care systems as a whole. Our approach builds on our pre-COIVD work to respond to the NHS Long Term Plan whilst also reflecting recent lessons and requirements. The South East London Community Provider Network has established a "Keeping People At Home" workstream, which oversees our Accelerator Programme of work.

Our Acute Provider Collaborative

Guy's & St Thomas' Hospital NHS FT, King's College Hospital NHS FT and Lewisham & Greenwich NHS Trust are working together to improve the way acute care is delivered, as the South East London Acute Provider Partnership.

We are committed to transforming the way in which outpatient services are delivered, addressing broader un-warranted variation in hospital care, and securing joined-up approaches to service planning and delivery across South East London.

Our Acute Provider Collaborative, supported by Out Healthier South East London, provides the vehicle through which we are driving this transformation, alongside our work with the broader NHS in London as part of the elective recovery programme.

The Acute Provider Collaborative is leading on elective recovery including development of clinical networks and collective approaches to waiting lists and managing capacity,

Our Local Care Partnerships: Bexley

Our Healthier South East London
Integrated Care System

The Bexley Local Care Partnership is a partnership between 13 health and care organisations, including many system partners. Our 2018 vision and values document is in effect a memorandum of understanding between partners, has three clear purposes:

1. **To outline the vision for how health and care services will look and feel in future**
2. **To set out the values and behaviours that partners agree to work to**
3. **To record the agreement of partners in working toward this vision according to the shared values.**

It heralds a new approach to meeting the needs of the changing Bexley population and to maintaining the borough with healthy residents and thriving communities. The new approach is for the NHS, local authority, service providers, charities and voluntary sector to come together to work in partnership, to design health and care services around the concept of 'place'. Prevention and early intervention, care at home, self-management of conditions, community resilience and healthcare access are all features of this place-based approach.

The Local Care Partnership vision is for services to be developed with the person at the centre, coordinated and tailored to the needs and preferences of the individual, their carers and family. The new systems of care will see partners working together on a strategic level to understand the population and agree how resources can be used to achieve shared objectives. This includes commissioners working together to take explicit responsibility for resources and outcomes, and to blur the lines of the traditional relationship between commissioners and providers.

Bexley has made progress in integrating services with the formation of integrated commissioning functions between the CCG and Borough Council; the federation of GP practices into Bexley Health Neighbourhood Care; the creation of Bexley Care, a new integrated care provider that brings together adult social care and adult community and mental health services into a single management structure; and in developing Local Care Networks.

London Borough of Bexley – Trusted by Bexley residents
Bexley Care – We're here for you
NHS South East London Clinical Commissioning Group
Lewisham and Greenwich NHS Trust
Oxleas NHS Foundation Trust
NHS Dartford and Gravesham NHS Trust
BVSC Bexley Voluntary Service Council – Strengthening voluntary and community action
Bexley Health Neighbourhood Care BHNC

Our Healthier South East London
Integrated Care System

Our Local Care Partnerships: Bromley

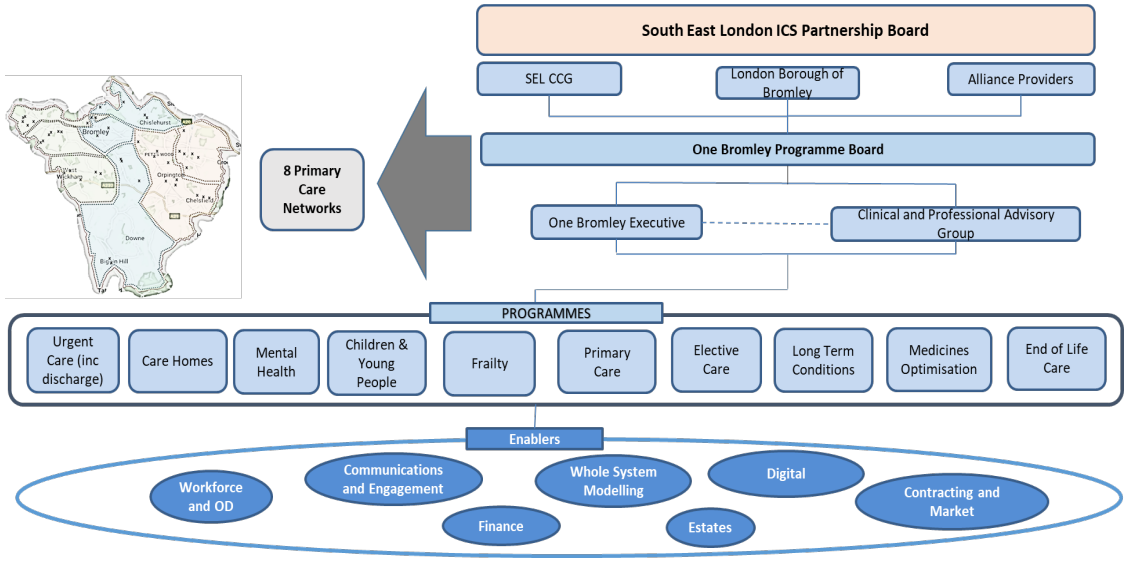
ONE BROMLEY

One Bromley brings together local organisations including King's College Hospital NHS Foundation Trust, Oxleas NHS Foundation Trust, Bromley Healthcare, Bromley GP Alliance, St Christopher's, Bromley Council, Bromley CCG and Bromley Third Sector Enterprise to more formally join forces and deliver seamless, personalised and joined-up care for individuals. It is about improving outcomes, independence and quality of life for the people of Bromley.

During the pandemic, we have sped up implementation of our improvement plans to ensure local people could continue to access the care and support they need, with a One Bromley "control centre" co-ordinating our response.

