Our Healthier South East London Joint Health Overview & Scrutiny Committee

Thursday 8 April 2021, 6.30 pm

Membership
Councillor Judi Ellis (Chairman)
Councillor Mark James (Vice-Chairman)
Councillor Marianna Masters (Vice-Chairman)
Councillor Gareth Allatt
Councillor Richard Diment
Councillor Liz Johnston-Franklin
Councillor Chris Lloyd
Councillor Nanda Manley-Browne
Councillor John Muldoon
Councillor David Noakes
Councillor Victoria Olisa

INFORMATION FOR MEMBERS OF THE PUBLIC

Location: The meeting will be held online as a Webex Event, and can be viewed by members of the public by visiting –

https://bromley.webex.com/bromley/onstage/g.php?MTID=ea3dff852dfe0c798b01021bdca4cda7c

Event number (access code): 183 524 9491

Contact Graham Walton on 0208 461 7743 or graham.walton@bromley.gov.uk

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MARK BOWEN
Director of Corporate Services
London Borough of Bromley

Date: 29 March 2021

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Thursday 8 April 2021, 6.30 pm

Order of Business

Item No.	Title	Page No.
1	**APOLOGIES**	
2	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at the meeting.	
3	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five working days of the meeting.	
4	**MINUTES** To approve as a correct record the Minutes of the open section of the meeting held on 2nd September 2020.	1 - 10
5	**DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING**	
6	**INTEGRATED CARE SYSTEMS - NEXT STEPS**	11 - 20
7	**COVID- WAVE 2 IMPACT AND RESTORATION - ACUTE SERVICES** (Please note that more up-to-date data should be available before the meeting.)	21 - 28
8	**COVID-19 VACCINATION PROGRAMME** (To follow)	
9	**THE IMPACT OF COVID-19 ON MENTAL HEALTH**	29 - 44
10	**PATHOLOGY SERVICES UPDATE**	45 - 48
11	**DATE OF NEXT MEETING//WORKPLAN**	

Item No.	Title	Page No.

12 PART B - CLOSED BUSINESS

13 EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the committee wishes to exclude the press and public to deal with reports revealing exempt information:

“That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to information Procedure rules of the Constitution.”

14 DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT

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Our Healthier South East London
Joint Health Overview & Scrutiny Committee

MINUTES of the virtual meeting of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held on 2 September 2020 at 4.30 pm.

PRESENT:

Councillor Judi Ellis (Chairman)
Councillor Gareth Allatt
Councillor Richard Diment
Councillor Alan Downing
Councillor Mark James
Councillor Marianna Masters
Councillor David Noakes
Councillor Victoria Olisa

NHS PARTNERS: Dr Angela Bhan, South East London Clinical Commissioning Group
Andrew Bland, South East London Clinical Commissioning Group
Andrew Eyres, South East London Clinical Commissioning Group
Kate Moriarty-Baker, South East London Clinical Commissioning Group
Stuart Rowbotham, South East London Clinical Commissioning Group
Usman Niazi, South East London Clinical Commissioning Group
Christina Windle, South East London Clinical Commissioning Group

46 APPOINTMENT OF VICE-CHAIRMAN

The Committee noted that the former Vice-Chairman, Councillor Philip Normal, was no longer a member of the joint committee and therefore it was necessary for a new Vice Chairman be appointed. Councillors Mark James and Marianne Masters both expressed an interest in the Vice Chairmanship.

RESOLVED that Councillors Mark James and Marianne Masters both be appointed as Vice-Chairmen.

47 APOLOGIES

Apologies for absence had been received from Councillor Robert Mcilveen from LB Bromley, and Councillor Gareth Allatt attended as substitute. Apologies were also received from Councillor Chris Lloyd from RB Greenwich and Councillors

John Muldoon and Liz Johnson-Franklin from LB Lewisham.

48 DISCLOSURE OF INTERESTS AND DISPENSATIONS

Councillor Richard Diment declared an interest as a governor of Oxleas NHS Foundation Trust.

49 NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

It had been drawn to the attention of the Chairman that the Committee's terms of reference were in need of being reviewed and updated. It was suggested that members give direct instructions to officers concerning this, and then a redraft could be drawn up.

The Chairman expressed the view that matters often came to the Joint Committee late in the day, and it would be preferable if issues could be drawn to the attention of the Joint Committee for scrutiny at the pre-consultation stage. The Chairman reminded members that the Joint Committee did not have decision making powers, but nevertheless it would be good if the Joint Committee could make comments and recommendations at an early stage, offering a strategic overview from the various London Boroughs represented on the Committee.

Councillor Diment considered that, just as CCGs had moved on and had been restructured, the JHOSC should be restructured and undertake a different role.

Councillor James expressed the view that the primary level of scrutiny should still be maintained and undertaken by the local boroughs. He said that it should be made very clear in the new terms of reference what matters should come to the Joint Committee for consultation/consideration. His understanding was that the Joint Committee should be focusing on matters relating to service change, and he welcomed input and comments from NHS colleagues regarding this.

Andrew Bland suggested using a template for the terms of reference that would make clear what was the responsibility of individual boroughs. Mr Bland agreed with Cllr James that the primary issue for the Joint Committee to deal with should be matters relating to service change.

50 MINUTES - 25TH SEPTEMBER 2019

The Joint Committee noted that since the last meeting a workshop had been held on 30th October 2019 to discuss issues of concern about the CCG merger and how this affected scrutiny and the JHOSC.

The Chairman referred to a note in the minutes of the previous meeting relating to the South East London engagement process for the NHS Long Term Plan that

BAME people were not well represented in the engagement process. Christine Windle responded that the concern at the time had been to ensure that there was widespread engagement with people across all the boroughs; an Equalities Committee had been set up and they were looking at engagement processes and working with Councils to support more diverse engagement in future. The Chairman commented that in Bromley the primary demographic taking up hospital beds were the over 65's, so the focus was different depending on the borough, and it was important therefore that engagement or consultation took place across all these demographics.

The Chairman commented that it would be helpful if a schedule of local CCG board meetings could be disseminated going forward - Christina Windle offered to do this.

Agreed that the minutes of the meeting held on 25th September 2019 be confirmed as a correct record.

51 UPDATE FROM SOUTH EAST LONDON CCG

Andrew Bland attended the meeting to provide an update on the South East London CCG merger.

The Committee was informed that the merger had taken place on 1st April 2020; this established the NHS South East London CCG as the formal body for the commissioning of health services for local residents across the six South East London Boroughs. NHS England had approved the merger application without any conditions or reservations. This had been part of a series of mergers nationally, including South West London and North Central London. The first major task of the newly formed body had been to co-ordinate the response to the Covid pandemic.

The Joint Committee was pleased to note that, in a relatively short space of time, the six South East London CCGs had merged to form the largest CCG in London, whilst at the same time ensuring a local borough focus for health and social care integration.

Mr Bland stated that it was important to maintain borough-based decision-making, as well as decision-making by the merged CCG body and this would be achieved through the work of the borough-based boards and by delegation. Borough-based board meetings were advertised on the merged CCG website in case members of the public wanted to observe the meetings.

Mr Bland explained that another important objective for the combined CCG was to promote the development of joined up health and social care. Membership of all of the borough-based boards had been incorporated into a single document for information, and the list was extensive. It brought together health and social care

decision makers from the health sector and from local government. It was noted that in four of the borough-based boards joint appointments now existed between both the CCG and the local authority. He expressed the view that considerable strides had been made regarding health and social care joined up working.

The Joint Committee heard that another important objective of the merger was to see if providers could work with the CCG in a more blended way - less transactional and more cooperative.

It was noted that since 1st April, the merged CCG had undertaken all of its required statutory functions, as well as focusing its efforts on dealing with the pandemic, and also the relocation of staff as required. At the time of the meeting, the severity of the pandemic seemed to have eased somewhat, which had enabled staff to be put back into their normal posts, and to enable more normal business activities to take place. Borough-based boards were working in operation and were considering how to develop and implement borough recovery plans.

In terms of governance, the merged CCG was operating on the basis of subsidiarity, so it was anticipated that much would happen at a borough level.

The decision was taken nationally for allocations of money to be controlled more at a central level. This had been extended to the first seven months of this financial year which meant that not only could the CCG not make its particular delegation to boroughs under the national arrangements, it was actually operating in a more nationally directed way as an entire organisation.

Mr Bland was pleased to report that 'in public' meetings of the CCG Governing Body, Primary Care Commissioning Committee and borough-based boards had still taken place virtually through the use of digital technology.

Cllr James acknowledged the tremendous pressures the NHS had been under and the various concerns expressed in relation to finance, and asked if recovery plans were now being agreed. He pointed out that many NHS Trusts had been in a difficult position financially before the pandemic, and he presumed that now the situation would be worse. He asked whether work was still being undertaken in the normal way, or if the NHS tariff had been suspended; he further enquired if any NHS Trusts were in danger of failing due to pressure on their finances.

Reassurance was given that providers within the NHS system had been allocated top up funding to ensure that every organisation would be supported to at least maintain a break-even position. This would be continued until the end of September. Assurance was provided that financial constraints would not be a reason for being unable to provide the resources necessary to deal with the pandemic. An updated briefing regarding financial processes and budgets was awaited, and this would be shared with local authority partners.

An update on response and recovery planning was provided by Dr Angela Bhan. The minutes of the Governing Body contained details of the Covid updates and fortnightly fact sheet updates were being provided for local authority leaders and MPs. There had been around 8,000 documented cases of Covid 19 in London and 1,650 deaths. Total deaths to date in Bromley were 345 which was the highest in south east London. Some of this could be attributed to the elderly demographic of the borough. Most of the deaths occurred either in hospital or in care homes. As soon as the outbreak had been declared as a category four incident, all local health and social care partners reacted very promptly. South East London CCG set up an incident control centre and this was replicated by all NHS organisations. There was a clear gold, silver and bronze command structure used by CCGs which was also used by local authorities. It was important that the chain of command was effective and robust, so that instructions and guidance from the centre could be disseminated effectively through different parts of the chain. It had been imperative that clear and effective communication channels remained open between all involved. The local authorities played an active part in this chain of command, particularly with regard to the work undertaken by place-based directors. South East London CCG set up a joint forum that incorporated the Gold Command of the CCG, the Directors of Public Health and the Directors of Adult Services. This joint forum met once a week and discussed issues that at the time were very problematical. At these meetings, issues that were discussed included testing, how to best support care homes, infection control/prevention; the meetings were attended by the major providers of health services.

