Open Agenda

Health and Wellbeing Board

Thursday 18 June 2015
2.00 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London
SE1 2QH

Supplemental Agenda No. 2

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Date: 16 June 2015

Agenda Item 9

Item No. 9.	Classification: Open	Date: 18 June 2015	Meeting Name: Health and Wellbeing Board
Report title:		Health and wellbeing strategy: children & young people and prevention priorities	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested:

   a) To note the update which sets out the activities relating to the children and young people and prevention priorities of the Health and Well being strategy

   b) To note the high level public health outcomes associated with these priorities

   c) To request a report back on the milestones associated with the implementation of the priorities at the next meeting.

EXECUTIVE SUMMARY

2. The Health and Wellbeing Board is required by the 2011 Health and Social Care Act to publish a joint health and wellbeing strategy.

3. The Health and Wellbeing Board requested an update on the children & young people and prevention elements of the health and wellbeing strategy: CYP, obesity, tobacco and smoking, mental wellbeing, drugs and alcohol and sexual health and HIV. The term 'prevention' used here refers in the main to 'primary prevention'.

BACKGROUND INFORMATION

4. The Health and Wellbeing Board received and endorsed the refreshed Health and Wellbeing Strategic framework in January 2015. This refresh is informed by the joint strategic needs assessment (www.southwark.gov.uk/jsna), by what local people are telling us (Southwark Lives Engagement) and evidence of what works to improve the health of the population and to reduce health inequalities.

KEY ISSUES FOR CONSIDERATION

5. The health and wellbeing strategy is intended as an overarching strategic framework which sets the high level direction for health and wellbeing improvement for the whole system. The Health and Wellbeing Board requested an update on the children & young people and prevention elements of the health and wellbeing strategy. Prevention is at the core of the Health and Wellbeing Strategy. The other priorities are:

- Addressing the wider socio economic determinants of health which we know determine our life chances: to maximise opportunities for economic wellbeing, development, jobs & apprenticeships, and make homes warm, dry and safe

- Helping people with existing long term health conditions to remain healthier and live longer lives by improving detection & management of health conditions including self management & support

- Tackling neglect & vulnerabilities by supporting vulnerable children and young people and ensuring positive transition, ensuring choice and control for people with disabilities and supporting independent living for older people in an age friendly borough

- Supporting integration for better health & wellbeing outcomes by integrating health and social care that is personalised & coordinated in collaboration with individuals, carers & families and by shifting away from over reliance on acute care towards primary care & self care.

6. This report focuses on two areas of the health and wellbeing strategy: children & young people and prevention. Under prevention, there is a description of the work that is taking place in relation to obesity, tobacco and smoking, mental wellbeing, drugs and alcohol and sexual health and HIV. The report also sign posts to the associated strategies, action plans and relevant partnerships.

7. The high level public health outcomes that relate to children and young people and the prevention priorities are identified. It is recognised that the high level indicators are useful for monitoring the health of the population and that to assist the Health and Wellbeing Board in monitoring progress, implementation related data as well as milestones will be required. This is being developed for consideration at the next Board meeting.

Policy implications

8. Southwark council and the Southwark CCG have a statutory duty under the 2012 Health and Social Care Act to produce a health and well being strategy for Southwark. The health and wellbeing board leads the production of the strategy. Local health and wellbeing commissioning and service plans have to pay due regard to the health and wellbeing strategy.

Community impact statement

9. There are health inequalities in Southwark: between Southwark and the rest of the country, between geographical areas within Southwark, between women and men, those on lower income, some ethnic groups and those who are vulnerable. The JSNA identifies and describes the inequalities and provides the evidence base to inform the programmes of action in the health and wellbeing strategy. The Southwark Lives engagement exercise has informed the development of the strategy.

Legal implications

10. The board is required to produce and publish a joint health and wellbeing strategy on behalf of the local authority and clinical commissioning group. The

proposals and actions outlined in this report will assist the board in fulfilling this requirement and will support the strategy's implementation.

Financial implications

11. There are no financial implications contained within this report. However, the priorities identified in the health and wellbeing strategy will have implications for other key local strategies and action plans and the development of commissioning intentions to improve the health and wellbeing of Southwark's population.

BACKGROUND PAPERS

Background papers	Held at	Contact
Southwark Joint Strategic Needs Assessment	www.southwark.gov.uk/jsna	jsna@southwark.gov.uk
Southwark Health & Wellbeing Strategy 2013/14	www.southwark.gov.uk	Public Health 020 7525 0280

APPENDICES

No.	Title
Appendix 1	Southwark Health and Wellbeing Strategy: CYP & Prevention update

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Author	Jin Lim, Assistant Director of Public Health	
Version	Final	
Dated	11th June 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		16 June 2015

APPENDIX 1

Southwark Health and Wellbeing Board

Health & wellbeing strategy update: children & young people and prevention priorities

- Children & young people health & wellbeing
- Obesity
- Smoking
- Sexual health & HIV
- Alcohol/substance misuse
- Mental wellbeing

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1,000 Lives – Stories from Southwark residents

Southwark Joint Strategic Needs Assessment
www.southwark.gov.uk/jsna

Southwark Health & Wellbeing Strategic Framework

Priorities & programmes

- Best start
- Wider socio-economic determinants
- Prevention
- Common chronic health conditions
- Neglect & vulnerabilities
- Integration

Priority and programme deep dive seminars and health & wellbeing board reports

Monitoring of health & wellbeing outcome

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Early years & children's health & wellbeing	♦ Purposeful action to reduce obesity in children and young people **(more detail is under the prevention update)**	2015/16	Children & young people strategy & action plans	Children & young people board CCG Commissioning strategy board	Strategic Director of Children & Adult Services Cabinet member for children & schools Chair of CCG Chief Executive – CCG CCG clinical lead for resilience, wellbeing & prevention Director of Public Health Kings Health Partners
	♦ Deliver Family Matters to ensure effective early support to children, young people and their families, including parenting support, to achieve better outcomes and help prevent problems from escalating.	2015/16			
	● Review the Children and Young People's Plan 2013-2016 through a Local Account for CYPP	2015/16			
	♦ Deliver a joint Children and Young People's Strategy across the CCG and the LA, underpinned by joint commissioning intentions				
	♦ Shifting the balance to preventing problems when they arise to relieve the pressure on specialist services e.g. A&E, specialist clinics	2015/16			
	● Ensure greater choice and control for children and young people with Special Educational Needs and disabilities.	2015/16			
	● Improve childcare provision across the borough, responding to the recommendations of the Childcare Commission.	2015/16			