Our borough recovery plan describes how as One Bromley we will continue to restart those services paused in the pandemic, take steps to reduce the risk and manage any "second wave" of Covid-19, and apply the lessons from the response so far to our long-term ambitions for health and care in Bromley. This includes:

- **Supporting and empowering our residents** to have healthier and more independent lives.
- **Giving every child in Bromley the best possible start in life.**
- **Reducing health inequalities.**
- **Providing personalised and proactive care** to our most vulnerable residents.
- **Ensuring mental health conditions are given the same priority** as physical health.
- **Enabling partners and services in Bromley to work as a single system** to deliver integrated care.
- **Reducing duplication and enabling more people to be cared for in the community.**



Our Local Care Partnerships: Greenwich

Our Healthier South East London
Integrated Care System

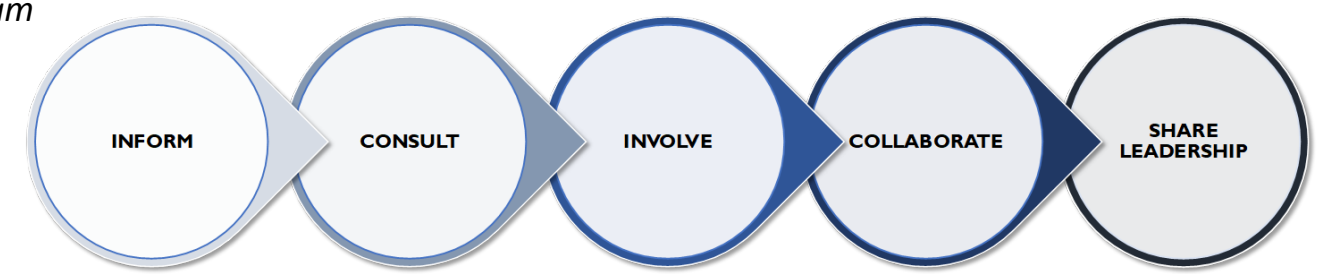
Healthier Greenwich Alliance is our Local Care Partnership which formally reports into the Health & Wellbeing Board. It brings together Greenwich partners in health and social care including:

- NHS South East London CCG – Greenwich
- Royal Borough of Greenwich – Public Health, Adults, Children & Young People
- Oxleas NHS Foundation Trust – Community Services and Mental Health provider
- Greenwich Health – GP Federation
- Primary Care Network Clinical Directors
- Healthwatch Greenwich
- Lewisham and Greenwich NHS Trust
- METRO GAVS – voluntary sector

Overall responsibility for our local plan sits with Greenwich Health & Wellbeing Board. Delivery will be through the Greenwich Borough Based Board and Healthier Greenwich Alliance. This is to ensure we have the depth and breadth of local engagement with all local organisations.

We are moving to a more integrated commissioning and delivery arrangements across health and care together with NHS system development work with Bexley, Lewisham and Greenwich Trust and Oxleas Trust. In order to deliver at pace and continue to manage with Covid – 19 within our population(s) we will also make use of the following operational groups:

- *Royal Borough of Greenwich Health and Adults Services Directorate Management Team*
- *Royal Borough of Greenwich Children's Directorate Management Team*
- *South East London CCG Greenwich senior management team (SMT)*
- *Greenwich and Bexley system group (Resplendent)*
- *Our A&E Delivery Board*
- *South East London Planned Care Board*
- *South East London Acute Based Care Board*
- *Our Healthy South East London Partnership (ICS)*



Our Local Care Partnerships: Lambeth

Our Healthier South East London
Integrated Care System

Lambeth is a diverse and densely populated borough and is the seventh highest population in Greater London with over 325,000 residents, speaking over 130 different languages. Over the last decade, Lambeth has become relatively less deprived. However, for certain indicators, it remains in the top 10% of most deprived boroughs nationally.

Lambeth Together is our health and care partnership bringing together the NHS, Lambeth Council, and the voluntary sector with service users and local people within the borough. Over the past three years it has been the vehicle by which we have developed our strategic leadership, our ways of working and a culture that brings us together; and a set of 'delivery alliances' delivering care in an integrated way with our local communities.

Through Lambeth Together, we are working to improve health and reduce inequalities in the borough by promoting better outcomes, improved experiences of receiving and providing care, and delivering better value.

We believe much of what we were doing through Lambeth Together before Covid-19 is as relevant now as ever before. We have a responsibility to work with local people and communities to accelerate those developments which will help keep people safe and well in the context of the ongoing pandemic; whilst learning the lessons from Covid, and taking the opportunity to address long-standing and worsening inequalities. To do this we must give local people and our health and care workforce a clear voice in developing our response.

Our plan therefore sets out:

- **The immediate actions we are taking as a partnership to support and safeguard our population, to address immediate needs, to restore key services** affected by the lockdown period, upon which our communities rely.
- **The insights and learning from local communities** and how these have shaped our current proposed priorities and plans.
- **The key questions we want to explore and our next steps**.

Our Healthier South East London
Integrated Care System

Our Local Care Partnerships: Lewisham

Lewisham Health and Care Partners (LHCP) includes:

- Lewisham & Greenwich NHS Trust (LGT)
- London Borough of Lewisham (LBL)
- NHS South East London Clinical Commissioning Group (CCG)
- One Health Lewisham (Pan-Lewisham GP Federation)
- Primary Care Network Leads & Lewisham's Local Medical Committee
- South London and Maudsley NHS Foundation Trust (SLaM)

Discussions are taking place to secure strategic input from the voluntary and community sector given the important role of the VCSE in maintaining and improving health and wellbeing.

Alongside Lewisham's integrated health and care commissioning arrangements, the borough has two alliance leadership groups for Care at Home and Mental Health.