Kate Moriarty-Baker (CCG Chief Nurse) and she updated on the situation with respect to Care Homes. She stressed how they were an integral part of the health care system. She explained that a forum had been set up across SE London, which included nominated leads from other boroughs. The forum focused on identifying areas where support may be required and the sharing of learning and provided a co-ordinated response in line with national guidance. The forum provided training across London to care homes in matters such as swabbing and the correct use of PPE. Across the sector, training was provided to 224 out of 240 care homes—the remainder provided their own in-house training and support.

Through that process a ‘train the trainer’ model was developed. The CCG looked at the resource that existed within the CCG to support Infection Protection and Control (IPC), and investment had taken place in additional IPC specialist nursing support which was currenly being recruited to. The CCG monitored the testing facilities that were being provided for care homes, and explained how they could take advantage of them.

The CCG was continuing with this work and continued to support care homes with testing. Since the beginning of the Pandemic, the CCG had tested in 83 care homes and this work was ongoing. The CCG ensured that end of life care was undertaken with dignity, to the correct professional standards, and facilitated medication supplies as required. This included having rapid access to end of life

medication, delivering medication reviews for existing and new residents and providing more accessible support to care homes with medication queries. The services provided included the undertaking of proactive reviews, virtual ward rounds and access to support and advice from a range of health and care professionals.

This work had provided an opportunity to strengthen the relationship between the CCG, councils and public health colleagues around how best to support the care home market which was a shared and jointly owned endeavour. The CCG was continuing to work with colleagues across South East London, particularly with the possibility of a second wave of the pandemic.

Dr Bhan explained that the final two slides of the presentation contained an overview of the work of the Incident Control Team which was continuing to meet at 8.00am every morning. The ICT currently was working with two main objectives, the first of these was to protect the population by undertaking winter preparation and providing flu vaccinations and that services were available to manage people as and when needed. The CCG was closely monitoring the data and the early surveillance systems were stronger than they had ever been. Monitoring was taking place to monitor a variety of issues including the number of people testing positive for the virus, the occupancy of ITU facilities and the number of people being admitted to hospital suffering with COVID-19.

Cllr Diment raised the matter of the alleged pressure (in the early days of the pandemic) that was put on care homes to receive patients from hospitals who had not been tested for Covid 19. He expressed concern regarding this and quoted a comment from the Public Accounts Committee which described this approach as ‘appalling’. He wondered what the implications of that approach had been - it had caused much concern amongst care homes.

Cllr Diment also raised the issue of the proposal that one emergency department in each NHS area would be operating a system whereby you had to pre-book to attend the emergency department, rather than just being able to walk in. He wondered how this would work in practice, and in which areas it was proposed to be introduced in. He further expressed concern regarding patients who had not received the treatment they required because of the pandemic - he enquired as to what the future held for them and how they would be updated going forward.

Dr Bhan acknowledged that there were problems at the start and that everyone involved had been on a steep learning curve. She stated that at the start of the pandemic, it was a national policy that patients would not be retested after being discharged from hospital. This process continued up until roughly mid April. However, very quickly after that, the policy changed and patients were tested before discharge; this policy was continuing. She commented that in her view, care homes had not been pressurised to take untested patients, and in fact some had refused to do so.

At the moment, South East London was undertaking a project to look at direct bookings from the 111 system (by a clinician) direct into A&E - it did not mean that A&E was closed to people who walked in and who needed services or were coming in by ambulance.

It was clear that the A&E departments could not carry on as they had been as in previous winters where there were very full A&E Departments. If the country was in the middle of a second wave of a Covid outbreak, it would not be good to have crowded waiting rooms - no one would want people to be further exposed to infection. As a result, a national proposal had been suggested that from the 1st December, all A&E's would have the ability to to be linked to 111, and if people rang 111 they could be directly booked in to the emergency department; they would also have the ability to be directed to the urgent care centres and indeed booked into specialist care beyond the emergency department if required. A pilot scheme had commenced with the Queen Elizabeth Hospital. The 111 Commissioning Team was working with the hospitals so that these systems would be fully embedded by December. Cllr Diment made a plea that any phone lines that the public needed to call to make appointments for services were properly staffed to avoid long waiting times. Dr Bhan said that the capacity of the 111 system was being increased.

Dr Bhan gave assurances that work was now being undertaken at pace to catch up on the elective surgeries and other treatments that had been put on hold because of the pandemic.

Cllr Downing asked what was happening with the emergency eye department at Queen Mary's Hospital. He narrated the story of a member of the public who had attended the emergency Eye Department at St Mary's, only to be told that he could not be seen; he was given an A4 form with a number on it to ring. This number referred him to three local opticians. He was told by one of the opticians that they could only see him to give him advice, but would not be able to treat him. He was then made an appointment to see the optician 10 days later.

Dr Bhan responded by saying that the West Kent Eye Centre would have to find a permanent home. It was intended that as part of the preparations for wave two of the pandemic, it would be located somewhere in between Orpington Hospital and the PRUH. Dr Bhan asked for the specific details of the incident to be provided so that the matter could be taken up with the eye centre.

Cllr James raised the issue of the number of disproportionate deaths that had occurred within the BAME community, and to the analysis that had been undertaken by Professor Kevin Fenton - he enquired how the South East London CCG was proposing to act on his findings going forward.

An Equalites Committee had now been established that was reporting directly to

the CCG governing body, and they had noted the recommendations outlined in the Kevin Fenton report. Not all of the recommendations were able to be implmented by the CCG, and collaboration was required with other organisations.

A discussion took place about the Mental Health Improvement Standard funding allocation and how this was reported on and audited. These audited findings would be subsequently published on the web.

Andrew Ayers updated the Committee concerning the Covid recovery planning process. The Committee was informed that national recovery planning guidance had been received and that this would be acted upon in conjunction with a local planning recovery process. Mr Ayers noted that in the initial stages of the pandemic concern was expressed not only about the abilty of the NHS to provide services, but also the fact that the public were not accessing services and also were not attending A&E departments.

Local recovery plans were being developed from the bottom-up and were not solely being developed by the CCG, but were also being a developed in partnership with local authorities, hospitals, GPs, community providers, and social care providers. The plans aimed to provide a recovery response that was not simply reactive, but which was also preventative. In the process of developing the plans, an effort was made to understand the needs of local people. The aim of the local recovery plans was to get a feel for what people had experienced and how they felt. The Committee heard that borough recovery plans were driven by Public Health, the needs of the local community and by the inequalites that had existed for some time. The local recovery plans would endeavour to provide a pathway for the return of the provision of normal services, along with the desire to capitalise on new ways of working.

Mr Ayers commented that there was a need to live within resources but in this uncertain climate it was difficult to pinpoint exactly what those resources were. He said that the Covid pandemic had brought into sharp focus those who were vulnerable in society along with better ways of partnership working. A discussion took place regarding waiting times for services, and demand in relation to capacity.

It was noted that clinicians would be keeping in close contact with patients in order to keep them updated regarding their treatment and the reopening of services.

Action reviews would be undertaken to understand what learning had been achieved, and what could be used as best practice in the future as a result. Planning for recovery was made difficult because at the same time there could be a surge in cases and transition into a second wave. Additionally, winter flu planning was also being undertaken.

A discussion took place around communications going forward regarding the flu vaccination and Covid communications aimed at younger people. It was explained

that as well as vaccinating the traditional group of people aged over 65, it was also intended to try and vaccinate the vulnerable in society who were under 65. It was noted that a communications campaign concerning the flu vaccination would be commenced at the end of September. Dr Bhan also explained that plans were in place to increase the number of people eligible for the vaccination. It was also the case that later on in the year it was hoped to extend the vaccination programme to those aged between 50 and 64. The vaccination programme would also be extended to those caring for the vulnerable. She explained that a joint flu vaccination programme was being co-ordinated between all six boroughs, and the plan was to vaccinate the most vulnerable first.

Dr Bhan explained that the flu vaccination communication programme would aim to encourage people to attend GP surgeries to get their flu vaccination. It would explain the process that would be set up so that they would be safe. For those who were not able to leave their houses for whatever reason, all boroughs would seek to set up a home visiting vaccination programme.

The Chairman thought it was likely that matters relating to the recovery plans would need to come back to the Joint Committee for scrutiny. It was anticipated that matters relating to mental health would also come back to the Joint Committee and also issues relating to the funding of community based treatment and 'in bed treatment'; both areas were suggesting that they needed extra funding. The Chairman also raised the matter of poor quality housing, with landlords not undertaking the requisite repairs, and so some people were living in poor quality housing. Dr Bhan felt that it was primarily a local authority issue, but that there was some overlap with Public Health. The Chairman raised the matter of mould in houses and the associated health problems that this caused in terms of lung and respiratory disease; linked with this and also linked with Covid was the matter of poor ventilation. For these reasons, she was reluctant to dismiss the matter as a purely local authority housing issue and wanted the matter regarded also as a public health issue that needed to be looked at by the Joint Committee.

There was a general consensus amongst Joint Committee members that there was a strong link between poor housing conditions and poor physical and mental health. A member expressed the view that Health and Wellbeing Boards would be better placed to look at this particular issue. He felt that at the moment, the Joint Committee should be focusing on Covid recovery plans.

Mr Bland felt that it was important that a distinction be made between what matters should come before the Committee on a six borough basis and what matters should be looked at individually within each borough. He felt that it was important that the six borough CCG did not duplicate work undertaken individually in each local borough. With respect to a future meeting he suggested that a December meeting may be appropriate. The Chairman proposed a meeting in early December, and suggested that at the meeting, the main area of focus should be on the pilot scheme requiring appointments at emergency departments and how

this had worked out in practice. A member suggested that the main area of focus should be access to primary care like GP services and walk in centres.

Dr Bhan stated that she would be able to provide an update on the trialling of appointments at emergency departments at a meeting in December if required, however this would be limited to a verbal update as there would not be enough data existing at that time for a formal report.

The Chairman proposed that preparations be made for a meeting in early December. This would commence at 4:30pm and should not last longer than two hours.

The clerk drew the Chairman's attention to an email that had been received from the Guys and St Thomas's NHS Foundation Trust, concerning their proposed merger with the Brompton Hospital. They had asked the Joint Committee whether or not they would like to receive a presentation concerning the merger, or if the Joint Committee would be content in receiving appropriate documentation. The suggested date for a possible presentation was given as early October. The Chairman felt that in this case, the submission of documentation from Guys and St Thomas's was sufficient. If subsequently any members of the Joint Committee wanted to comment on the documentation, the comments should be directed to Mr Walton (Joint Committee Clerk,) who would draft a collective response on behalf of the Committee.

Finally, the Chairman thanked everyone for their hard work and for attending and congratulated Councillors Mark James and Marianna Masters on their appointment as Vice Chairs of the Committee.

52 WORK PROGRAMME

The Chairman suggested that the matter of the recommendations of Professor Kevin Fenton's report, and the effect of Covid-19 on the BAME population may be something that could be added to the Work Programme.