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Obesity	**Strategy & commissioning** ♦ Develop a Southwark Obesity Strategy which takes a whole systems approach to effectively tackle obesity ♦ Continue to progress the commissioning of agreed children's healthy weight services: - Implement INICEF Baby Friendly Initiative - Implement good nutrition and dietary practice in children's centres - Implement healthy schools programme - Provide specialist healthy weight practitioner support - Provide capacity building training to professional workforce to implement healthy weight care pathway - Provide Levels 2 and 3 weight management services ♦ Maximise opportunities of supporting plans,	2015/16 2015/16	Southwark Plan Council Plan Physical Activity & Sports Strategy Walking Strategy (in progress) Cycling strategy (in progress) CCG Prevention& Resilience Programme Action Plan Action plans for healthy weight, Kings public health committee work programme	Council Cabinet Proactive Southwark CCG Resilience & Prevention Board Healthy Weight Network King's Public Health Committee	Leader, Southwark Council Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Chief Executive of Southwark Council Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
	strategies and policies	2015/16			
	Diet and nutrition				
	● Monitor the free healthy school meals programme	2015/16			
	● Monitor and obtain feedback from the implementation of the free fruit scheme	2015/16			
	Healthier environment				
	● Embed health into the Southwark Plan to create healthier physical environments by promoting active urban design, access to quality green space, balanced mixed local economy and prevent over concentration of uses including A5, active travel and social infrastructure.	2015/16			
	Physical activity				
	● Embed cycling policies in all strategic documents to improve cycling safety, cycling routes, access and targeted promotion.	2015/16			
	♦ Proactive Southwark Partnership to develop programmes to increase participation in physical activity from at risk groups (early years, CYP, women & girls, older people,	2015/16			

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
	disabled, people at risk of ill-health conditions) ● Deliver free swims and gym for all Southwark residents and support less active to be more active. Focus on under 18s, older people and people with disabilities 2015/16.	2015/16/17			

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Smoking	♦ Produce a comprehensive tobacco control strategy - Stopping the promotion of tobacco use - Making tobacco less affordable and more effective regulation of tobacco products - Helping tobacco users to quit - Reduce exposure to second hand smoke - Effective communication for tobacco control	2015/16	Action plans for tobacco & smoking Kings public health committee work programme	Council Cabinet CCG Resilience & Prevention Board Tobacco Alliance King's Public Health Committee	Leader, Southwark Council Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Chief Executive of Southwark Council Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Alcohol & substance misuse	● Review the Southwark Statement of Licensing Policy to ensure that the Licensing Act objectives are met and best practice followed. ♦ Review prevention and treatment services for drugs and alcohol to re-commission services ● Adult Integrated Drug and Alcohol Treatment System tender exercise. ● Award of Adult Integrated Drug & Alcohol contract. ● Adult Integrated Drug and Alcohol Treatment System implementation. ● Tier 4 (Residential Rehabilitation & Inpatient Detoxification) delivery pathway review and restructure. ● Development of a Drug & Alcohol Treatment Plan based on our Needs Assessment findings. ● Review of Southwark Alcohol Strategy 2013-16- Development of an Alcohol Strategy for Southwark 2016/19 ● Integrate the Hidden Harm service into the	2015/16 2015/16 Q1-Q3 2015/15 Q3 2015/16 Q4 2015/16 Q2-Q3 2015/16 Q2 2015/16 2015/16	CCG Prevention& Resilience Programme Action Plan Action plans for, substance misuse & alcohol Kings public health committee work programme Drug & Alcohol Needs assessment 20/15/16 Southwark Alcohol Strategy 2013/16 Drug & Alcohol Treatment Plan (in development. Due September 2015)	Southwark CCG Resilience & Prevention Board Alcohol Strategy Group SSP Substance misuse performance Delivery Group Safer Southwark Partnership Executive King's Public Health Committee	Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
	Adult Integrated Drug and Alcohol Treatment System.	Q4 2015/16			

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Sexual health & HIV	♦ Implementing the Lambeth, Southwark and Lewisham Sexual Health Strategy which includes a commitment to improving access to HIV testing by delivering on programmes of work outlined below ♦ Implementing NICE guidance on HIV testing ♦ Widening access to HIV & STI testing across primary care settings (this may include expanding testing in specific locations and could include GP practices and potentially in high street pharmacies) ♦ Widening provision of HIV testing in acute settings (this may include providing additional testing services in medical wards, A&E and out patient services) ♦ Engaging with stakeholders (GUM, Primary Care, Community Services and patients/public) in designing and implementing	2015/16 - 2020 2015/16 2015/16 2015/16 2015/16	Southwark Plan Council Plan Sexual health & HIV strategy misuse & alcohol Kings public health committee work programme	Council Cabinet Resilience & Prevention Board Sexual health board King's Public Health Committee	Cabinet member for public health, parks & leisure Cabinet member for adults care, arts & culture Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
	testing services				
	♦ Widening access to HIV testing through SH24, Lambeth and Southwark's online sexual health service (SH24 is working with GUM clinicians to provide a viable alternative to people who are asymptomatic by signposting appropriately to the online service and reducing service cost)	2015/16			
	♦ Establishing an LSL wide C-card scheme (condom distribution) for both young people and vulnerable adults as part of a wider sexual health promotion programme	2015/16			
	♦ Developing a 'Halve it delivery plan' (which includes prevention) for consideration by Cabinet in six months.	2015/16			

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
Mental health & wellbeing	♦ Build community resilience & wellbeing across the system: - Increase mental health literacy and reduce stigma - Implement the PHE framework on public mental health workforce development (mental health awareness, suicide awareness) - To work with faith communities by delivering a Spiritual and Pastoral Awareness course - Host a wellbeing network, e-bulletin and wellbeing small grants scheme - To work with education to deliver an emotional wellbeing strand within the PSHE & Health & Wellbeing Programme (schools) - Work with the CCG to support the development of the Southwark Wellbeing Hub - Promote the impact of arts/creativity on health and wellbeing through the Lambeth & Southwark Arts and Health Group	2015/16	Housing Strategy CCG Mental wellbeing & parity of esteem Programme Action Plan Lambeth & Southwark Mental Wellbeing Programme Joint Mental Health Strategy	Council Cabinet CCG Mental wellbeing & parity of esteem board Mental health strategy group	Leader, Southwark Council Cabinet member for Adult care, arts & culture Chief Executive of Southwark Council CCG clinical lead for resilience, wellbeing & prevention Kings Health Partners

