Open Agenda

Health and Wellbeing Board

Thursday 31 March 2016
10.00 am
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Peter John OBE (Chair)	Leader of the Council
Andrew Bland	NHS Southwark Clinical Commissioning Group
Councillor Stephanie Cryan	Cabinet Member for Adult Care and Financial Inclusion
Aarti Gandesha	Healthwatch Southwark
Councillor Barrie Hargrove	Cabinet Member for Public Health, Parks and Leisure
Jonty Heaversedge (Vice-Chair)	NHS Southwark Clinical Commissioning Group
Eleanor Kelly	Chief Executive, Southwark Council
Gordon McCullough	Community Action Southwark
Professor John Moxham	King's Health Partners
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Dr Yvonneke Roe	NHS Southwark Clinical Commissioning Group
Dr Ruth Wallis	Director of Public Health

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Contact
Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 21 March 2016

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Thursday 31 March 2016
10.00 am
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in 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 clear days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 28 January 2016.	1 - 5
6.	**SUMMARY VIEW OF RESPONSES TO THE LAMBETH & SOUTHWARK EARLY ACTION COMMISSION** To note the responses from the Council, Community Action Southwark and the Southwark NHS Clinical Commissioning Group to the recommendations of the Lambeth & Southwark Early Action Commission report.	6 - 53

Date: 21 March 2016

Agenda Item 5

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Thursday 28 January 2016 at 10.00 am at Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Peter John OBE (Chair) Andrew Bland Councillor Stephanie Cryan Aarti Gandesha Councillor Barrie Hargrove Jonty Heaversedge Eleanor Kelly Gordon McCullough David Quirke-Thornton
ALSO PRESENT:	Councillor Fiona Colley
OFFICER SUPPORT:	Everton Roberts, Principal Constitutional Officer

1. APOLOGIES

Apologies for absence were received from, Professor John Moxham, Dr Yvonneke Roe and Dr Ruth Wallis.

2. CONFIRMATION OF VOTING MEMBERS

Those members listed as present were confirmed as the voting members for the meeting.

3. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

The chair gave notice that the following late information item would be accepted.

Item 15 – Policy and Resources Strategy 2016/17 – 2018/19: Revenue Budget

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the minutes of the meeting held on 21 October 2015 be approved as a correct record and signed by the Chair.

6. HEALTH AND WELLBEING STRATEGY: ALCOHOL, DRUGS & SEXUAL HEALTH

Jin Lim, Assistant Director / Consultant in Public Health introduced the report.

RESOLVED:

1. That the update on alcohol, drugs and sexual health, Appendices 1 and 2 of the report be noted.

2. That the proposed actions for 2016 as summarised in Table 1 of the appendices for alcohol, drugs and sexual health be noted.

3. That the summary of the findings from Healthwatch Southwark's engagement on sexual health be noted.

4. That the issue of school involvement into the work of the health and wellbeing board by way of membership be looked at.

7. SOUTHWARK CHILDHOOD OBESITY DATA AND OPTIONS FOR 5 YEAR CHILDHOOD OBESITY OUTCOME AMBITIONS

Jin Lim, Assistant Director / Consultant in Public Health introduced the report.

Concern was raised by a member of the board about the promotion of a babyfood product [within Southwark] with a high sugar content which was popular with ethnic groups whose children were at the highest risk of obesity or being overweight.

Through the discussions it was suggested that the council may wish to take a view on whether it only wants healthy advertising on its hoardings. It was agreed that a report be brought back to the next meeting on advertising hoardings.

RESOLVED:

1. That the most up to date Southwark data for childhood obesity be noted.

2. That the evidence based interventions required to effectively tackle childhood obesity in the borough be noted.

3. That the scale of the challenge be noted and option 2 for each of the ambition outcomes (as set out in paragraph 4 of the report) be agreed as the 5 year outcomes for childhood obesity that Southwark should seek to work towards in the new Obesity Strategy.

8. SOUTHWARK SMOKING DATA AND OPTIONS FOR 5 YEAR SMOKING PREVALENCE OUTCOME AMBITIONS

Jin Lim, Assistant Director / Consultant in Public Health introduced the report.

RESOLVED:

1. That the most up to date Southwark data for smoking as set out in Appendix 1 of the report be noted.

2. That the evidence based interventions required to effectively tackle smoking in the borough as set out in paragraph 6 of the report and detailed below be noted:

    - Making tobacco less affordable
    - Stopping the promotion of tobacco
    - Effective regulation of tobacco products
    - Helping tobacco users to quit
    - Reducing exposure to second hand smoke
    - Effective communications for tobacco control

3. That the proposed 5 year outcome ambitions for smoking prevalence that Southwark should seek to work towards, set out in paragraph 4 of the report and detailed below be agreed:

    - Reduce smoking prevalence in the Southwark general adult population to 14.5% by 2019/20 (approximately 23% reduction over 5 years).
    - Reduce smoking prevalence in the Southwark routine and manual occupations population to 20.2% by 2019/20 (approximately 23% reduction over 5 years).