The Chairman felt that there should be a re-focus on mental health issues and that this should also be factored into the work programme. The Chairman asked who was going to lead on the mental health side and was extra money going to be made available for mental health. Andrew Ayers responded that CCGs took investment in mental health services seriously, and they had been directed (for a variety of reasons) to allocate a higher percentage of their funding pro-rata to mental health service provision.

Chairman

Our Healthier South East London
Integrated Care System

Integration and innovation:
Working together to improve health and social care for all

ICS next steps – South east London JOSC Briefing

08 April 2021

Recap

Our Healthier South East London
Integrated Care System

NHS Long Term Plan (2019) confirmed all parts of England would be served by an ICS

Our Healthier South East London becomes one of the first 15 ICSs in England.

April 2020: NHS South East London CCG became a statutory organisation – putting us in a good position ready for progressing into ICS arrangements

November 2020: NHS England and Improvement (NHSEI) published *Integrating Care* - proposing two legislative options to further develop ICSs – option two was preferred by NHSEI

December: National engagement

The CCG submitted it's response on 8 January 2021 and shared with you in January

These responses have informed the NHSEI *document 'Legislating for ICSs: five recommendations to government and parliament'* published on 11 February

The Department of Health and Social Care published *Integration and innovation: working together to improve health and social care for all* (11 February) based on NHSEI's recommendations

Decisions on legislation will now be for Government and Parliament to make

Engagement principles inform proposals

Our Healthier South East London
Integrated Care System

On 26 November 2020 NHS England and Improvement's Board received and approved a paper on the future of integrated care and launched an engagement process on the changes proposed. This paper:

Reiterated the aims and ambitions of integrated care in the Long Term Plan

Outlined changes required to deliver this

And options for how Integrated Care Systems could be embedded in legislation or guidance

Proposals serving Four fundamental purposes:

- **Improving population health and healthcare**
- **Tackling unequal outcomes and access**
- **Enhancing productivity and value for money**
- **Helping the NHS to support broader social and economic development**

We believed that in overall terms the ambitions and the purpose outlined nationally align and build upon our own development aspirations and we made that clear in our response as an ICS partnership in our feedback in early January 2021.

What is an ICS expected to do?

Our Healthier South East London
Integrated Care System

- **Distribution of financial resources** to places and sectors that is targeted and seeks to tackle inequalities;
- **Improvement and transformation resource** that can be used flexibly to address system priorities;
- **Operational delivery** arrangements that are based on collective accountability between partners;
- **Workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **Emergency planning and response** to join up action at times of greatest need; and
- **Digital and data** used to drive system working and improved outcomes.

1. Enable decisions to be taken as close to communities as possible

2. Support provider collaboration

3. Deepen collaboration between partners (particularly with local government)

Enabling these changes were at the heart of our recent SEL system reforms:

- **CCG Merger and Place Based Boards**
- **Borough Local Care Partnerships**
- **Provider Collaboration in Acute, Community and Mental health**

So what does the White Paper say?

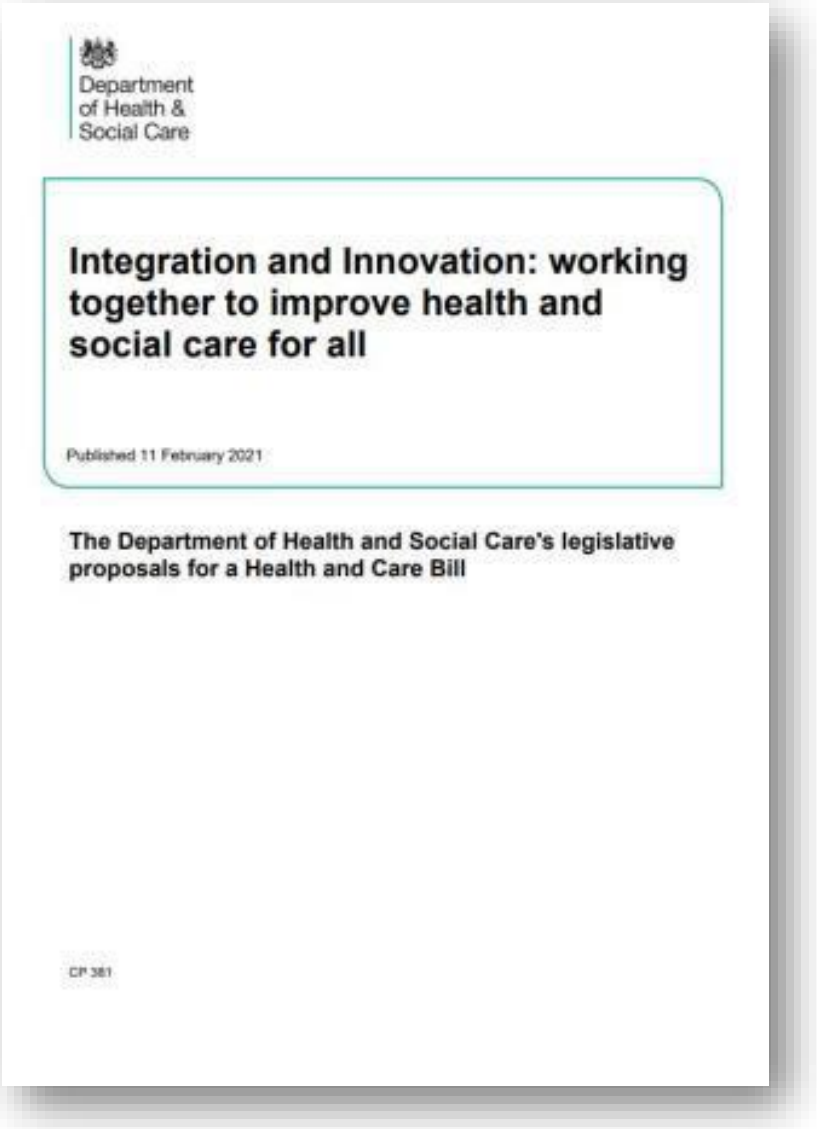
Our Healthier South East London
Integrated Care System

These proposals **represent a specific set of proposals** where change to primary legislation is required.

The proposals can be **grouped** under the following themes:

1. **working together and supporting integration**;
2. stripping out needless bureaucracy;
3. enhancing public confidence and accountability;
4. additional proposals to support social care, public health, and quality and safety.

The government's plan is that legislative proposals for health and care reform outlined in the paper will begin to be **implemented in 2022**


Department of Health & Social Care

Integration and Innovation: working together to improve health and social care for all

Published 11 February 2021

The Department of Health and Social Care's legislative proposals for a Health and Care Bill

CP 381

Working together and supporting integration

Our Healthier South East London
Integrated Care System

- Two forms of integration will be underpinned by new legislation:
  - Within the NHS to remove boundaries to collaboration
  - Greater collaboration between the NHS and local government and other delivery partners.
- ICSs will be made up of an ICS NHS Body and an ICS Health and Care Partnership, bringing together the NHS, local government and partners:
  - The ICS NHS body will be responsible for the day to day running of the ICS
  - The ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.
- A 'triple aim duty' will be placed on health bodies, which will require them to secure:
  - Better health and wellbeing for everyone
  - Better quality of health services for all individuals, and
  - Sustainable use of NHS resources.
- Legislation will remove barriers to integration by allowing ICSs to establish joint committees, collaborative commissioning approaches and joint appointments.
- New legislation will ensure more effective data capture and data sharing across health and care.
- There will be further changes which reconfirm the legal basis of the Better Care Fund

The WP proposed ICS governance model

Our Healthier South East London
Integrated Care System

NHS England FAQ (February 2021)

Our Healthier South East London
Integrated Care System

How will a statutory ICS be different from a CCG?	• ICSs will be a different type of decision-making body from CCGs – by bringing in the perspectives and skills of a wider range of partners. We want to empower them to take the best of CCGs, but to be better equipped to respond to the whole needs of the population they serve. • Although we propose the ICS takes on many of the CCG functions, its remit will be much broader and have a much greater system role. NHS trusts, FTs or local authorities will be full and active partners in the leadership of the ICS and could also delegate some of their functions into the collaborative arrangements in the system.
Will this change accountability arrangements for NHS trusts and foundation trusts?	• Our recommendations for ICS will not fundamentally change the core duties and functions of NHS trusts and foundation trusts to improve quality of care for patients and meet key financial requirements. • The move towards greater collaboration will foster mutual accountability for health outcomes between NHS and other organisations at system level, drawing on the collective expertise of commissioners and providers to plan services in the best interests of local people and the wider health economy. • To help achieve this, NHSEI's legislative recommendations for government include new duties to support more collective decision-making in order to improve quality of care, ensure effective use of resources and take into account the health needs of the local community.

Next steps – timeline

Our Healthier South East London
Integrated Care System

2019 NHS Long Term Plan

November 2020
NHSEI propose x2 legislative options to further develop ICS

January 2021
Responses submitted to inform legislative proposals

February 2021
White Paper published

Summer 2021
?? Received by Parliament ??

Autumn / Winter 2021/22
?? Legislation ??

April 2022
?? New Statutory Body begins ??

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Our Healthier South East London
Integrated Care System

NHS

Covid Wave 2 impact and restoration Acute Services

The Joint Health Overview and Scrutiny Committee March 2021

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

Our Healthier South East London
Integrated Care System

Acute services overview

Covid demand – Wave 2 and beyond

- Significant build in Covid related demand in to the acute hospital sector from mid December 2020. Demand built through to an end January 2021 peak following which we saw a plateauing and then a reduction in demand from mid/late February and in to March 2021.
- Critical care demand and associated pressures particularly stark – on 27 January 2021 SEL had all its critical care surge and super surge capacity open with each hospital site operating at significant levels of critical care capacity - overall critical care beds occupied totalled 421, of which 324 were Covid positive patients. By 19 March 2021 these figures had reduced to 235 critical care beds occupied of which 76 were Covid positive patients.
- Very high numbers too in general and acute beds with an equivalent trend albeit the plateauing and reduction in Covid demand was at a faster rate than that experienced in critical care.
- Our acute hospitals, supported by the rest of the system, worked collaboratively to manage this unprecedented demand, including ensuring mutual aid was enacted across hospital sites to enable each site to effectively manage its demand against available capacity. Mutual aid approaches were adopted across both critical care and our general and acute bed base.
- The gradual reduction on Covid demand enabled us to initiate our Covid decompression plans from end of February, noting this process remains on going – these supported planned reductions in critical care surge and super surge capacity and the flipping of Covid to non Covid capacity.
  This in turn enabled a corresponding step up in planned elective work, as it freed up staff, theatres and beds to allow for a reconfiguration of the hospital bed and wider capacity base.