Priority	Programmes All programmes require ♦ partnership working but ● have a Council lead and ○ a NHS lead)	Timescale	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
	♦ Access the impact of policies and plans using wellbeing impact assessment eg phases 2 and 4 regeneration of Aylesbury Estate ♦ Promote the measurement of wellbeing in services and inclusion as part of JSNA as well as suicide and self harm data. ♦ Invest in mental health and achieve parity of esteem: - Implement CAMHS service development plan - Re procurement of IAPT - Review & invest in mental health urgent care ● Improve access to specialist mental health support, alongside preventative work to reduce emotional ill-health.	2015/16 2015/16			

Health & wellbeing strategy update: prevention priorities

Public Health Outcomes Indicator Set

- Children & young people
- Obesity
- Smoking
- Sexual health & HIV
- Alcohol/substance misuse
- Mental wellbeing

Children & young people

Southwark Child Health Profile — March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile — England average — 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	22	4.3	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	8	15.9	12.5	21.7	4.0
Health protection	3 MMR vaccination for one dose (2 years)	3,994	85.7	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	4,340	93.1	96.3	81.9	99.4
	5 Children in care immunisations	260	72.2	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	2,423	57.2	34.4	89.1	14.1
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	2,166	59.6	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,529	65.2	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	10	26.7	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	640	7.7	5.8	10.5	2.0
	11 First time entrants to the youth justice system	147	651.5	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	16,565	30.7	20.6	43.6	6.9
	13 Family homelessness	508	3.8	1.7	9.5	0.1
	14 Children in care	565	95	60	166	20
	15 Children killed or seriously injured in road traffic accidents	14	25.5	20.7	45.6	6.3
Health improvement	16 Low birthweight of all babies	402	7.9	7.3	10.2	4.2
	17 Obese children (4-5 years)	348	13.8	9.3	14.8	5.7
	18 Obese children (10-11 years)	570	26.0	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	21.9	27.9	53.2	12.5
	20 Under 18 conceptions	180	42.7	30.7	58.1	9.4
	21 Teenage mothers	27	0.6	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	9	14.6	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	19	42.5	75.2	218.4	25.4
Prevention of ill health	24 Smoking status at time of delivery	220	4.8	12.7	30.8	2.3
	25 Breastfeeding initiation	4,107	89.6	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	-	-	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	14,652	700.6	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	561	108.6	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	442	104.4	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	158	250.0	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	54	89.6	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	90	157.6	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

Obesity

Compared with benchmark: Better Similar Worse

* a note is attached to the value, hover over to see more details

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Southwark		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Reception: Prevalence of underweight	2013/14	34	1.09%	1.47%	0.95%	2.95%		0.28%
Reception: Prevalence of healthy weight	2013/14	2,204	70.9%	75.4%	76.5%	70.4%		81.6%
Reception: Prevalence of overweight (including obese)	2013/14	871	28.0%	23.1%	22.5%	29.5%		15.9%
Reception: Prevalence of obesity	2013/14	406	13.1%	10.8%	9.5%	14.4%		5.5%
Year 6: Prevalence of underweight	2013/14	30	1.16%	1.67%	1.36%	3.44%		0.50%
Year 6: Prevalence of healthy weight	2013/14	1,427	55.0%	60.7%	65.1%	55.0%		74.5%
Year 6: Prevalence of overweight (including obese)	2013/14	1,137	43.8%	37.6%	33.5%	43.8%		24.4%
Year 6: Prevalence of obesity	2013/14	692	26.7%	22.4%	19.1%	26.7%		11.1%

Compared with benchmark: Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

* a note is attached to the value, hover over to see more details

Indicator	Period	Southwark		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.11i - Fruit and Veg '5-a-day'	2014	227	47.8%	51.9%	56.3%	39.8%		64.5%
2.11ii - Average portions of fruit eaten	2014	1,226	2.50	2.56	2.64	2.23		2.92
2.11iii - Average portions of vegetables eaten	2014	1,011	2.10	2.22	2.36	1.80		2.64
2.12 - Excess Weight in Adults	2012	389	56.3%	57.3%	63.8%	74.4%		45.9%
2.13i - Percentage of physically active and inactive adults - active adults	2013	259	58.2%	56.2%	56.0%	43.5%		67.0%
2.13ii - Percentage of active and inactive adults - inactive adults	2013	171	25.6%	27.5%	28.9%	40.5%		15.9%

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Smoking

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	Smoking Prevalence (IHS)	2013	20.7	18.4	29.4		10.5
2	Smoking prevalence - routine & manual	2013	29.3	28.6	47.5		16.5
3	Successful quitters at 4 weeks	2013/14	2859	3524	1251		8946
4	Successful quitters (CO validated) at 4 weeks	2013/14	1667	2472	525		6950
5	Completeness of NS-SEC recording by Stop Smoking Services	2013/14	42.2	86.2	25.2		100
6	Smoking status at time of delivery	2013/14	3.8	12.0	27.5		1.9
7	Low birth weight of term babies	2012	2.7	2.8	5.0		1.5
8	Smoking prevalence age 15 years - regular smokers	2013		8			
9	Smoking prevalence age 15 years - occasional smokers	2013		10			
10	Lung cancer registrations	2010 - 12	97.7	76.0	146.8		40.1
11	Oral cancer registrations	2010 - 12	10.2	13.2	21.5		8.1
12	Deaths from lung cancer	2011 - 13	73.7	60.2	111.6		32.3
13	Deaths from chronic obstructive pulmonary disease	2011 - 13	74.4	51.5	101.0		26.8
14	Smoking attributable mortality	2011 - 13	329.8	288.7	471.6		186.6
15	Smoking attributable deaths from heart disease	2011 - 13	32.7	32.7	65.5		20.6
16	Smoking attributable deaths from stroke	2011 - 13	10.7	11.0	21.5		7.2
17	Smoking attributable hospital admissions	2012/13	1834	1688	2884		906
18	Cost per capita of smoking attributable hospital admissions	2011/12	36.1	38.0	59.3		23.0