- **The Care at Home Alliance Leadership Group** brings together local health and care organisations to work together to establish proactive, accessible and coordinated community based care in order to achieve better health and wellbeing outcomes for adults.
- **The Mental Health Alliance Leadership Group** 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. The group's remit is being expanded to include Children's Mental Health and Older Adult Mental Health.

Our LHCP Executive Board provides shared leadership, helping to set strategic direction and oversee the changes required for better health and care across Lewisham. The Council and CCG are seeking to further strengthen shared commissioning arrangements for health and care services as part of ensuring our work is integrated around local people, communities, and our borough as a whole.

Our recovery plan reflects a number of key priorities for 2020-21.

Alongside our work on preventing and managing any future outbreaks of Covid-19, protecting and empowering our most vulnerable residents and building on learning since March, we will continue to work together to join-up community based care at a neighbourhood level, including in areas such as prevention, early intervention, care at home and end of life care.

Informed by local experiences, we will develop the links between our neighbourhoods and our hospitals, helping to keep people living safely, independent and well, and to regain their independence after a hospital stay.

These plans sit within the context of and support broader Lewisham Council recovery planning, including restoring essential social care and wider council services, and the linked priorities of promoting community development and resilience; a local economic recovery that is inclusive and sustainable; tackling widening social, economic and health inequalities; supporting cultural recovery, including the Borough of Culture 2022; delivering a Green recovery, with decisive action on the climate emergency; and one that creates educational opportunities and promotes the achievements of all our young people.

Our Local Care Partnerships: Southwark

Our Healthier South East London
Integrated Care System

Partnership Southwark includes Southwark Council, NHS, and a range of local health, care and voluntary, education & community organisations with service users, carers and local communities. Our focus is on making Southwark an amazing place to be born, live a full healthy life, and spend one's final years.

Our Partnership Southwark Recovery Plan describe our shared priorities and how we will work together with local communities to ensure these commitments are fulfilled, delivering better services and better outcomes for all the people of Southwark.

We recognise that whilst the pandemic has affected everyone's lives in Southwark, the impact has disproportionately affected certain communities including those from Black, Asian and Minority Ethnic groups; older people; people living with multiple underlying health conditions; living in areas of deprivation; working in public facing roles (including in a health and care-giving capacity); and living in care homes.

Our plan sets out learning and how we will respond, to prevent and manage any further outbreaks, to confront pre-existing, new and worsening inequalities, and to deliver better health and wellbeing for everyone in Southwark.

We recognise that this journey will not be quick or easy.

- **In some areas our plan describes the steps we are taking now to re-open services and provide additional support** as we continue to manage the effects of COVID-19 in our communities;
- **in other areas, it describes our proposals for developing new models of neighbourhood support** to better meet the needs of all of our population;
- **and it sets out how we will engage and work with local people to shape and deliver** on these priorities.

A phased approach

Our Healthier South East London
Integrated Care System

We recognise that recovery from COVID will not be a "linear" process – we need to support all parts of our systems to respond to levels of COVID and COVID-related demand which are likely to fluctuate over time, whilst maintaining a consistent focus on our population and staff health and wellbeing.

This process will require flexibility, agility, and a high degree of mutual trust. A critical measure of our success will be our ability to sustain a broad range of services, and to offer each other "mutual aid", to ensure that the population of South East London continues to be effectively supported even in the event of multiple further local or regional outbreaks of COVID-19.

Crisis management	Transition	Recovery

Escalation Phase

- Gearing up to manage COVID-19 response as a critical incident.
- Significant refocussing of capacity and services to support COVID-19 response.
- Changes to pathways and associated services with benefits we will want to embed.

Stabilisation Phase

- On going management of COVID related demand and requirements.
- Planning for and ability to manage likely increased non-COVID demand.
- Scaling up of existing non-COVID services in some areas, whilst embedding new ways of working in others.

Recalibration Phase

- New operating models and ways of working agreed and embedded – building on the service transformation that has happened.
- Targeted intervention to support us in addressing the consequences of COVID e.g. on morbidity, waiting lists.

Triggers to inform or drive the point at which we move from one phase to another
combining population / disease and operational triggers e.g. COVID-19 demand & bed occupancy

Population driven, targeted action and intervention
Early work to identify the population and patient / service user groups we need to prioritise in each phase

Regional recovery tests & expectations
Working with NHSE/I Regional Team to support each phase e.g. Stabliisation - (1) & (2), Recalibration/recovery – (4), (6) & (7) and Recovery – (3) & (5)

Patients, Staff & Partners (GPs, LAs, Providers) – culture and behaviour
Ensuring ways of working that build in culture and behaviour change, secure shared objectives/outcomes and support innovative approaches

Key outcomes for the next 18 months

Our Healthier South East London
Integrated Care System

Meeting patient needs

1. COVID Treatment Infrastructure (Exp 1, 2 & 6)

Permanent doubling of our critical care infrastructure at our tertiary hospital sites, plus providing future additional support e.g. ECMO life support capacity for the Nightingale Hospital

A proven "Surge" capability to ensure we have critical care capacity when we need it.

The ability to meet future COVID demand across South East London whilst meeting other health and care demands.

Segregating COVID / non-COVID patients - by site or within sites.

Ensuring that improvements and learning become part of business as usual.

2. Non-COVID Urgent Care (Exp 1, 4, 5 & 6)

Identifying and prioritising patients and services to ensure that people can access diagnostic services in a timely way, to ensure that all treatment and care plans are reviewed and up-to-date, and that physical and mental health services are accessible way through the coming months.

Proactive communication and engagement with and across frontline professionals, patients and service users, and the public to effectively manage demand in this period.