9. PROJECT PROPOSAL ON ENHANCING THE IMPACT OF PLANNING POLICY ON HEALTH OUTCOMES AND INEQUALITIES IN SOUTHWARK AND LAMBETH

Simon Bevan, Director of Planning introduced the report.

RESOLVED:

1. The health and wellbeing board confirms its support for the proposal put forward for the Guys and St Thomas's Charity Health Innovation Fund on enhancing the impact of planning policy on health outcomes and inequalities in Southwark and Lambeth.

2. That the aims of the projects be endorsed and objectives supported and further updates on the progress of the project (subject to funding being agreed by the Guys and St Thomas's Charity) be received by the board.

3. That a joint letter from the chair and vice-chair of the health and wellbeing board indicating the board's strong support be submitted to the charity.

10. DELIVERING THE FORWARD VIEW: NHS PLANNING GUIDANCE 2016/17 - 2020/21

Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group introduced the report.

RESOLVED:

1. That the briefing paper on Delivering the Forward View and the associated planning guidance for 2016/17 be noted.

2. That the requirements of the CCG and partners included in the planning guidance be noted.

3. That the board play an active role in the development of the Sustainability and Transformation Plan, which is proposed to be developed across south east London in 2016/17.

4. That it be noted that the health and wellbeing board will receive a final draft of the CCG's Operating Plan at the March meeting and that it will be asked to take assurance that the CCG's plan sufficiently constitutes a credible plan, which ensures Southward patients receive the services they are entitled to; that the CCG are planning appropriate interventions to improve the outcomes of Southwark's residents; and that the CCG plans are aligned with the objectives of the Health and Wellbeing Strategy and Better Care Fund in Southwark.

11. SOUTHWARK FIVE YEAR FORWARD VIEW

Mark Kewley, Director of Transformation and Performance and Dick Frak Director of Commissioning introduced the report.

RESOLVED:

That the joint strategy document be endorsed.

12. SOUTHWARK SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2014-15

Michael O'Connor, Chair of the Southwark Safeguarding Children Board introduced the report.

RESOLVED:

That the Southwark Safeguarding Child Board Annual Report 2014/15 be noted.

13. DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK

Jin Lim, Assistant Director / Consultant in Public Health introduced the report.

RESOLVED:

That the Director of Public Health Report covering the period October to December 2015 attached as Appendix 1 to the report be noted.

14. PRIMARY CARE JOINT COMMISSIONING COMMITTEE - HEALTH AND WELLBEING BOARD OBSERVER

RESOLVED:

That Councillor Barrie Hargrove be nominated as the named member to attend the (NHS Southwark) Primary Care Joint Commissioning Committee and the South East London Primary Care Joint Commissioning Committee in the capacity as an observer from the health and wellbeing board.

15. POLICY AND RESOURCES STRATEGY 2016/17 - 2018/19: REVENUE BUDGET

Councillor Fiona Colley, Cabinet Member for Finance Modernisation and Performance introduced the item. She reported on the budget challenges faced by the council and focussed attention to the issues relating to the work of the health and wellbeing board.

RESOLVED:

That the Council's Policy and Resources Strategy 2016/17 to 2018/19 Revenue Budget be noted.

The meeting ended at 12.13pm

CHAIR:

DATED:

Agenda Item 6

Item No. 6.	Classification: Open	Date: 31 March 2016	Meeting Name: Health and Wellbeing Board
Report title:		Summary view of responses to the Lambeth & Southwark Early Action Commission	
Ward(s) or groups affected:		All	
From:		Strategic Director of Housing and Modernisation	

RECOMMENDATIONS

1. That the Board notes the responses from the Council, Community Action Southwark and the Southwark NHS Clinical Commissioning Group to the recommendations of the Lambeth & Southwark Early Action Commission and thanks the Commission for its work.

2. That the Board members commit to working towards a cultural shift in their organisations to deliver the ambitions of the Early Action Commission.

BACKGROUND INFORMATION

3. The Southwark & Lambeth Early Action Commission responded to a commitment in the Council Plan to establish a commission to enhance the vital work of the voluntary and community sector.

4. In July 2014 the Southwark Health and Wellbeing Board approved the creation of an independent Early Action Commission. The broad aim of the Commission was to make a series of recommendations about how organisations such as the local council, NHS, police and voluntary sector can work together to prevent problems that damage people's lives and trigger future demand for services.