Sexual health & HIV

	Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
Syphilis diagnosis rate / 100,000	2013	241	82.1	5.9	90.9		0.0
Gonorrhoea diagnosis rate / 100,000	2013	1,168	397.9	52.9	533.2		3.6
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) < 1900 1900 to 2300 ≥ 2300	2013	1,362	3218	2016	840		5758
Chlamydia proportion aged 15-24 screened	2013	14,917	35.2	24.9	10.6		58.2
Genital warts diagnosis rate / 100,000	2013	640	218.0	133.4	288.6		70.7
Genital herpes diagnosis rate / 100,000	2013	365	124.3	58.8	182.9		21.4
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2013	5,508	2516	832	3269		349
STI testing rate (exc Chlamydia aged < 25) / 100,000	2013	83,957	38354	14685	6588		53921
STI testing positivity (exc Chlamydia aged <25) %	2013	5,508	6.6	5.7	4.0		9.9
HIV testing uptake, MSM (%)	2013	4,018	94.1	94.8	86.1		100
HIV testing uptake, women (%)	2013	8,158	69.6	75.8	29.0		94.4
HIV testing uptake, men (%)	2013	9,598	87.7	84.9	58.4		95.9
HIV testing coverage, MSM (%)	2013	2,963	86.4	86.1	63.3		100
HIV testing coverage, women (%)	2013	7,306	68.1	65.6	26.0		85.2
HIV testing coverage, men (%)	2013	8,026	82.6	77.5	50.6		86.9
HIV late diagnosis (%) (PHOF indicator 3.04) < 25 25 to 50 ≥ 50	2011 - 13	248	38.7	45.0	77.3		25.9
HIV diagnosed prevalence rate / 1,000 aged 15-59	2013	2,692	12.63	2.14	0.37		14.70
Proportion of TB cases offered an HIV test (TB Strategy Monitoring Indicators)	2013	85	93.4	81.1	0.0		100
Antenatal infectious disease screening – HIV coverage (PHOF indicator 2.21i)	2013/14			98.9			
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii) < previous years England average ≥ previous years England average	2013/14	1,189	85.7	86.7	51.1		96.6

Alcohol

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	1.01 - Months of life lost due to alcohol (Male)	2011 - 13	12.7	12.0	6.1		28.0
2	1.01 - Months of life lost due to alcohol (Female)	2011 - 13	4.6	5.6	13.5		2.8
3	2.01 - Alcohol-specific mortality (Persons)	2011 - 13	12.1	11.9	31.2		3.4
4	2.01 - Alcohol-specific mortality (Male)	2011 - 13	20.4	16.6	44.5		3.6
5	2.01 - Alcohol-specific mortality (Female)	2011 - 13	4.7	7.5	29.9		1.6
6	3.01 - Mortality from chronic liver disease (Persons)	2011 - 13	13.8	11.7	31.7		3.3
7	3.01 - Mortality from chronic liver disease (Male)	2011 - 13	21.5	15.5	44.8		2.4
8	3.01 - Mortality from chronic liver disease (Female)	2011 - 13	6.7	8.2	23.7		0.0
9	4.01 - Alcohol-related mortality (Persons)	2013	46.7	45.3	83.6		27.9
10	4.01 - Alcohol-related mortality (Male)	2013	78.0	65.4	117.3		38.5
11	4.01 - Alcohol-related mortality (Female)	2013	22.2	28.4	68.7		14.8

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
12	5.01 - Alcohol-specific hospital admission - under 18s	2011/12 - 13/14	13.9	40.1	105.8		11.2
13	6.01 - Alcohol-specific hospital admission (Persons)	2013/14	493	374	1074		131
14	6.01 - Alcohol-specific hospital admission (Male)	2013/14	748	515	1494		170
15	6.01 - Alcohol-specific hospital admission (Female)	2013/14	261	241	658		77
16	7.01 - Alcohol-related hospital admission (Broad) (Persons)	2013/14	1551	1253	2070		731
17	7.01 - Alcohol-related hospital admission (Broad) (Male)	2013/14	2146	1715	2820		1011
18	7.01 - Alcohol-related hospital admission (Broad) (Female)	2013/14	1064	859	1386		498
19	8.01 - Alcohol-related hospital admission (Narrow) (Persons)	2013/14	469	444	808		264
20	8.01 - Alcohol-related hospital admission (Narrow) (Male)	2013/14	651	594	1049		338
21	8.01 - Alcohol-related hospital admission (Narrow) (Female)	2013/14	311	310	583		190
22	9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)	2013/14	2650	2111	3493		1115
23	9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)	2013/14	3797	2917	4848		1582
24	9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)	2013/14	1724	1426	2392		727
25	10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)	2013/14	601	645	1231		366
52	11.01 - Claimants of benefits due to alcoholism	2014	175.2	131.0	528.3		15.7

25

Substance misuse

Compared with benchmark: Lower Similar Higher

Data quality: Significant concerns Some concerns Robust

* a note is attached to the value, hover over to see more details

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Southwark		Region	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
Estimated prevalence of opiate and/or crack cocaine use	2011/12	2,829	13.1	9.6	8.4	1.9		20.8
Admission to hospital for mental and behavioural disorders due to alcohol	2012/13	363	138.0	90.9	84.1	18.8		212.0
Smoking Prevalence (IHS)	2013	-	20.7%	17.3%	18.4%	10.5%		29.4%

26

Mental wellbeing

Compared with benchmark: Better Similar Worse Lower Similar Higher Not Compared

* a note is attached to the value, hover over to see more details

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Southwark		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.23i - Self-reported well-being - people with a low satisfaction score	2013/14	-	*	5.5%	5.6%	-	-	-
2.23ii - Self-reported well-being - people with a low worthwhile score	2013/14	-	*	4.1%	4.2%	-	-	-
2.23iii - Self-reported well-being - people with a low happiness score	2013/14	-	10.6%	9.6%	9.7%	15.0%		5.8%
2.23iv - Self-reported well-being - people with a high anxiety score	2013/14	-	22.9%	20.6%	20.0%	29.3%		9.3%
2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12	-	-	34.1	37.7	-	-	-

Agenda Item 10

Item No. 10.	Classification: Open	Date: 18 June 2015	Meeting Name: Health and Wellbeing Board
Report title:		Update on Local Care Networks and approach to Commissioning and Contracting	
Wards or groups affected:		All	
From:		David Smith – Head of Transformation – Integration, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

   a) Note the attached presentation as an update of progress on establishing GP Federations and Local Care Networks and their role in the broader context of integration
   b) Note and approve in principle the approach outlined in the 'Approach to Commissioning and Contracting' as to the practical next steps in commissioning health and social care services on an outcome basis for the population of Southwark.

EXECUTIVE SUMMARY

2. Southwark CCG has expressed a clear wish to modify the way the way that it commissions services by moving from an activity based model to an outcome based system. We recognise that activity based contracts can create perverse incentives, and do not always promote joined up care. An unintended consequence of such contracts is that they address only the patient's immediate needs without seeking to prevent ill health or address the underlying health and social issues that may be impacting on their wellbeing.