3. Elective Care (Exp 1, 4, 5 & 6)

Agreed South East London principles for managing demand and capacity on a system basis.

Modelling of capacity requirements and options for securing additional capacity across all services, including mental health and community services

Maximising productivity, efficiency by supporting each other to learn from and share best-practice across South East London.

A clinically-led and agreed framework for prioritising areas such as cancer and elective care

Capturing the gains from working differently and using these to support further improvement.

Addressing new priorities

4. Public Health Burden of Pandemic Response (Exp 5 & 7)

The shared resources of the Integrated Care System and local partners to be focused on reducing inequalities and improving health outcomes.

Joint working between local councils, the NHS and the voluntary and community sector to address the socio-economic and health impact of COVID – including physical and mental health.

An immediate focus on identifying patients and service users with immediate treatment whilst encouraging people to access care more generally.

Understanding developments in areas such as the shielded population, hubs and mental health as foundations to build upon.

5. Staff and Carer Wellbeing (Exp 7 & 10)

Delivering on our existing commitments to support and invest in our workforce including as part of the NHS Long Term Plan.

A specific focus and commitment on staff health and well being as we recover from the pandemic – including recognizing and addressing the psychological impact of the pandemic

A focus on supporting at risk and vulnerable staff, including clear risk assessment and support for BAME staff

Shared approaches to recruitment and development of staff and voluntary partners to help build local capacity, resilience and flexibility across our frontline teams.

Resetting to a new & better NHS

6. Innovation (Exp 3, 4, 5, 6, 8, 10 & 12)

Developing support networks to enable our hospitals to better manage future demand..

Providing enhanced digital and virtual support for primary care and outpatient services, improving access and quality of care whilst also addressing digital divides.

Supporting enhanced community-based care and "home-first" models, integrated with hospital discharge and broader changes to the way we work.

Accelerating the development of supporting "infrastructure" – including becoming a learning system and better population health management.

7. Equality (Exp 7 & 12)

Ramping up of existing inequalities programme, whilst responding to identified COVID related challenges:

- **Building on the targeted interventions successfully applied during the first wave of COVID** – shielding, mental health support, action on homeless, drugs and alcohol.
- **Ensuring equity of access where innovation has been applied** e.g. in the introduction of new digital services.
- **Targeting key patient cohorts for expedited review and treatment** working jointly to identify those in the greatest need.

8. The New NHS Landscape (Exp 11 & 12)

Delivering significant progress, as London's first Integrated Care System, on demonstrating the value of and outcomes from:

- **Improved ICS governance and infrastructure** reflecting the key role of local government and VCSE organistions, including through our borough-based boards and neighbourhood working.
- **Formalising collaborative arrangements between providers** including around acute services
- **Reforming the way we commission and deliver services** with enhanced clinical leadership, and effective citizen and patient and public engagement.

Leadership and governance

Our Healthier South East London
Integrated Care System

The purpose of our Integrated Care System Recovery Plan is to support the NHS organisations, six local authorities and our voluntary and community sector partners which make up the South East London "system of systems" to manage and recover from COVID-19 – to build back better. To achieve this we have identified a number of key enablers which will need to be delivered in order to support local and South East London wide-plans, together with the joint leadership to oversee and co-ordinate associated activity and deliverables:

KEY STAKEHOLDERS

- Local authority leaders and elected members
- NHS Chairs
- Chief Executives and system leads
- Patient and service user representatives
- Local borough partnerships
- London Strategic Oversight & Work Programmes
- SE London Operational Leads Group

ICS RECOVERY LEADERSHIP GROUP

Chair: ICS Chair **Members**: ICS Lead, Acute Provider CEO, MH/community provider CEO, CCG Chair (PLG & Primary Care), Local Authority CEO Lead, Local Authority DAS Lead

SYSTEM RECOVERY "ENGINE ROOM" (Children & Young People, Adults and Older People)

- PRIMARY CARE
- COMMUNITY & SOCIAL CARE
- MENTAL HEALTH
- ACUTE CARE
- PUBLIC HEALTH
- VOLUNTARY & COMMUNITY SECTOR

SEL COVID ICC

Connects recovery and current COVID state

SEL COVID PLG

Supports ICC response PLUS provide clinical leadership to recovery

SYSTEM ENABLERS (supporting SE London wide and local recovery)

- CAPACITY AND DEMAND PLANNING
- WORKFORCE
- DIGITAL
- CARE HOMES SECTOR SUPPORT
- FINANCE
- BUILDINGS AND ESTATES

Our Healthier South East London
Integrated Care System

Key challenges

We recognise that even without COVID, the journey to having an effective integrated care system, one which balances capacity and demands on health and care resources across South East London with local priorities and tackling long-standing inequalities, was never going to be an easy or straight-forward one. We know our integrated working is not uniform across our ICS and we have further integration opportunities as well as excellent examples from which to learn and build.

We believe responding to the pandemic has strengthened our integrated and partnership working across the ICS – our ICS Recovery Leadership Group has supported a whole-system view across health and care; our Clinical Advisory Group has helped galvanise shared clinical leadership; our local authority Community Hubs have helped safeguard and support people in their homes and communities; and our provider collaboratives have seen a step-change in engagement and collective action and responsibility.

We have made good progress in putting in place key structures and enablers including in the appoint of an independent ICS Chair, a single Clinical Commissioning Group for South East London, development of our 6 borough-based partnerships and 35 Primary Care Networks (with Clinical Directors in-post and working collaboratively, including thorough GP Federations, to provide services at scale); and most recently, the development and agreement of borough recovery plans.