Non Covid urgent and emergency care demand

- Non Covid demand continued throughout the second wave of the pandemic – with demand across A&E, general and acute and critical care beds.
- In overall terms however non Covid related A&E attendances and emergency admissions remained at lower levels than they were pre pandemic – demand has however increased as the pandemic impact has reduced.
- Within this increase we have seen a spike in mental health patients which has caused further pressure in our acute Emergency Departments and in our mental health providers – we saw an equivalent step increase immediately after Wave one last year.

Our Healthier South East London Integrated Care System

Acute services overview

Elective restoration plans

- As Covid demand has reduced we have worked to ramp up our elective (planned care) capacity – this has been and will continue to be a gradual process as we implement our staff, theatre and bed roadmap which allows for staff recovery and the decompression and recalibration of our acute capacity.
- We have been managing elective activity on the basis of clinical prioritisation – ensuring that the most clinically urgent patients are able to access the treatment they need as capacity becomes available.
- We have made demonstrable and significant progress and have been able to increase the number of clinically urgent patients treated each week.
- As a result our average 'clearance rate' – the length of wait for clinically urgent patients - is now below the ideal threshold of 4 weeks (at 3.2 weeks) – an improvement from an 11 week average clearance rate 7 weeks ago.
- To secure this improvement we have continued to access Independent Sector providers within the SEL ICS footprint, alongside available SEL NHS capacity, to maximise our capacity.
- We have also been focussing on our wider elective restoration plans, with an immediate focus on short term 'spring' recovery which includes plans across elective and diagnostic services, linked to and triangulated with our on going critical care/general and acute bed decompression plans and staff recovery and redeployment.
  This plan includes our expected capacity ramp up across diagnostics, outpatients and day case/inpatient capacity - our plans are ambitious and assume that by the beginning of July we will have managed to secure a return to at least 90% of our pre pandemic capacity across these services.

Our Healthier South East London
Integrated Care System

Acute services overview

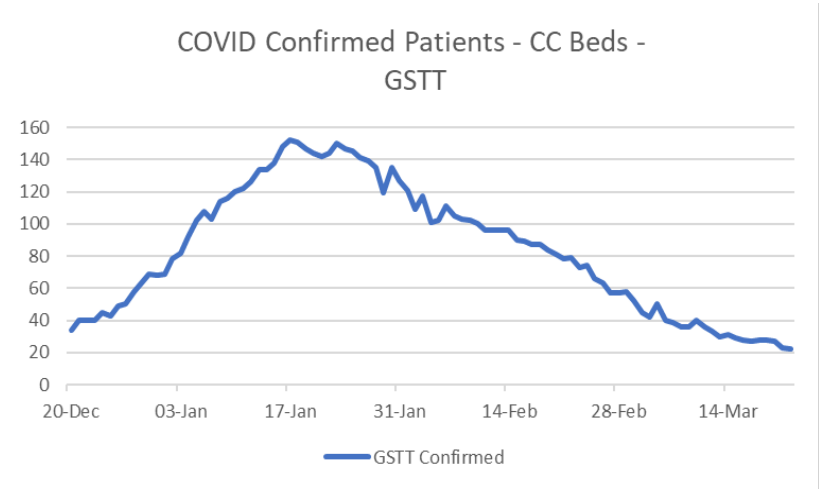
Current waiting list position

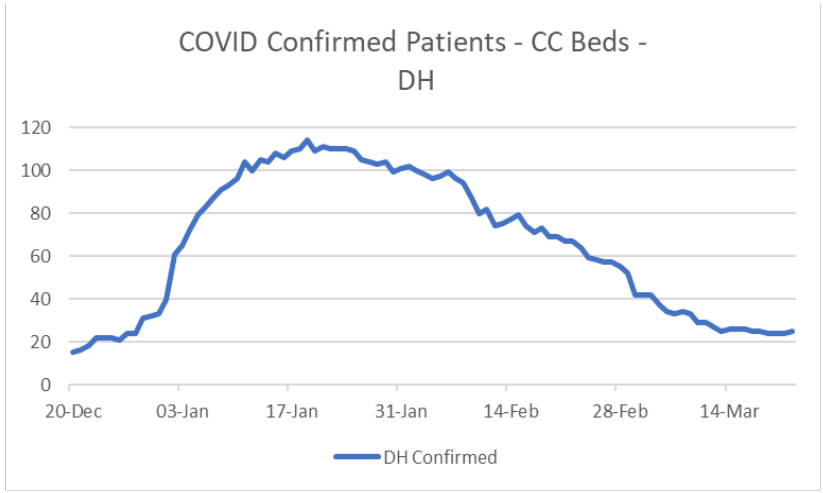
- The pandemic – both the first and the second wave – had had a very significant impact on our waiting lists.
- Whilst the overall number of patients waiting has decreased due to reduced overall referrals, the number of over 18 and over 52 week waiters has increased very significantly.
- In terms of our longest waiters at end November there were 8,700 over 52 week waiters on SEL provider waiting lists - our end March 2021 position is a forecast of approximately 15,000.
- We are therefore faced with an unprecedented number of long waiters split across admitted (inpatient and day case) and non admitted (outpatient) waiting lists.
- Our spring recovery plans have sought to assess the impact our activity ramp up will have on these longest waiters, noting the waiting list is dynamic with removals and tip ins rather than static – our forecast is that by 4 July 2021 we will have stabilised the admitted position and reduced the non admitted waiting list, with a forecast of 13,700 long waiters by 4 July.
- Importantly the shape of our waiting list means we then expect the post 4 July position to deteriorate further before it improves, despite the planned maintenance of our ramped up capacity.
- The scale of the challenge means we anticipate a lengthy programme of backlog reduction to clear the waiting list that has built up and this means routine patients are likely to wait significant periods of time for treatment, noting capacity is our biggest rate limiting factor.

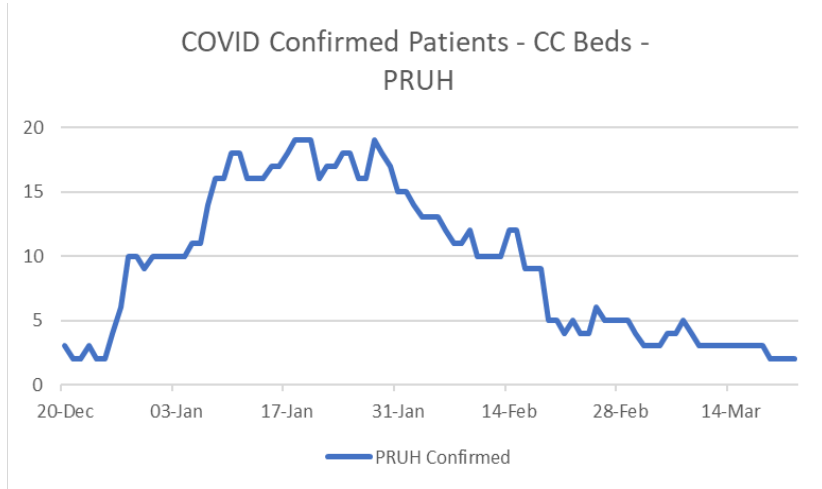
Impacts and mitigations

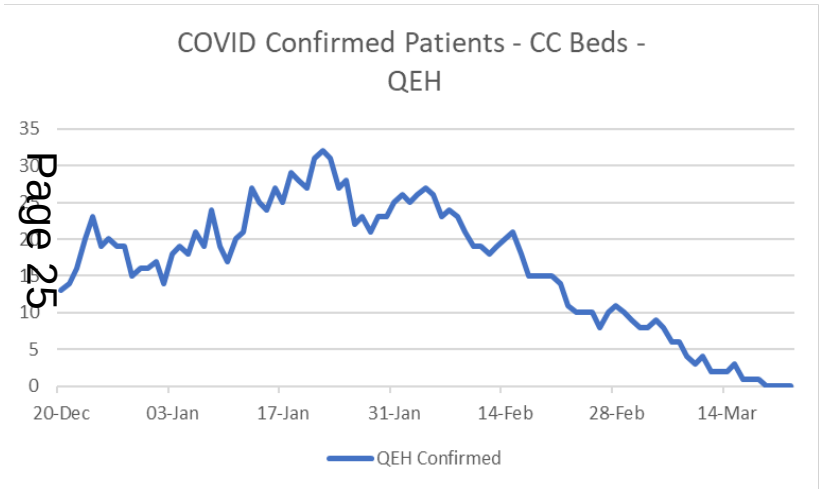
- We have been taking a system approach to the management of available capacity to ensure equitable access for patients and to support treatment in line with a consistently applied clinical prioritisation process.
- We continue to ensure optimal out of hospital support - in terms of admission avoidance and support discharge but also in terms of referral management, patient initiated follow ups and increasing community based alternatives to ease elective pressures in the hospitals wherever possible and appropriate
- We are also focussing on the well being of staff and the need to provide support to them as we transition back to business as usual and seek to restore non Covid services and capacity.

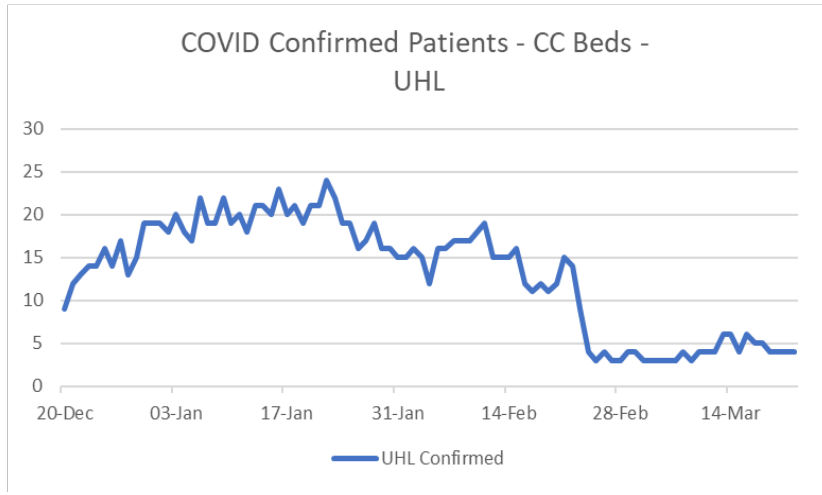
Critical Care Beds – Confirmed Patients from 20 December