3. The attached appendices highlight the important role Local Care Networks will have as delivery vehicles, and suggest practical next steps in identifying segments of the population that we commission for on an outcome based whole-pathway contract.

BACKGROUND INFORMATION

4. Southwark CCG has supported general practice to develop geographically coherent neighbourhood GP provider organisations, where practices work collectively to improve the quality of services and outcomes for their combined registered populations. These GP provider organisations are collaborations of the 20 practices in the South, and 23 practices in the North, and have successfully bid to deliver a range of population based services; including 8-8 7 day Primary Care Services, and Population Health Management (e.g. NHS Vascular Health Checks, Smoking Cessation, Holistic Assessments and Case Management for over 65s).

5. Local Care Networks (LCNs) will be introduced during 2015/16, and will bring together all health and social care organisations within Southwark to develop and transform services for the populations they serve. They will be centred around the needs of patients and aim to ensure that all providers provide joined-up holistic care for all residents.

6. There will be two LCNs within Southwark, one serving the north of Southwark (Borough, Walworth, Bermondsey and Rotherhithe, and one serving the south of Southwark (Peckham, Camberwell and Dulwich).

7. Local Care Networks will have the autonomy to act to improve health and wellbeing outcomes for their designated population with a strong emphasis on prevention and early intervention.

KEY ISSUES FOR CONSIDERATION

8. See attached appendices.

Policy implications

9. Integration of services involves agreeing shared policy goals with partners as set out in the draft vision, developing neighbourhood multi-disciplinary team models with care co-ordinated by a lead professional, and jointly agreeing how pooled resources will be invested under the Section 75 pooled budget arrangements. Specific policy implications will be identified during the detailed design phase and agreed through integrated governance arrangements.

Community and equalities impact statement

10. The health and care related services covered by the integrated care plans should have a positive impact on the community as a whole. In particular it will impact on older people and people with long term conditions (many of whom have disabilities or mental health problems) who are most at risk of admission to hospital or needing intensive social care support. The plan aims to promote the health and wellbeing, independence and quality of life of these groups who are recognised groups with protected characteristics under Equalities legislation. The informal carers of these groups will also benefit, who are disproportionately female. The draft vision will also contribute to the wider prevention and public health agenda benefitting the population as a whole in the longer term, and reducing health inequalities. Plans are being co-designed with patient and service user groups, such as Patient Participation Groups, the SLIC Citizens Board and the Older Peoples Partnership Board.

Financial implications

11. None at this stage, but more detailed proposals which may have financial implications will be brought back to the Health and Wellbeing Board as detailed planning progresses.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Integrated Care – Vision for the Future
Appendix 2	Approach to Commissioning and Contracting - Integration

APPENDIX 1

NHS
Southwark
Clinical Commissioning Group

Integrated Care – Vision for the Future

Dr Jonty Heaversedge, Chair, NHS Southwark CCG

David Smith, Head of Transformation – Integration, NHS Southwark CCG

The best possible health outcomes for **Southwark people**

Introduction

NHS
Southwark
Clinical Commissioning Group

- Southwark is undertaking a major transformation programme to deliver integrate care.

- As well as being a focus locally, integration is a key priority nationally as set out in the Five Year Forward View.

- This presentation aims to update the Health and Wellbeing Board on the progress we have made so far, and sets out the vision for the future and how we hope to achieve it.

National Context – The Five Year Forward View

NHS
Southwark
Clinical Commissioning Group

- Published in October 2014, the Five Year Forward View sets out a joint vision from NHS England, Public Health England and Regulators as to the direction of travel for the NHS.

- One of its key points is that the NHS needs to take 'decisive steps to break down the barriers in how care is provided', between primary and secondary care, between physical and mental health and between health and social care.

- In order to do this, the Five Year Forward View suggests that all health and social care economies should adopt 'new models of care' such as the Multispecialty Community Provider model which envisages groups of GPs combined with nurses, hospital specialists, mental health, social care and community services working together to create integrated out-of-hospital services. These groups would seek to harness the collective skills and knowledge of those within them, to work much more intensively and proactively with service users with complex and on-going needs.

How are we responding locally?

NHS
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Clinical Commissioning Group

- For Southwark, rather than being a change in policy, this is a welcome affirmation of own direction of travel.

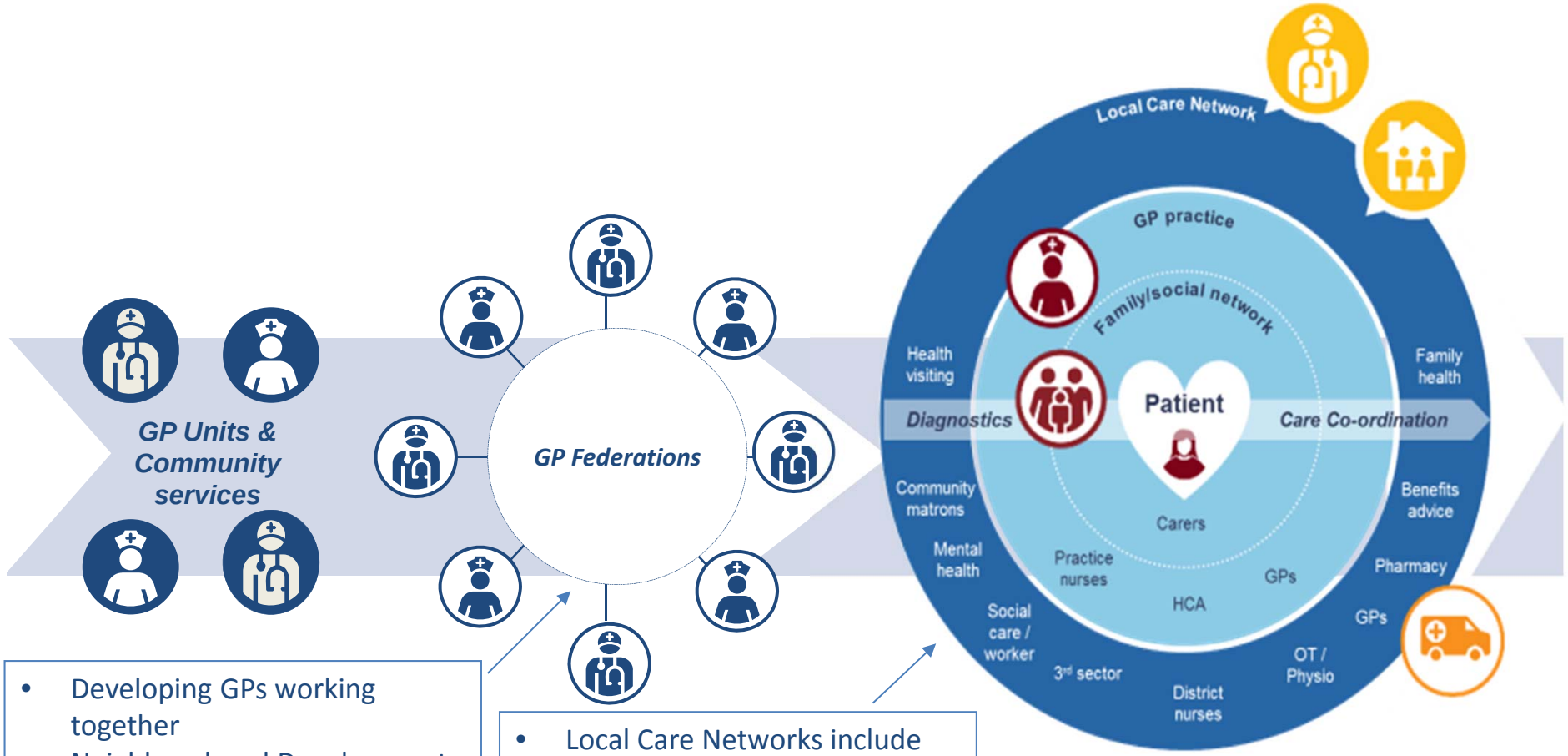
- We have already been establishing GP Federations on a neighbourhood basis. These enable GP practices to deliver a greater range of extended services and will be the cornerstone of better integrated care.