Some of the key challenges we are now working on across South East London include:

A. **Decision making and governance** – under review with new governance arrangements planned for 2021.
B. **Interfaces & relationships** – developing common understanding and ways of working between our Integrated Care System, commissioners and providers of health and care services, our provider collaboratives and Local Care Partnerships / Local Care Networks.
C. **Finance** – working jointly through budgetary constraints, underlying deficits, the funding requirements for our recovery plans, investing in out-of-hospital services, developing the right levers and incentives and addressing historic inequity of investment across our boroughs and services.
D. **Operational performance** – COVID-19 has exacerbated historic challenges including around waiting times and created new challenges to maintaining and enhancing access to services during the ongoing pandemic.
E. **Exacerbated health needs and inequalities** – alongside increasing needs and the requirement to maximise capacity and activity safely.
F. **Workforce** – ongoing challenge in terms of recruitment and retention, and looking after and supporting staff, including in integrated teams.
G. **Demand & Capacity** – services were under pressure pre-COVID. Backlogs and fragility in the care home, domiciliary care and voluntary sectors will add to the challenges as we recover.

We will continue to work jointly within South East London and with colleagues at a regional and national level to name and address these challenges as we develop and deliver on these plans.

A new relationship to delivery

Our Healthier South East London
Integrated Care System

Public engagement is a fundamental part of our service redesign and transformation plans in South East London. We understand that as part of our recovery journey there is an opportunity – and more to do – in relation to developing our work at a South East London level, including in better engaging those communities traditionally underrepresented but often in most need, our older population, carers, and the children and young people who are the future of South East London. This will involve working in close partnership with local organisations, community leaders and elected representatives.

The COVID pandemic has required an emergency response and a number of rapid and significant changes have been made to ensure patients and service users can continue to receive safe, high quality care, including a shift to more virtual consultations. Such changes involve trade-offs and implications which may emerge only over the longer-term. Virtual consultations offer convenience and safety for many but will have access implications across our communities if not part of a broader conversation and approach to delivering inclusive and equitable services.

We are committed to exploring how deliberative engagement can support our decision making and to involving a wide range of stakeholders and elected members in shaping and delivering these plans. This approach will build on initiatives already in place such as the recent One London Citizen's summit, Lambeth's planned Citizens Assembly on climate change and the existing deliberative ward panels in Lewisham.

A full communications and engagement plan is being developed with partners to support each borough recovery plans. This includes:

- **Reflecting on what we know** from previous engagement work.
- **Understanding further what we have learned** from people's experiences of receiving care during the pandemic and the impact this has had on them.
- **Identifying and addressing gaps** in our knowledge and understanding.
- **Considering how this will shape our recovery planning and delivery** going forwards at both a borough and South East London level.
- **Working collaboratively across our systems** in a coordinated way for the good of all of our residents.

Given COVID-19 has disproportionately affected older people and those from the BAME community – alongside the impact on men, lower paid workers, people with long term conditions, people with learning disability and/or autism and people with mental health needs – we will engage proactively and work with people from these communities and groups to understand the impact across South East London's boroughs.

Our ambition is to build a new social contract with our communities – enabling people to become partners in shaping our new health and care system and service offer. We intend to take an South East London-wide approach to engagement on system-wide issues, whilst at borough level we will work with our new local care partnerships and borough-based boards, alongside existing forums such as Health & Wellbeing Boards, Healthwatch and the voluntary and community sector to enable effective and comprehensive engagement. At neighbourhood level we will link with Patient Participation and local community groups working with community hubs, peer supporters, and local elected members, to enable in-depth local discussions.

Your feedback will inform how our recovery priorities are taken forward, as well as continuing to shape our longer-term plans for better health and wellbeing across South East London.

Our Healthier South East London
Integrated Care System

Appendices

A partnership of NHS commissioners and providers, the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, and the voluntary and community sector

Bexley Local Care Partnership

Our Healthier South East London
Integrated Care System

Making tackling inequalities a reality

Managing Long Term Conditions	Mental Health	Supporting Children & Young People	Digital Inclusion	Thamesmead

Developing our out of hospital system

Urgent & Emergency Care	Planned Care	Improving Discharge – Home First	Outpatient Transformation	Domiciliary Care & Reablement

Managing and mitigating the effects of Covid-19

Shielding	Rapid Testing	Infection Prevention & Control	Supporting Care Homes	End of Life

One Bromley

Our Healthier South East London
Integrated Care System

2. Our priorities for recovery

Improving the health & wellbeing of our communities
including addressing health inequalities

Urgent Care	Frailty	Mental Health	Elective Care	Children & Young People	Long Term Conditions	Care Homes	Medicines	End of Life Care
planning for winter and any future Covid-19 "spikes", developing our Single Point of Access those being discharged with future care needs.	supporting early identification and proactive support to those at risk, across our hospital and community-based services.	delivering our commitment to better mental health and wellbeing, early intervention, rehabilitation and recovery in the community.	ensuring patients are informed around the services now available and working with them to prioritise next steps for our improvement.	improving access to support, including via digital, and ensuring safe, effective and proactive care across all local settings.	joining up care including with our Primary Care Networks and tackling key factors in long-term ill-health in Bromley such as diabetes.	applying the learning of Covid-19 and working together as a health and care partnership to support those in our care homes.	ensuring safe access to effective medicine for higher risk patients and providing more pharmacists working closely with GP services.	working in partnership with St Christopher's to ensure care for at the end of their life is co-ordinated and respects their wishes.

Working with communities to safeguard our population
managing any second wave of COVID-19 and providing support to vulnerable or at risk residents.

Delivering the enablers our "One Bromley" approach
including management of capacity and demand, estates, digital, contracts & procurement, workforce, and leadership.