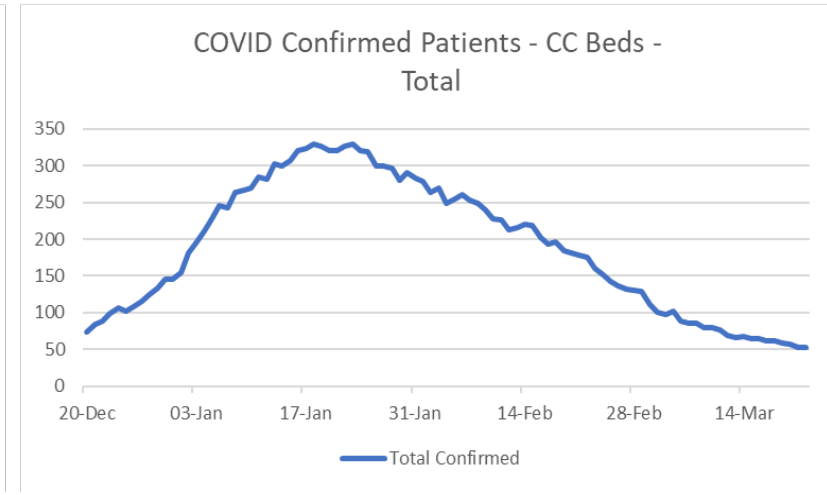




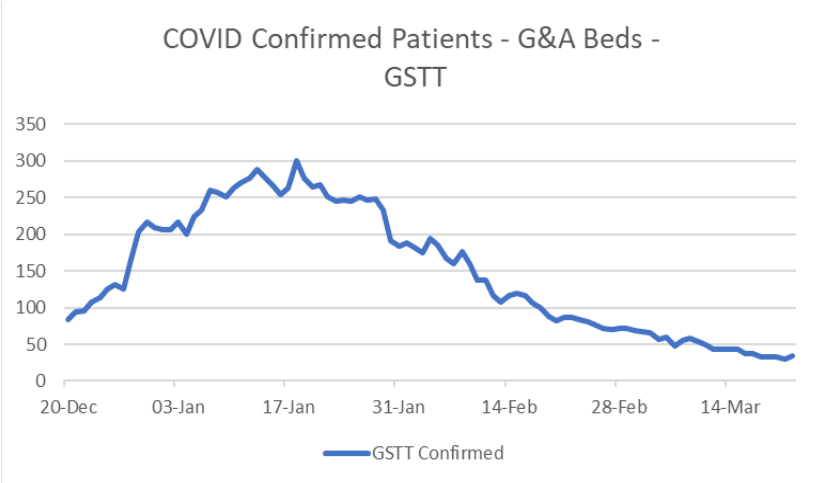


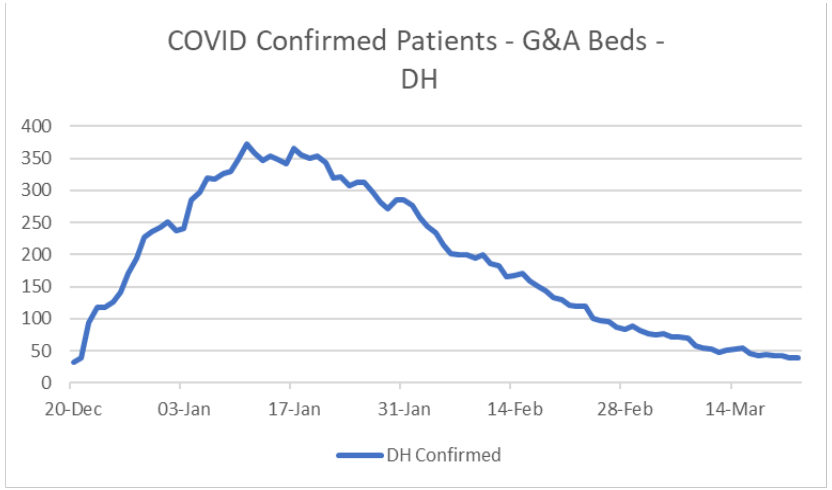


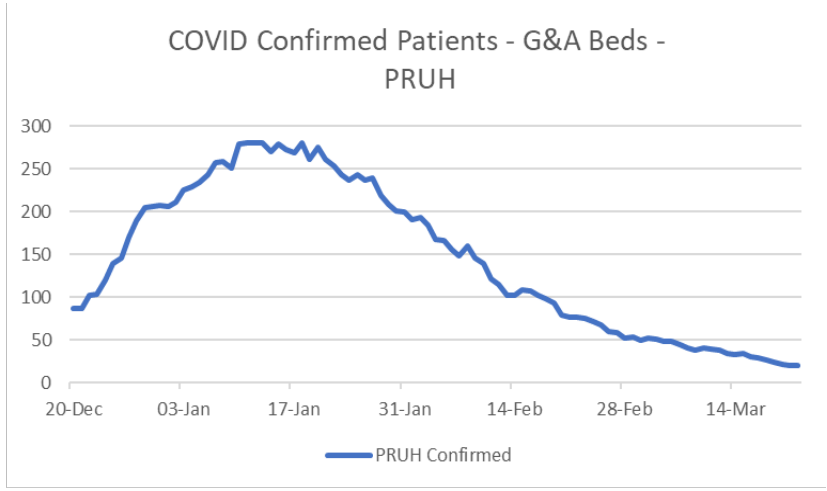


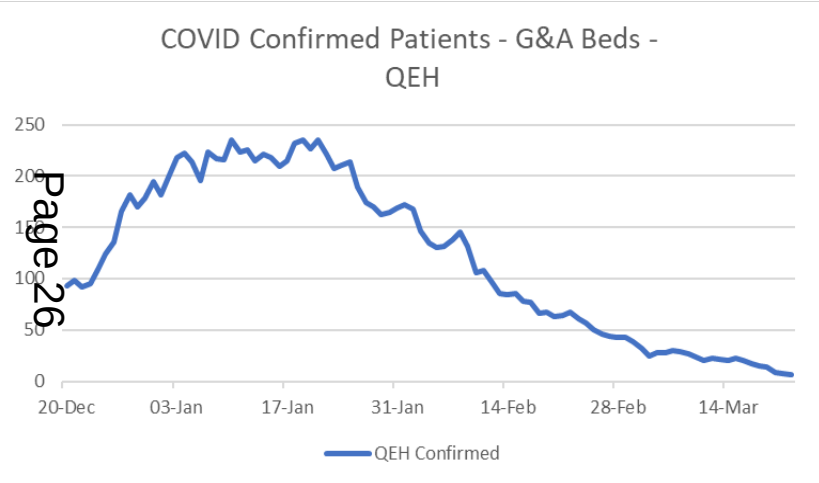


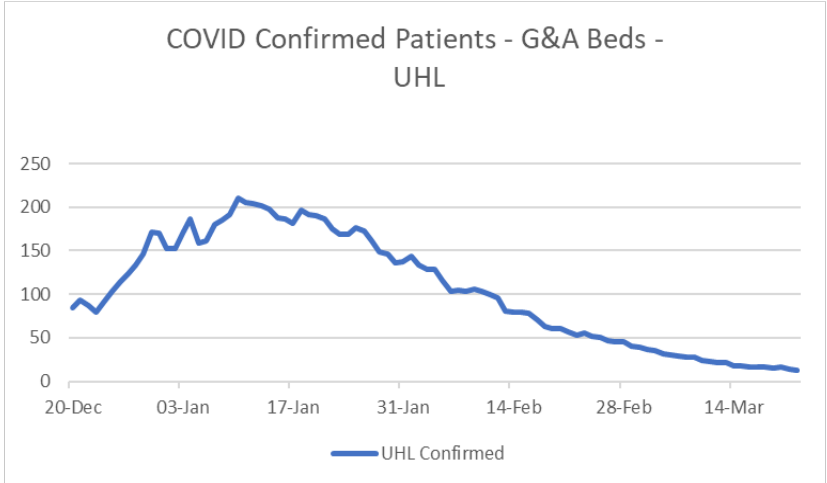
General & Acute Beds – Confirmed Patients from 20 December