- The next step is the development of Local Care Networks (LCNs). These will mirror the geographies of the GP Federations and will bring together local health and social care providers to develop and transform services for the populations they serve. The LCNs aim to deliver better quality, community-based services that take a holistic, proactive and preventative approach to care, and support multi-disciplinary working at neighbourhood level. Following a series of exploratory workshops, LCNs will now begin to meet formally from the start of July.

- Taken together, this means that we are adopting the 'Multi Specialty Community Provider model'

The Local Care Network model

NHS
Southwark
Clinical Commissioning Group



- Developing GPs working together
- Neighbourhood Development Plan Scheme
- Neighbourhoods providing range of extended services
- Challenge Fund – Extended Access (8-8 access to GPs) now live across the borough

- Local Care Networks include GP Federations, acute, mental health and community services, social care, housing, & voluntary sector.
- Integrated leadership team

Primary care working within LCN's

Commissioning for Outcomes

NHS
Southwark
Clinical Commissioning Group

- It is important to remember that the establishment of GP Federations and LCNs is not an end in itself. Rather it provides a mechanism for delivery of whole system transformation.

- More fundamentally, we wish to change the way the way we commission services by moving from an activity based model to an outcome based system. We recognise that activity based contracts can offer perverse incentives, and do not always promote joined up care. We are thus seeking to incentivise providers to work collaboratively to integrate care pathways which prioritise clinical and functional outcomes that are meaningful to patients.

- To do this, we will start to contract for services on a whole-pathway basis. This type of contracting (examples of which include lead provider or alliance contacts) allows a number of providers to enter into an agreement to work co-operatively and share risk and reward to care for a segment of the population. We believe this approach would this approach would encourage greater investment in prevention and in primary and community care – reducing demand on costly secondary and tertiary services.

Why are we taking this approach?

NHS
Southwark
Clinical Commissioning Group

- Put together, this is a major transformation programme which we hope and believe will make integrated care a reality

- If we are successful it will enable us to:
  - **Be less prescriptive.** Focusing on outcomes incentivises personalised solutions to better support patients.
  - **Be more innovative.** Providers can experiment and channel funding into new service models
  - **Get serious on prevention.** All providers will share the incentive to invest in preventative services, rather than the responsibility resting with one part of the system
  - **Achieve better quality and value.** Improvements in communication and collaboration will allow us to improve the care we are able to give, whilst helping us keep our health and social care system sustainable.

How will we achieve this?

NHS
Southwark
Clinical Commissioning Group

- During 2015/16 we will look to make significant progress on a number of areas, to help move integrated care from a vision to a reality.

- Key steps include:
  - **Moving to joint commissioning with Social Care.** This will enable funding to be pooled, plans to be better aligned, and reduce duplication of effort
  - **Support the continued development of GP Federations** to allow them to deliver services at scale, and play an active part in Local Care Networks.
  - Work with providers, both new and incumbents, across health and social care to **help develop capability and readiness** to successfully participate in alliance contracts .
  - Agree the population segments which we will start to commission for on **outcome based whole-pathway contracts**.
  - Help **Local Care Networks** drive the integration of services, and seek to support them on the transformation of preventative services.

APPENDIX 2

Approach to Commissioning and Contracting – Integration Discussion Paper

11/06/2015

Purpose of the paper

Following discussions at the Integration and Neighbourhood Working Programme Board, this paper seeks to identify the next steps in commissioning health and social care services on an outcome basis for the population of Southwark.

Background

Southwark CCG has expressed a clear wish to modify the way the way that it commissions services by moving from an activity based model to an outcome based system. We recognise that activity based contracts can create perverse incentives, and do not always promote joined up care. An unintended consequence of such contracts is that they address only the patient's immediate needs without seeking to prevent ill health or address the underlying health and social issues that may be impacting on their wellbeing.

We are thus seeking to incentivise providers to work collaboratively to integrate care pathways which prioritise clinical and functional outcomes that are meaningful to patients, enhance patients experience of care and promote prevention, wellness and well bring in order to reduce the burden of disease and health inequalities for the whole population. We are currently reviewing a number of whole-pathway contractual options, such as alliance or lead provider contracts, which will best meet these aims by transferring greater accountability to providers and in so doing ensure more joined up care, improve the quality and consistency of local services, encourage innovation and drive better value. We are also progressing plans for joint commissioning between health and social care as a key enabler for more integrated models of health and social care in the future, and we have embarked on a program of provider engagement, development and alignment to ensure that the system locally is able to respond to our ambitions.

Our plans locally will, over the next 5 years, result in a new model of integrated care for the population of Southwark consistent with the Multispecialty Community Provider (MCP) model described in the 5 Year Forward View, and with the shared vision across Lambeth and Southwark co-created by commissioners, providers and citizens in both boroughs that we articulated in our joint Vanguard bid to NHS England for support with system transformation.