ONE BROMLEY

Healthier Greenwich Alliance

Our Healthier South East London
Integrated Care System

Our Recovery Plan Priorities

Addressing Health Inequalities

proactively tackling health inequalities, including working with our BAME communities, to improve outcomes for all

Improving Mental Health & Wellbeing	Healthy Weight and Active Lives	Start Well	Prevention & Live Well	Age Well	Developing our Health & Care System
where individuals and communities take the lead: a borough with a happy, healthy and productive workforce, free from mental health stigma & discrimination, one that maximises the potential of children and young people, and where services are there for people when and where needed. A zero-suicide city.	Creating environments, activities and opportunities for people to enjoy healthy food cultures, be active in their everyday lives and maintain a healthy weight. Tackling food poverty, developing cooking skills and confidence. Supporting active lives through travel, leisure, sport and daily living. Working with workplaces, shops, the hospitality industry, schools, health services and others. Improving weight management services for children and adults.	delivering for all of our Children & Young People: improving physical and mental health, providing for well-supported Special Educational Needs and Disabilities (SEND), supporting achievement at Key Stage 4 and 5 and being well prepared for adulthood. Working with families to ensure children & young people are safe from harm in their home, online, in schools and in the community.	helping to prevent ill-health including through immunisations, health checks including for people with learning disabilities, early detection and screening, and working with the voluntary & community sector to improve overall population health and wellbeing; whilst providing joined-up support for those living with Long Term Conditions. Delivering co-ordinated care for people with Learning Disability and Autism	support to live long, healthy, active and independent lives: with care and effective treatment for both sudden and unexpected, and longer term health problems or disabilities; support from "Home First" help to recover from periods of ill-health; and access to safe and high-quality home, residential and nursing care when needed. Support co-designed with individuals and carers themselves.	joining-up the way in which we plan, deliver and fund services: bringing together prevention, primary care, community support, acute, mental health, social care, care providers and VCSE partners; and building on our community hub to establish effective and sustainable neighbourhood models of working.

Working with our communities to keep each other safe

developing our Community Hub, Infection Prevention & Control, "Covid-19 Secure" services and support for shielding

Lambeth Together

Our Healthier South East London
Integrated Care System

Addressing Health Inequalities

acknowledging and addressing inequalities within Lambeth which result in poorer outcomes for deprived and BAME communities

Lambeth Staying Healthy Board

Staying Healthy

- recovering preventative services.
- embedding innovation including digital and phone access.
- developing our neighbourhood plans for public health with primary care, voluntary & community sector, mental health and key partners.

Sexual Health

- developing our online contraceptive and sexual health offers.
- integrating with recovered clinic services through the LSL partnership improvement programme.
- ensuring that residents at highest risk of poor sexual health outcomes are targeted effectively and take up support.

Our Delivery Alliances

Children & Young People, Neighbourhood & Wellbeing, Living Well

Children & Young People

- managing safeguarding concerns and complex / crisis care referrals.
- tackling waiting lists.
- developing digital community and mental health.
- re-instating elective activity in hospitals.
- providing continuity-of-care.
- developing our system-wide estate plan.

Joining up services in neighbourhoods, and identifying & supporting residents with the most needs

- more people have and know how to access good quality care at home and in the community.
- more people receive good quality aftercare, with rapid and effective joint decision making.
- a shared plan, proactive care and support for people at most risk of poor physical or mental health.
- supporting loneliness, multiple long term conditions, frailty or last years of life; at home, in care homes, and for carers.

Adult Mental Health

- co-produced digital and place-based services that promote individual and community resilience.
- improving joint working to address physical and mental health.
- improving support to staff and service users.

People with complex care needs

Learning Disabilities & Autism and people with Continuing Complex Needs

- mitigating the effect of Covid for those with continuing complex needs, learning disabilities & autism.
- with support that helps adapt to a changing society.

Homeless people and Rough Sleepers

- delivering the 'in for good' principle with measures to prevent future homelessness.
- improving outcomes for BAME, rough sleepers with complex health needs, and people experiencing domestic violence.

Safeguarding our communities and those who support them

being able to prevent and predict a potential second wave of Covid-19, and responding in the event of a surge, with developed & shared plans

Lewisham Health & Care Partners

Our Healthier South East London
Integrated Care System

Addressing Inequalities
addressing inequalities and disparities in risks and outcomes, including a specific focus on our BAME communities and staff.

Care Homes supporting care homes locally including co-ordinated support and safeguarding of all residents and staff	**Prevention** restarting services reduced or put on hold during lockdown with a focus on addressing inequalities	**Planned Care** including proactive immunisations, cancer screening, Long Term Conditions support and management, postnatal and health checks	**Building Community Resilience** recognising individual strength, knowledge and skills to ensure people have more control and a greater voice	**Children, Young People & Families** catch-up immunisations, screening and weight management, mental health support and support to schools Implementation of the i-Thrive model across early help and emotional health services to develop a common language and enable better access to services, creating improved family resilience
Frailty understanding and mapping mild, moderate and severe frailty, links to other conditions, and how best to provide more responsive care	**Diabetes** including patients with undiagnosed diabetes, at risk of developing diabetes and with gestational diabetes	**Respiratory** integrated respiratory community hubs, review of Lung Education Exercise Programme (LEEP), and implementation of multi-disciplinary working for respiratory patients	**Mental Health** Front Door & Rapid Crisis Response, Community Support, Rehabilitation & Complex Care, including addressing inequalities and improving outcomes for BAME communities	

Safeguarding our communities and those who support them
mitigating and managing the risks of a "second surge" of Covid-19 in Lewisham, including Test and Trace, Shielding, "Covid-19 Secure" services

Partnership Southwark

Our Healthier South East London
Integrated Care System

Addressing Inequalities
actively listening and responding to partners and residents
in support of Southwark Stands Together and in building broader community engagement