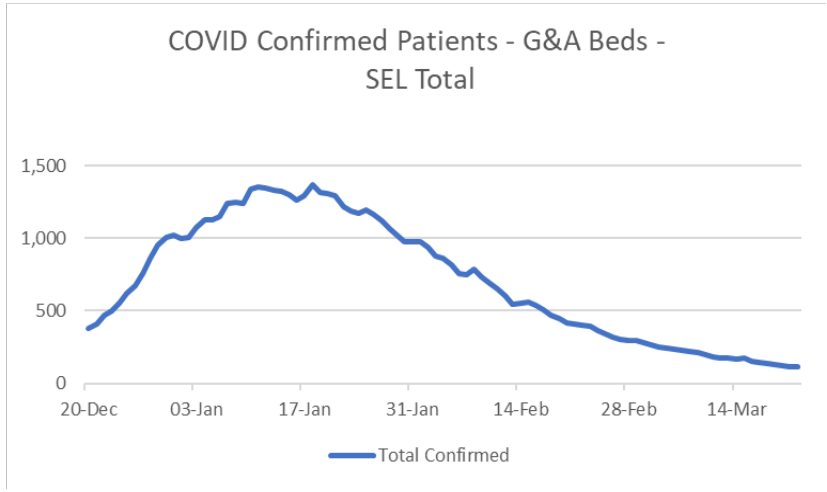




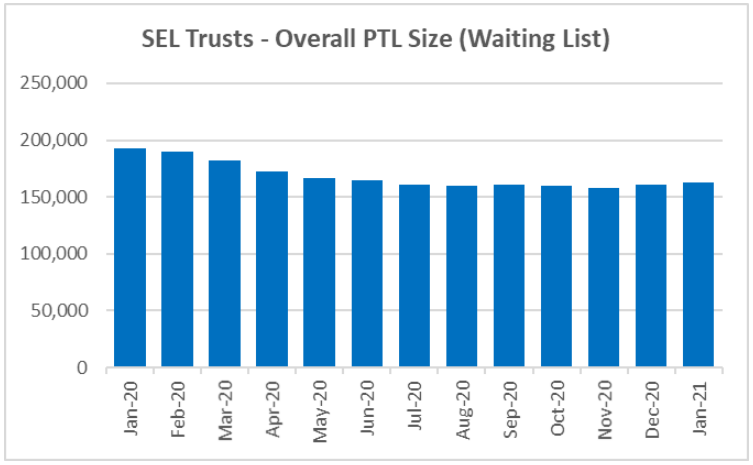


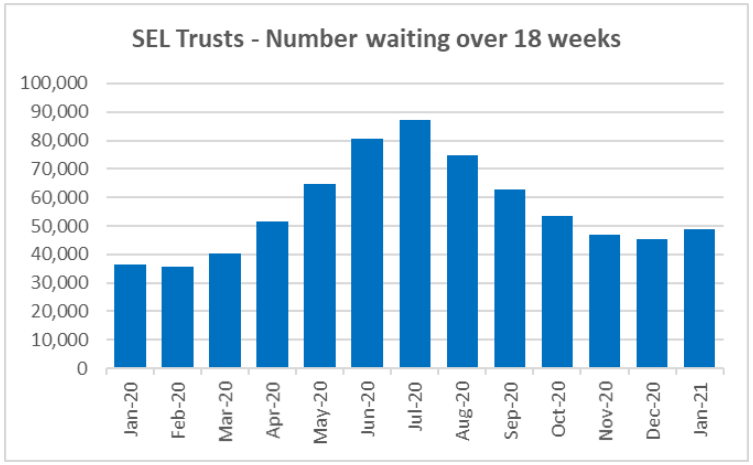


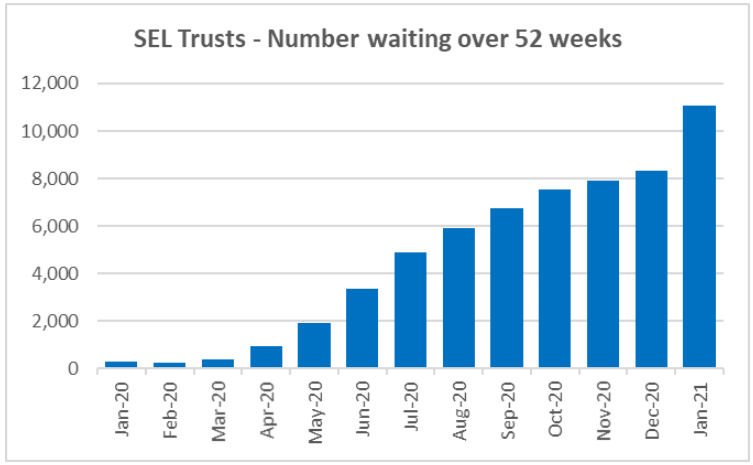


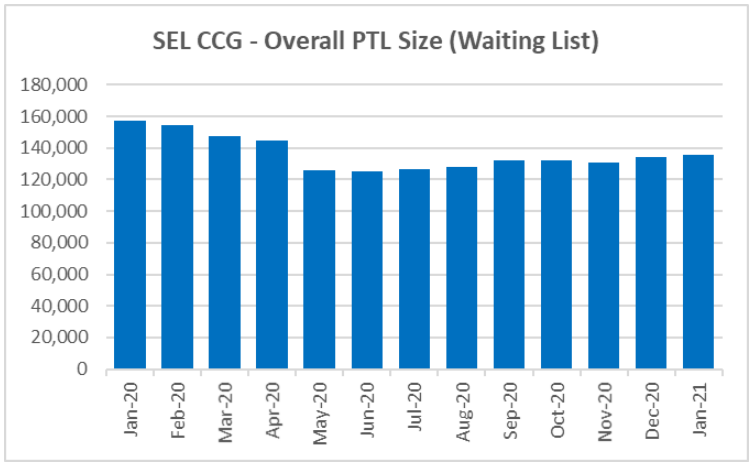


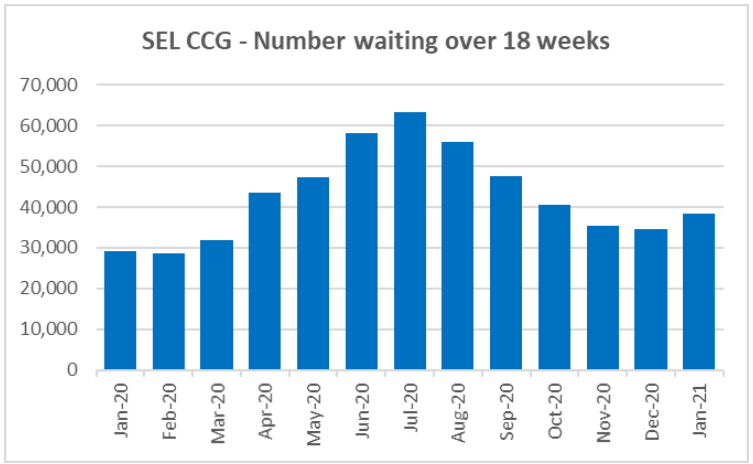
Referral to Treatment (RTT) – Waiting Time Trends – Last 13 months

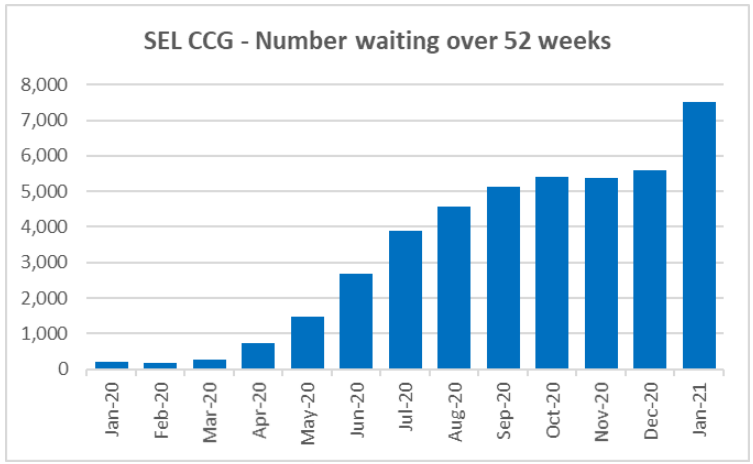












PTL Size

	Jan-20	Jan-21	Variance
GSTT	78,129	60,835	-17,294
KCH	73,777	57,831	-15,946
LGT	41,227	44,479	3,252
SEL Trusts	193,133	163,145	-29,988
SEL CCG	157,464	135,341	-22,123

 # Waiting over 18 weeks

	Jan-20	Jan-21	Variance
GSTT	13,210	19,164	5,954
KCH	15,139	17,088	1,949
LGT	8,139	12,585	4,446
SEL Trusts	36,488	48,837	12,349
SEL CCG	29,169	38,271	9,102

 # Waiting over 52 weeks

	Jan-20	Jan-21	Variance
GSTT	100	3,366	3,266
KCH	160	5,201	5,041
LGT	9	2,506	2,497
SEL Trusts	269	11,073	10,804
SEL CCG	194	7,520	7,326

Source: Consultant Led Referral to Treatment Waiting Times – Published data

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NHS
South East London
Clinical Commissioning Group

The Joint Health Overview and Scrutiny Committee

The impact of COVID on Mental Health

March 2021

NHS
South East London
Clinical Commissioning Group

Purpose and Contents

Purpose

The purpose of this slide deck is to provide an update to South East London's Joint Health Overview and Scrutiny Committee on the impact of the COVID pandemic on Mental Health.

Contents

Impact of COVID: Adult Mental Health Services (1/3)

NHS
South East London
Clinical Commissioning Group

Summary

- Generally, the provision of adult mental health services has been maintained during COVID. During Wave 1, some services were restricted whilst services adapted to the new conditions, however, during Wave 2 mental health services remained fully operational.
- There have been challenges to service delivery including:
  - Staff sickness levels in line with rising cases across the Capital.
  - Reduced capacity in some services due to social distancing and new infection control policies and procedures.
- In response to the pandemic, the two mental health providers across SEL:
  - Brought forward the Long Term Plan (LTP) commitment for 24/7 all ages crisis lines across the geography.
  - Piloted Crisis Assessment Units (CAUs) across a discrete number of emergency sites in order to support the flow patients across the system.
  - Moved as much activity as possible to non-face to face. Data from NHS Benchmarking indicates that the two mental health providers in SEL are above the national average for use of digital technologies (see Appendix 1 as example).

Impact of COVID: Adult Mental Health Services (2/3)

NHS
South East London
Clinical Commissioning Group

Summary Cont.

- During all three national lockdowns, adult mental activity reduced across both inpatient and community settings. This was due to a number of factors including changes to primary care access during COVID and stay at home restrictions resulting in less people presenting to emergency departments (EDs).
- Access to Improving Psychological Therapies also saw a reduction in referrals During Wave 1, services were able to clear waiting lists and therefore overall activity for IAPT reduced. There was a gradual return to pre-COVID levels for many of SEL's IAPT services by December 2020 but this has been impacted by the latest lockdown
- Subsequent easing of restrictions has resulted in spikes in activity, particularly through EDs with the proportion of people presenting to EDs who are unknown to mental health services increasing (see Appendix 2). This spike is currently being experienced across all five EDs across SEL.
- In addition, mental health providers across SEL are reporting increased acuity across services with greater numbers of people being detained under the Mental Health Act in comparison to the same time period the previous year.

Impact of COVID: Adult Mental Health Services (3/3)

South East London Clinical Commissioning Group

Recovery Priorities

- Ensuring sufficient capacity to manage any increases post easing of lockdown. Both mental health providers are working with the private sector to flex their inpatient capacity and are focusing on general bed flow. Both providers will also be closely monitoring the impact of the easing of restrictions on other services such as perinatal services.
- CAU models being evaluated, alongside other crisis initiatives for mental health, by partners in SEL to ensure these models are sustainable and appropriately support flow through emergency departments for 2021/22.
- IAPT services being promoted through various national and local campaigns (see further information on the Free Your Mind Campaign, Slide 12).
- Investment in community mental health services as part of both the allocation of the mental health investment standard for 2021/22 and development of the community mental health transformation programme (see Slide 9).
- Continued expansion of Peer Support Worker workforce to support crisis services, inpatient services and community services.

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Clinical Commissioning Group

Impact of COVID: Children and Adolescent Mental Health Services (1/2)

Summary

- Unlike adult services, referrals and caseloads for children and adolescent mental health services (CAMHS) have been maintained during COVID, and across SEL we have seen approximately a 30% increase in demand for services during 2020/21 compared to 2019/20.
- Eating Disorder Services for children and young people (CYP) have also seen a significant increase in demand, with referrals doubling from early 2020. Although referrals did flatten in October 2020, a further increase in demand is expected post easing of the current lockdown. This increase in demand has placed significant pressure on waiting times and inpatient capacity. This trend has been seen London wide.
- Similar to adult services, SEL has experienced an increase in CYP presenting in EDs and similar trends are being seen in presentations to EDs with the number of children and young people unknown to mental health services increasing.
- To support the response to the pandemic, SEL established a dedicated CAMHS crisis line to support the 24/7 all ages crisis line during key operating hours.
- Mental Health Support Teams in Schools (MHSTs) are in place across five of our boroughs. In some boroughs, pilot schemes were extended to cover all primary and secondary schools as a result of the pandemic. Services have continued to be operational, however, referrals have fluctuated in line with school closures.