Commissioning for a population

In order to commission for outcomes on a population basis, it is necessary to identify segments of the population that have similar characteristics. These would include shared service or treatment needs or support, and could be defined by medical condition or key demographic data such as age. By segmenting the population in this way it is possible to identify common clinical and functional outcomes that are of importance to people within the target group. New contractual arrangements

will mean that providers share responsibility for delivering improvements in these outcomes. The work of identifying cohorts of people within the local population with similar enough characteristics to enable such outcomes based contracts to be developed between providers and commissioners has already begun through the work of the Southwark and Lambeth Integrated Care Programme (SLIC). From a pragmatic perspective it is important that the population segments are homogenous enough to share a set of outcomes that are meaningful to everyone, but not so narrowly defined that that the contract value does not effectively incentivize transformation and innovation within the health and social care system.

The Integration and Neighbourhood Working Programme Board will take a practical, evidence based approach to identifying potential segments of the population for whom we could commission care differently. They will be characterized by a common set of outcomes that are identified as important by the people who constitute these segments.

Over the next two years it is intended that we transform the local model of care delivery in line with the vision of the MCP. This population-based model of care will have at its heart two Local Care Networks (LCNs) – one in the south of the borough and one in the north. These will bring together community health and social care providers from both the statutory and voluntary sector and deliver multidisciplinary care that reflects the needs of individual patients in an empowering, holistic, and personalised way. These LCNs are dependent on primary care being delivered at greater scale and their geographical coherence will support and empower the local population to stay well and make healthier choices - to promote mental and physical wellbeing and reduce health inequalities.

Transformation at this scale cannot be achieved at once. As commissioners we will identify pathways of care and segments of the population to prioritise, and will support the provider and market development necessary to achieve best value for our population. We recognise that this will be a process of discovery and not design and requires us to work collaboratively with providers and share some of the risk associated with this level of transformation in order to stimulate innovation and proceed at the pace necessary to meet the financial challenges we face in the local health and social care economy. In order to prioritise the parts of our population to focus on initially we will take the following approach:

1) Work with Public Health to identify population segments where indicators suggest that outcomes are worse than expected, or where there is potential for significant quality and/or value improvement, for example through a greater emphasis on prevention
2) Ensure that segments are of adequate size and scope so that all relevant providers would have sufficient incentive to dedicate time, resources and energy into redesigning pathways and service offerings to deliver improved outcomes
3) Ensure that segments span multiple provider groups from across health and social care where there is a clear imperative to better integrate services and shift activity from acute settings to community based services

Developing a population based approach

Once a segment has been identified that is suitable for a whole-pathway contracting approach, commissioners will need to develop a tender specification. In order to do this it is recommended that:

1. Commissioners actively engage with service users, patient groups and the public to fully understand their needs, ensure that the contract specifies outcomes that matter to people within the population cohort and that services are co-designed with those who will be using them.
2. Commissioners work with incumbent providers to understand the barriers within the existing model to ensure that any specification acknowledges these challenges and seeks to overcome them.
3. Work with providers to determine the contract cost. This is a complex process based on the current price paid, the true cost of care and the opportunity for increasing value through improved quality, collaboration, innovation and prevention. This process will require a deep understanding of our population and potentially additional actuarial support to forecast and predict clinical and financial risk across the system, including changing population demographics, cost and utilisation. It is recognised that understanding costs and predicting risk in this way across an entire pathway or part of the population will be a challenging process. As such, it may be necessary to engage independent external support to work with providers and commissioners to provide specialist expertise in determining the cost of these contracts.
4. Commissioners, public health and service users would need to agree what outcome metrics, both clinical and functional, they would wish to see from the service. These indicators should cover the entire pathway, but be relatively few in number to ensure clear focus on the areas for improvement.
5. Commissioners will work proactively with providers (both incumbent and potential new entrants) on developing new ways of working and operating models. We recognise that in order for a whole-pathway contract to function effectively, providers must be in a position to engage with each other on an equal footing. The establishment of GP Federations is an example of how this work is being taken forward, but we recognise that these Federations will need continued support as they begin to take on greater responsibilities. A similar approach will also need to be taken with community pharmacies and the voluntary sector to ensure that robust governance arrangements are established, which will enable greater collaboration and integration of services.
6. Consideration will need to be given as to what analytical support is needed to ensure the outcomes in these contracts can be effectively measured and monitored. This is likely to involve significant organisational and workforce development for both providers and commissioners. This will need to be appropriately considered as part of development plans and budgeting arrangements.

Contracting arrangements

There are a number of whole-pathway contractual mechanisms that would support collaborative working between providers and require a shared commitment to improve outcomes for the population. These approaches would help incentivise providers to work together, whilst reducing perverse incentives, which can inadvertently increase activity and costs. In addition, these approaches would encourage greater investment in prevention and in primary and community care – reducing demand on costly secondary and tertiary services. Under a risk/gain share arrangement,

providers would be able to share the rewards accrued by reductions in, for example, hospital and care home admissions.

Whilst we would always wish to work productively and collaboratively with incumbent providers, we also have a responsibility to ensure that we commission services which are innovative and deliver the best value for money against the outcomes that they deliver. We will therefore ensure that we test the market and, as required,, invite interested collaboratives of providers to tender for delivery of services for particular population segments.

We believe that contracting with providers collectively to deliver a shared set of outcomes identified as important by specific segments of the population will be an enabler to achieving more integrated, innovative services. We are aware that whilst whole-pathway contracting potentially has significant benefits, it also carries inherent risks, not least because, for many providers, it would be an entirely new way of working.

Whilst we will ultimately seek to move all commissioned activity to outcome based whole-pathway contracts, we recognise that this will take a number of years. However, to ensure that we are able to maximise impact, the segments that we would choose to prioritise initially would be those that would most benefit from an integrated approach in order to improve quality of outcome and experience. Specific examples currently being considered are:

- People approaching the end of their life
- People with severe mental health problems
- People with diabetes – and possibly other long-term conditions such as COPD or heart failure
- People who are over 75 years old
- People who are experiencing breathlessness as their primary symptom

These are just some initial examples that will enable us to progress our plans and learn experientially as we implement our vision. Whilst developing our understanding of the commissioning mechanisms to catalyse change in the local health and social care system we have also prioritised the need for a parallel process of 'bottom up' organisational and workforce development and alignment to bring about the formation of Local Care Networks.