Safeguarding our communities and those who support them
mitigating and managing any second wave of COVID-19
with dedicated support to those who are vulnerable or at risk

Start Well	Live Well	Age Well	Care Well
supporting children and young people - "keeping families strong"	supporting working age adults with joined up services that tackle the causes of ill-health and promote wellbeing	neighbourhood-based networks to keep people as healthy and independent as possible in their home	supporting those in care and residential settings for older people and physical disabilities, mental health and learning disabilities

Appendix 2: Sector Plans on a Page

Primary Care
The following themes have been consistently highlighted within our borough primary care plans as priorities for recovery

Our Healthier South East London
Integrated Care System

What we deliver

- Population health management approaches which proactively address health and wellbeing inequalities
- Safe and agile services that a) build upon new models of access and delivery; and b) can respond to further surges in demand

How we work

- Continue to develop Primary Care Networks
- Work in wider partnerships to integrate local services
- Establish robust delivery & governance processes
- Maintain entrepreneurial ethos and foster new ways of working

Enabling delivery

- Invest in and support our workforce
- Optimise our estate and support IPC
- Develop our technology and digital infrastructure
- Communicate and engage with, and listen to, our communities
- Enabling finance and contracting arrangements

Community Services
South East London Stabilisation, Recalibration and Renewal

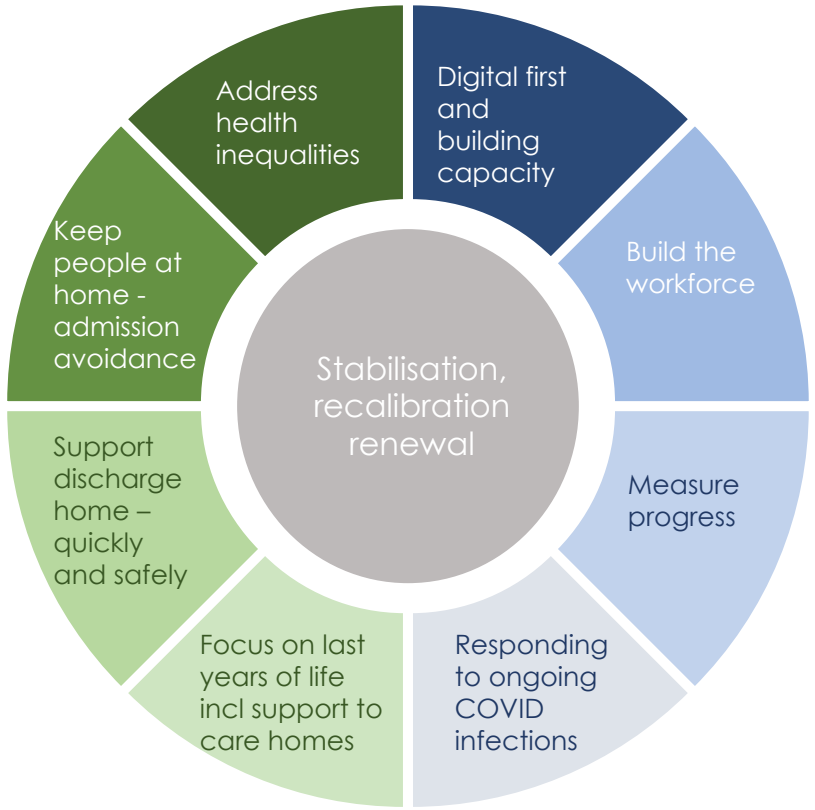
Our Healthier South East London
Integrated Care System

Our approach to stabilisation, recalibration and renewal plan

- **Learnt from COVID and informed by discussions** with the four community providers, six social services, hospices, primary care and borough colleagues.
- **Cross checked against NHS London** 12 expectations and 8 tests.
- **Builds on our response to the NHS Long Term Plan** and our national exemplar Accelerator programme for an Urgent Community response.
- **Takes a population health approach** and expects multi-disciplinary and partnership working.
- **Anticipates potential future peaks** in infection.

Priorities

Enablers



If our plan is successful, by Sept 2021 for every SEL resident living in their own home / care home:

- **Shielded patients are known** by their PCNs, community providers, social care and vol sector, leading to a proactive multi-disciplinary team (MDT) intervention to maintain health and reduce the risk of admission.
- Patients from **BAME communities** receive services that respond to their increased risk from COVID and are targeted to their needs.
- Patients and their carers are **supported to remain at home** during periods of ill-health, with a care plan that addresses their physical and mental health and wellbeing, and what to do in a crisis.
- In a crisis, a community assessment and **response is offered within 2 hours** to people living with frailty/ multiple conditions, leading to less people from this cohort being admitted.
- If admitted, patients are safely **discharged as soon as medically fit** and offered appropriate support in their home to promote independence and wellbeing. Patients discharged from critical care services have an MDT approach to their recovery needs, including access to psychological support.

Underpinned by principles of 'Home First' and 'Right Care, Right Time, Right Place'

Mental Health
Reshaping Our Mental Health Services Across South East London

Our Healthier South East London
Integrated Care System

Front Door / Crisis Offer
Learning and building on what was successful during our Covid-19 response – delivering a best in class mind and body offer on the crisis pathway

Housing / Welfare / Employment
Picking up the Long Term Plan ambitions for our community rehabilitation offer

Pharmacy and Prescribing
Focus on psychosis and schizophrenia

Primary Care Network Therapies Offer
Meeting the post Covid-19 demand to support local communities and staff

Reducing Health Inequalities
Roll out the Mind and Body Programme across all services to strengthen link between good physical and mental health

Patient safety and wellbeing supported with best in class infection control: testing, cohorting, isolating and social distancing

Sustainable community offers in place learning from pace and what's achievable as part of Covid-19 response. Supported with new internally commissioned housing rehab models

Continuation of SLP Provider Collaborative model to consolidate and strengthen centres of excellence in specialist and tertiary care across South London

The journey to the new normal will be innovative and exciting for staff with good care for patients at its centre. The national good feeling will be used to attract new staff into Trust roles

Development of mental health crisis assessment offers to support and enhance the existing Acute ED offer

Working hand in glove with communities and other health and care partners across SEL to meet population health needs and improve access for our hard to reach communicates

C-19 infection rates & bed usage
- Provide clear line of site to manage surges and hospital infection risks.
- Informed breakdown of C-19 positive patients. .