Impact of COVID: Children and Adolescent Mental Health Services (2/2)

Recovery Priorities

- Ongoing investment into CAMHS via the mental health investment standard. Further investment into CAMHS services is also expected in 2021/22 through national transformation funding and dedicated funding for CYP services through the Spending Review.
- As a result of increases in demand, reducing waiting times for all cases is a high priority for services, particularly for face to face appointments. Secondary care services continue to work collaboratively with voluntary and community sector organisations to provide support for individuals on the waiting list, using appropriate risk stratification tools.
- Closer multi-disciplinary team working across different settings including primary care, education and secondary mental health services in order to identify individuals early and work collaboratively to develop appropriate care plans.
- Expansion of Mental Health Support Teams in Schools, in line with national initiatives and funding opportunities.
- Continued focus on inequalities and equitable access to services for all from across different groups across SEL (e.g. people from BAME backgrounds).

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Clinical Commissioning Group

Impact of COVID: Focus on Prevention

- Preventing the onset of mental health problems before their occur and supporting people to stay well is an important approach to improving mental health.
- Across SEL, there has been continued investment into services to supporting communities to stay well. This has included:
  - Ongoing investment into the Kooth Platform for CYP across SEL.
  - Local borough based initiatives focused on providing open access to emotional wellbeing services for CYP, such as The Nest in Southwark which opened in May 2020.
  - Piloting of the Qwell platform, an online self-help and counselling platform for adults over the age of 25 years across SEL. This is the sister platform to Kooth.
- Throughout 2020, the mental health providers, in collaboration with their local authorities have held two Urgent Mental Health Prevention Summits to address how services can work together to protect the mental health of local communities as result of Covid. The summits have attracted 1600 attendees and key themes included a focus on prevention, the need for better community networks and improved integration of voluntary and community sector services.
- This has resulted in the launch of the South London Listens campaign (supported by Citizens UK) to better understand what is important to communities with regards to their mental health. Part of the next steps is a community-led summit in June 2021

Impact of COVID: Transformation Programmes

- Despite COVID pressures, the Integrated Care System has continued to push ahead with its key priority areas for transformation in order to secure national funding pots and ensure implementation plans are in place from 2021/22.

- These priority areas include:

1. **Suicide Prevention** – circa. £1.2 million for SEL over a three year period, with first tranche of money to be released in April 2021. SEL is part of Wave 4 of this national programme. A new suicide bereavement support service is being rolled out in early 2021/22 as part of this initiative.

2. **Crisis Alternatives** – circa. £5.4 million for SEL over a three year period. This transformation pot builds on existing monies released in 2019/20 and 2020/21, with funds available from April 2021. Both providers will be establishing Crisis Houses as part of this initiative.

3. **Community Mental Health Services (CMHS)** – circa. £35 million for SEL over a three year period. This is new transformation monies and if done well, could result in a significant shift in service provision and ways of working across SEL. Place based delivery plans are in development to implement new community MH posts between secondary, primary care and local VCS providers.

Impact of COVID: Staff Resilience Hub

- The COVID pandemic has brought to light the importance of supporting staff health and wellbeing.
- In November 2020, all systems received national monies to develop staff resilience hubs and additional money has been released throughout 2020/21 specifically for staff health and wellbeing. This work has been overseen by the SEL Integrated Care System People Board.
- In the last 6 months, SEL has received circa. £1 million to support NHS and care staff health and wellbeing and the funding has been used to:
  - Test and develop a SEL mental health and wellbeing hub and outreach model. This work has involved developing a digital platform for staff, increasing access to IAPT services and interventions and carrying out focus groups to better understand the needs of different staff groups.
  - Supporting individual acute providers in SEL in providing psychology support to staff working in key front line services.
  - Providing specific support to hospices and social care staff in SEL.
- Additional funding is expected for 2021/22 to further develop and grow services available for staff working across health and social care in SEL.

Impact of COVID: Future Predicted Demand

South East London Clinical Commissioning Group

- Different modelling tools across the country are indicating that need for mental health services will increase as a result of the COVID pandemic. This could be due to:
  - **COVID supressed demand** (people who didn't access services during the pandemic);
  - **COVID-exacerbated demand** (people whose mental health has deteriorated during COVID; or
  - **COVID-induced demand** (additional people needing support due to the impact of the pandemic) (see Report from NHS Confederation for further definitions).
- The Centre for Mental Health has predicted that up to 10 million people (almost 20% of the population) will need either new or additional mental health support as a direct consequence of the crisis. When applied to SEL (by Thrive London), this modelling indicates:
  - **A 25% increase in people without pre-existing mental health conditions requiring access to mental health services** for anxiety and depression.
  - **Approximately 50% of people with pre-existing mental health conditions requiring additional services** for anxiety and depression.
- SEL is yet to see this demand emerge fully for adult mental health services, however, there have been increases in ED presentations over recent weeks. Work is ongoing across system partners to better understand the potential impact of this demand and develop plans to ensure appropriate capacity is in place.

Free Your Mind Campaign (1/2)

NHS South East London Clinical Commissioning Group

Digital behavioural science campaign to ‘nudge’ people to take action to look after their mental health and wellbeing. Increase take up of self-help resources and signpost to services.

Phase 1 ran from June to August 2020. Results:

- 1.5 million residents reached (total SEL population 1.9 million)
- 5 million+ impressions
- Engagement 3x the average (4.5x the average on Facebook and Instagram)
- 21,000 visitors to the Free Your Mind website
- 54% of visitors took one of the calls to action
- 44% of engagement from BAME residents
- Contributed to increase in uptake of IAPT services

Public Service Communications **Excellence Awards 2020** — Silver Award

Global Social Media Awards **FINALIST**

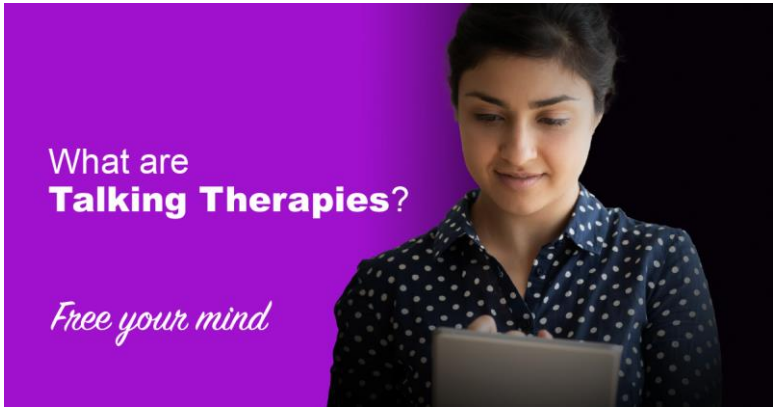
PRCA DIGITAL AWARDS 2021 FINALIST

Free Your Mind Campaign (2/2)

NHS South East London Clinical Commissioning Group

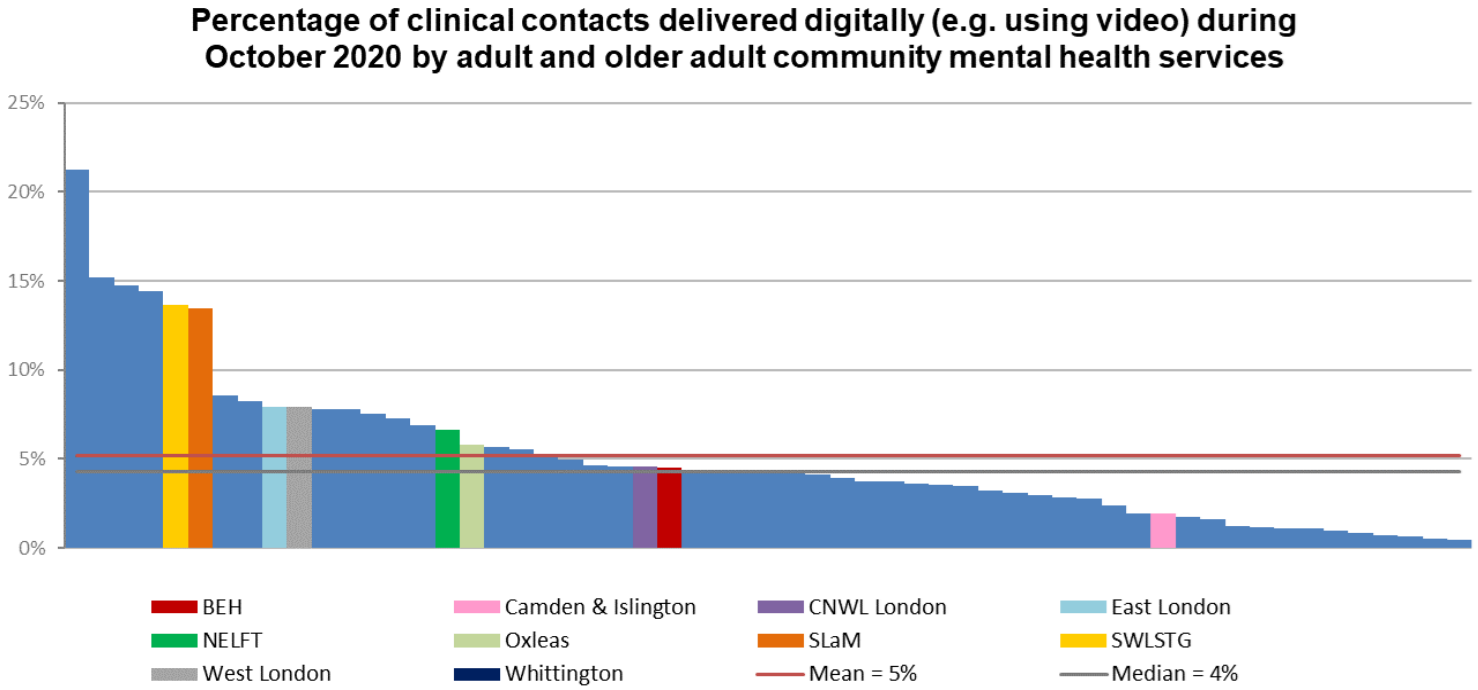
Phase 2 ran from February to March 2020 with a specific aim of encouraging people to access IAPT services or the online support at Kooth.com (aged 10-25) and Qwell.io (26+). Results*:

- 350,000 residents reached
- 1 million+ impressions
- Engagement 5x the average
- 13,000 visitors to the Free Your Mind website
- 36% of people who visited the talking therapies page clicked one of the links to a referral form



*Phase 2 has only just completed so these are provisional results. The budget for phase 2 was much smaller than phase 1 as the campaign had a more defined focus.