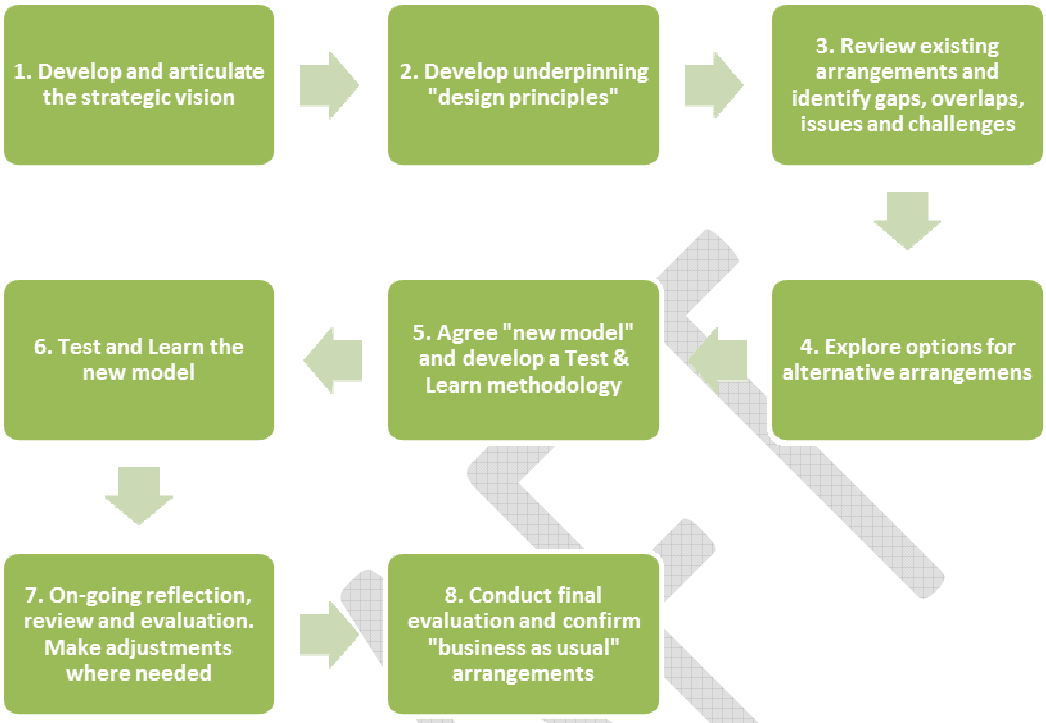
Developing Local Care Networks

As previously described, Local Care Networks will lead in the delivery of care transformation for identified population or patient groups. At any one time they will have a number of different transformative projects that they will participate in. To manage this workload, and to ensure that front-line staff and service users are actively engaged, LCN subgroups will be established to lead on the design and implementation of pathway transformation.

To address the challenge of introducing whole system transformational changes in a considered and focused way it is suggested that a 'Test and Learn' approach could be adopted where appropriate. Blending evidence based methodology and reflective action learning, this approach is focused on introducing transformational change in a stakeholder led, safe and reflective 'test' environment. As opposed to a pilot, the new integrated models of care delivery will need to be implemented at LCN,

borough or bi-borough scale and refined on an on-going basis. The starting point is that system transformation will take place in line with our agreed Vision.

The stages are as follows:



Essential to the design and execution of a 'Test and Learn' approach is the need for demonstrable strong leadership from key stakeholders (sponsors) throughout the process. Experience of using this methodology by the Institute of Public Care (IPC) from Oxford Brookes University has shown that by supporting the approach, leaders are confirming and committing to a vision of transformation where the tangible changes needed (structures, roles, systems, processes etc) will be developed and implemented during the process. This then filters down through organisations, helping empower staff at all levels to challenge existing ways of working, propose new ways of working, and help develop a new cadre of leaders. Commissioners and providers are required to encourage and support innovation and accept that in some instances 'risk and failure' are acceptable and manageable components of the test and learn processes.

This shared approach would support integrated working from the beginning and be a means to implement models of working in practice that can then inform the on-going development of commissioning and contracting approaches. The benefits are that it:

- Provides a practical and structured starting point for operational transformation – tests all aspects of the model - can understand what's happening, why it's happening and through this develop the detail of the operating pathway, systems and processes.
- Front line practice directly informs the model and makes it real for practitioners. Also identifies where there is resistance to change that needs to be addressed.
- Enables understanding and development of the working culture that will need to be embedded and sustained to fully support working across organisational and professional boundaries to deliver an integrated response to people in practice.

- Begins to build and strengthen the inter-professional working relationships as well as develop operational transformational leaders.
- Is a means to quickly and effectively identify and manage the risks as the test develops rather than waiting until the end of a pilot process – enabling the model to be refined and developed from the beginning.
- Creates a safe learning environment – allows for reflective practice through action learning meetings. Gives permission to work across boundaries, to be innovative and creative in trying out different solutions.
- The message to staff and stakeholders is that change will take place – whether the model is the right one or not – there will be learning that can be taken forward and it will inform how commissioners should commit and realign finances to commission integrated and more proactive support.
- Identifies the right information to inform the final service specification(s).

Next Steps

For the year ahead, it is proposed that the following areas are prioritised:

1. Organisational development:
    - Establish joint commissioning arrangements between CCG and Local Authority
    - Commence co-commissioning of primary care and review options regarding full delegation
    - Explore opportunities to increase analytics capability to measure outcomes and activity and forecast and predict clinical and financial risk across the system, including changing population demographics, cost and service utilisation
    - Develop expertise in whole-pathway contracting
2. Provider development:
    - Continue to provide system wide leadership locally by aligning our work with strategic plans at a borough, bi-borough, SE London, London-wide, and national level
    - Participate in a local system wide transformation partnership that acknowledges the necessity for health service transformation at a Lambeth and Southwark scale
    - Continue to work closely with GP Federations on their development
    - Establish Local Care Networks and agree ways of working between providers. Within this, we will encourage and support service developments on preventative services to ensure that new, integrated services that seek to deliver improved outcomes are brought on-stream over the next year.
    - Strengthen collaborative working across pathways
    - Encourage and support federated models for pharmacy and the voluntary sector
    - Use 'Test and Learn' approach within LCN sub-groups
3. Identify 'population segments':

- Identify segments which should prioritised for outcome based whole-pathway contracts
- Establish appropriate outcomes for these segments and evaluate current and future levels of activity and cost for the segments

4. Progress some initial joint working and new contractual arrangements to support commissioner and provider learning and catalyse service transformation

Whilst we would wish all of the identified areas to progress at pace, it is acknowledged that some may take longer than others. As such we would seek to ensure that any slippage on any of these areas should not impede progress on the remaining priorities.

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Dated: June 2015