Capacity planning
- Provide evidence to support capacity planning and future surge.
- Different models to outline need for potential second surge.
- Effective planning of C-19 wards pan London.
- Data will identify vulnerable groups.

Staff wellbeing
- Clear catalogue of interventions that will support staff affected by treating C-10 patients.
- Inform treatment requirements- Trusts able to lead ICSs on most valued treatments.
- Inform new compact and address unequal impact (BAME, gender)

runs throughout all projects

1 Covid Treatment Infrastructure
2 Non-Covid Urgent Care
3 Elective Care
4 PH Burden of pandemic Response
5 Staff & Carer Wellbeing
6 Innovation
7 Equality
8 The New H&C Landscape

MH Crisis Care
- Provide a catalogue of service innovations verified by clinical leads.
- . Provide recommendations for new single 111 access route.
- Rapidly progress evolution of crisis system.

IAPT
- Provide a catalogue of service innovations verified by clinical leads.
- Inform design considerations of new models for London that are best able to meet population needs.
- Support rapid integration of IAPT in PCN and borough level.

The pandemic has further highlighted the pressures and requirements of different care settings and the importance of building effective partnerships for care alongside the treatment provided by NHS, the role of local community assets, and the need for ensuring adequate funding for social care in the future.

Whilst there are successes to build upon, including the speed of decision making and action, collaborative approaches, the development of the community hubs and support to the most vulnerable residents we need to ensure that future discharge arrangements are effectively co-ordinated with support to care homes. Technology will play in a key part in these developments but safeguarding and developing the care workforce will be central to our response.

We recognise that funding will remain a key challenge and could jeopardise progress. Priorities in developing our shared response include:

- **Supporting shielded residents** to an independent life.
- **Addressing exacerbated health inequalities caused by COVID-19** and the wider economic impact of COVID.
- **Supporting the voluntary and community sector** to address funding pressures and to sustain critical support through any subsequent waves.
- **Management of care home market** and addressing financial instability affecting to long-term care provision.
- **Maintaining the supply of PPE to the care sector** as we step down the emergency arrangements
- **Continuing to support effective discharge from hospital to appropriate care settings** whilst applying lessons from the first wave of the pandemic.
- **Building on the community resilience** and creative solutions developed including alternatives to day care, online support for those learning disabilities.
- **Exacerbated health inequalities caused by COVID** and the wider economic impact including on BAME communities and those on low incomes.
- **The increase in food insecurity across SE London** and potential link to health inequality
- **Work to develop programmes to support residents out of shielding** and to access support and services affected by lockdown restrictions.

Acute Care

Our Healthier South East London
Integrated Care System

Key changes made as part of COVID response:

- Routine elective surgery and routine diagnostic activity was stood down across all providers for around 13 weeks – backlogs have therefore increased significantly. Additional infection prevention and control measures were introduced including COVID protected pathways, additional PPE for staff and patients and additional cleaning / air changes between patients.
- Digital by default, in particular the use of telephone/video for outpatient appointments.
- Significant surge capacity for critical care opened, including the use of theatres and recovery areas, with very successful networked approaches to critical care provision across the three SEL providers.

Key elements of recovery plan:

- **Restarting activity** via a phased approach, with additional precautions in place, such as patients isolating before admission, to ensure patient and staff safety.
- **Redesigning services,** in line with infection prevention and control guidelines – e.g. spacing in Emergency Departments – and in response to evaluation of new ways of working introduced in the response phase. Key initiatives include:
  - **Urgent and Emergency pathway transformation schemes** driven through the system-wide Help Us Help You programmes, including Same Day Emergency Care .
  - **Building from the rapid expansion of virtual models** during the pandemic to drive our outpatient transformation programme at pace and scale.
- **Establishing a programme of work** to be progressed via the Acute Provider Collaborative, including:
  - **Elective surgery** – orthopaedics, urology and ophthalmology as initial priorities, to be followed by ENT, general surgery and gynaecology.
  - **Specialised services** – critical care as a top priority.
  - **Clinical support** – pathology (GSTT/KCH only) and endoscopy as initial priorities, to be followed by radiology/imaging and pharmacy.

Borough interfaces

- **Ensuring effective and timely access to swabbing** for patients ahead of admission.
- **Three diagnostic community hubs** will be established in SEL by April 2023. Locations are to be determined but likely to include Queen Mary's Sidcup with plans to develop from April 2021.
- **Maintaining discharge arrangements** to ensure that patients do not spend longer than necessary in hospital.
- **Supporting virtual access** to acute services and referral support to primary care e.g. using Consultant Connect.

Ways of working:

- To ensure the safe and effective recovery of clinical services post COVID-19 and to address the ongoing variation within the acute system in terms of access and outcome, SEL's three acute providers have formed an Acute Provider Collaborative (APC), a mutually beneficial model of collaboration between the three Trust Boards, enabled through transparent governance and decision making.
- To support delivery the APC will continue to work in collaboration with other organisations / partnerships across SEL via both informal discussions, borough partnerships and ICS arrangements, for example through the SEL ICS Recovery Leadership Group.