Appendix 1 – Use of Digital in Community Mental Health Services

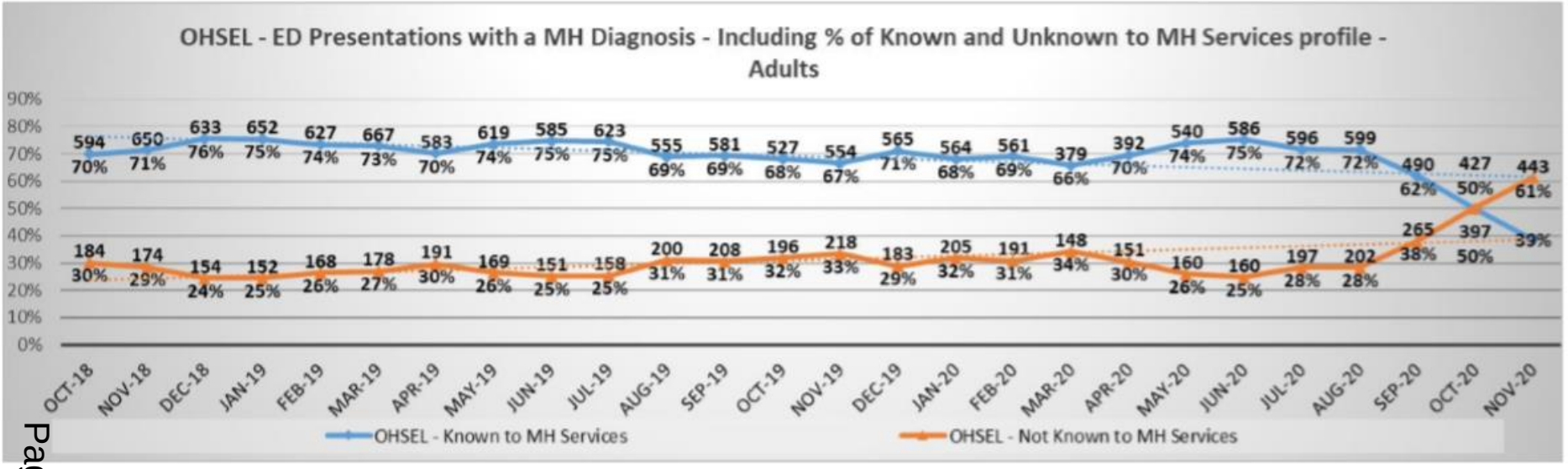


Notes

Data provided by NHS Benchmarking.

In London Trusts where digital contacts were reported, this averaged 7% of the total number of contacts delivered in October by adult and older adult community mental health teams (compared to a national average of 5%). Both SLAM and Oxleas are towards the upper end of use of digital technology.

Appendix 2 – Overview of People Presenting to ED (Known/Unknown)



Notes

This is preliminary data which is still under review by Healthy London Partnership to verify the known/unknown to mental health services data collection.

Adult mental health presentations at EDs showing split where they are either known or not known to mental health services prior to the ED visit. The orange line is showing new mental health demand. The blue line is an indication that mental health crisis and community services are operating at an optimal level to support patients, with fewer known patients presenting in ED. The convergence and continuation of the known/unknown lines is not only a percentage change but a significant number change.

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Pathology Update for Our Healthier South East London Joint Health Overview and Scrutiny Committee

8 April 2021

Presented by: Neil Kennett-Brown, Place Based Director (Greenwich) & SRO for Pathology Programme, NHS South East London CCG

1.0 Background

1.1 This paper is to update the Our Healthier South East London Joint Health Overview and Scrutiny Committee (JHOSC) on progress made since these changes were discussed with JHOSC on 22/07/2019. The paper presented at that committee is available from page 43 of the JHOSC papers 22/07/21.

1.2 It is important to note that these developments will mean no change to the service received by patients or the service provided to GPs.

1.3 The changes to local pathology service were driven by a national directive issued in 2017. This directive was that each Sustainability and Transformation Partnership (STP), now known as an Integrated Care System (of which we were one of 44 at that time) was to create a local pathology network across providers.

1.4 The local network was to comprise of Guy's and St Thomas' NHS Foundation Trust (GSTT), King's College Hospital (KCH) NHS Foundation Trust, Lewisham and Greenwich NHS Trust (LGT), South London and Maudsley NHS Foundation Trust (SLaM), Oxleas NHS Foundation Trust and the GP Direct Access pathology which was commissioned by all six former south east London Clinical Commissioning Groups (CCGs); note that this was before the six CCGs merged to become NHS South East London CCG in April 2020.

1.5 In late 2018 Lewisham and Greenwich NHS Trust decided not to be part of the SEL Pathology Network and the procurement and has, instead, developed a pathology network with Barts Health NHS Trust and Homerton University NHS Trust, and in July 2020 agreed a full business case to develop a network with Barts Health and Homerton (with outline business case in Nov 2019). The new network will go live from May 2021, and it will continue to provide pathology services, working within its new network and continue to have labs on both the QEH and UHL sites.

1.6 The LGT Board recognises the close clinical links between LGT and the other trusts in SEL, especially the role of GSTT and KCH as specialist ("tertiary") referral centres for patients (particularly when tests for cancer are needed). The Trust has continued to work with ICS partners and the SEL Pathology Programme Board to ensure that these clinical links are not negatively affected by joining a pathology network outside SEL. When rapid patient diagnosis of pathology samples is needed, for example, for haemato-oncology, LGT will continue to refer samples to the local tertiary centre in SEL.

1.7 There was no requirement for a public consultation as there is no change to pathology services from the point of view of patients. The only difference is which laboratory is

used for processing samples. The quality of service will be maintained and the CCG's contract with King's College NHS Foundation Trust and Guys & St. Thomas' NHS Foundation Trust will ensure this is so.

1.8 In September 2020, the procurement process had concluded, and the Governing Body of NHS South East London CCG made the decision, on the basis of best value, to confirm that it would commission all direct access GP pathology activity from King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust, who will work with their newly procured laboratory partner Synlab from April 2021. The Governing Body meeting was held in public and the papers can be downloaded from here.

1.9 Whilst the NHS South East London CCG's decision on the commissioning of GP Direct Access services was driven by a best value assessment there are also important non-financial benefits associated with the new contract. The Synlab bid was the highest scoring qualitative bid received by the network and proposed the strongest service offering for primary care. These specific benefits for GPs and other community based services will include:

- Fast tracking of urgent GP requests to support the prevention of hospital admissions and enable more patient conditions to be managed within the community
- Community services to benefit from improvements in consistency, reliability and flexibility of services, including collection arrangements, electronic ordering and access to a GP hotline
- A dedicated queue for urgent GP requests via the online phlebotomy booking system
- New, integrated Information Technology (IT) systems to link laboratories and referral sites, providing easier, faster access to testing services for clinicians in hospitals and the community
- Real-time logistics dashboards to bring the visibility and tracking of tests that primary care users do not currently have.

1.10 In terms of bidders, the opportunity to tender for the pathology service was widely publicised, and ultimately the role of the CCG was to consider the applications it received. The direct access pathology for Bexley, Greenwich and Lewisham GP services will transfer from LGT to the joint venture with KCH and GSTT in the autumn of 2021, and the CCG is working with partners to ensure the transition is smooth.

2.0. Update

2.1 A Transition and Transformation Pathology Programme Board has been established with a robust programme structure and dedicated resources to oversee the implementation plan. This will cover the key workstreams, including finance, IM&T, GP direct access, operations/governance, clinical governance & quality, research and development, estates, workforce, and stakeholder engagement & communications. The CCG will be actively involved in the programme, and Neil Kennett-Brown, Place Based Director Greenwich, is the Senior Responsible Owner for SEL CCG. All parties are

committed to working together.

2.2 In the months following establishment of the NHS/SYNLAB partnership on 1 April 2021, existing acute and direct access GP services, presently operated by Viapath, will continue to operate as they do now for GPs and patients (requesting/getting tests/receiving results). There will be no immediate changes for GPs, and no initial requirement to do anything differently as a result of the new partnership. For any changes in the future, there will be timely notification and opportunity for general practice input.

2.3 Direct access GP services in Bromley, Lambeth and Southwark will see no immediate change at all as their current providers – GSTT and KCH – are not changing, though their laboratory partner changed from Viapath to Synlab on 01/04/21.

2.4 Direct access GP services in Bexley, Greenwich and Lewisham are expected to transfer from Lewisham & Greenwich NHS Trust to the partnership in autumn 2021, with planning already underway, working with the Trust, SYNLAB and general practice.

2.5 The NHS/SYNLAB partnership are working with stakeholders to develop these plans to ensure a safe transfer of service, again aiming to ensure continuity for GPs and patients.

2.6 The partnership's vision is to co-develop a world-leading, integrated pathology network which supports high quality patient care for residents of south east London and beyond. The service will be clinically led, with the needs of patients and service users at its heart.

2.7 In addition to services provided by the two NHS partner trusts (KCH and GSTT) and GP services, the partnership will also provide NHS pathology services to many clinics, mental health and community services, including those provided by Oxleas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust.

2.8 As joint owners of the new partnership, the two NHS Trusts (KCH and GSTT) will set the strategic direction of pathology services, which will continue to benefit from the expertise of present pathology staff, including those working for Viapath and a small number of NHS pathology staff who will transfer. With respect to delivery and improvement of services, SYNLAB has a successful track record of partnering with the NHS and other hospitals across Europe to enable large-scale transformation.

2.9 SYNLAB and NHS partners plan to develop a 'hub and spoke' pathology model in accordance with the national NHS clinical vision and strategy. This will see significant improvements made to the quality and accessibility of testing and diagnostic services, which in turn will enable more rapid diagnosis, better patient outcomes, and an improved experience for clinicians and other service users.

2.10 The NHS/SYNLAB partnership has agreed an ambitious programme to transform pathology services over the next four years, resulting in major improvements to the quality of patient care and to the experience of clinicians providing that care. Central to this transformation, which directly responds to the national clinical vision for the NHS, is the creation of a hub laboratory which will be based in the community. This new

laboratory will be purpose-built with access to state-of-the art facilities and equipment, and supported by a central IT system which will allow clinicians to order, track and access test results online. Existing processes to enable the fast tracking of urgent requests will be enhanced. As well as improving patient and clinician experience, these improvements will help clinicians to manage care in the community, preventing avoidable visits and admissions to hospital. Within the first year of the new partnership, plans for service transformation will be finalised with the involvement of GPs and other clinicians from across the south east London health and care system.

2.11 The location of the future hub laboratory has now been confirmed as Friars Bridge Court, 41-45 Blackfriars Road, SE1 8NZ. The building was chosen based on a range of key criteria, including distance from the various NHS organisations it will serve and its ability to house modern pathology services which respond effectively to the needs of the NHS across South East London. About the hub laboratory.