5. On 21 October 2015 the Health & Wellbeing Board received the final report of the Commission. The Board agreed to note the report and to prepare a response for a future meeting in 2016.

KEY ISSUES FOR CONSIDERATION

6. The council, Community Action Southwark and Clinical Commissioning Group reports in response to the Commission's recommendations each set out an approach for moving forward with the challenges identified which are linked to the broader policy framework.

7. At the core of each of these is an agreement that a shift towards prevention and early action is needed. There are common themes, as well as differences in emphasis and approach that reflect the cultural and policy priorities of the different entities. There is a richness of ideas and many examples of good practice on which to build.

8. The three entities involved are committed to building on the momentum from the EAC. The Council Plan, the CCG Five Year Forward Plan and Community Action Southwark's response to the Early Action Report each set out specific proposals for change.

9. The council response, which has a strong focus on the VCS, is just one part of the vision for the future. The Council Plan sets how the council will make Southwark a fairer place by building new homes, making existing housing warm and safe, strengthening the local economy by creating new jobs and apprenticeships, improving public health and wellbeing by providing free access to swimming and gyms.

10. The development of a new voluntary and community sector strategy (VCS) to be co-produced by the CCG, VCS and council will have a shift to prevention and early action at its core. The council's review of commissioning will be underpinned by the same strategic objective. Through engagement with stakeholders and the broader VCS, the development of the strategy will provide an opportunity to build awareness of existing good practice and test how new approaches could be developed and coordinated.

11. The timeline for reporting back on these strategic developments is October 2016.

No.	Title
Appendix 1	Council response to the Lambeth and Southwark Early Action Commission report
Appendix 2	Community Action Southwark's response to the Lambeth and Southwark Early Action Commission report
Appendix 3	Southwark CCG's response to the Lambeth and Southwark Early Action Commission report

AUDIT TRAIL

Lead Officer	Gerri Scott, Strategic Director of Housing & Modernisation	
Report Author	Andrew Matheson, Senior Commissioning Officer	
Version	Final	
Dated	14 March 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		17 March 2016

APPENDIX 1

Item No. 21.	Classification: Open	Date: 9 February 2016	Meeting Name: Cabinet
Report title:		Response to the Lambeth and Southwark Early Action Commission	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Michael Situ, Communities and Safety	

FOREWORD - COUNCILLOR MICHAEL SITU, CABINET MEMBER FOR COMMUNITIES AND SAFETY

The *Local Early Action: how to make it happen* report provides a welcome contribution to thinking and planning on how all those involved in delivering services can make the most of current resources. It sets out a number of challenges to the council.

This report responds to these challenges in two ways. It lists a great number of initiatives in which the council is working with other public bodies and partner organisations at a local level, to find new ways of working that will prevent problems from developing and will improve health and wellbeing in Southwark. These are drawn from across a wide range of service areas and demonstrate the richness of ideas, energy and commitment that is driving a shared desire to improve public health and to reduce preventable problems.

The report also sets out a number of changes that will improve the coordination of how services are delivered at a time of diminishing resources. Planned changes to commissioning are intended to ensure that the impact of these services achieves their full potential for the benefit of our residents especially those who are most vulnerable.

Getting residents more involved with local decisions, being more accountable to local people and taking residents' views into account when making decisions: all of this will help to create a fairer borough where everyone takes part and where every resident can make the most of their potential. This report not only recognises the important recommendations from the commission but also sets out how we plan to use our collective resources to achieve its aims.

RECOMMENDATIONS

That Cabinet:

1. Notes the recommendations of the Lambeth & Southwark Early Action Commission, thanks the Commission for its work and welcomes the opportunity that the report has given us to put prevention at the heart of what we do across the council including Public Health and the NHS Clinical Commissioning Group.

2. Notes the significant investment (£25 million) that the council currently makes to the Voluntary & Community Sector (VCS) and that a substantial part of this can be categorised as preventative spend.

3. Instructs officers to work with the NHS Clinical Commissioning Group (CCG) and the VCS to co-design a new tri-partite voluntary sector strategy to be approved by cabinet in October 2016 that follows these basic principles:

- A recognition of the significant financial challenges across the partners meaning that we must reduce duplication between services, commission efficiently and reduce demand on more intensive interventions such as hospital based services and care homes. The approach is to invest in enabling people to remain healthy and independent in their own homes and communities.

- The need to focus on outcomes for our residents and work that integrates services to improve the quality and experience for users. The need to work together across the council (including Public Health), the CCG and the VCS on services that best support our residents and communities and provide services that offer all residents support appropriate to their needs in their local area so that Southwark is a fairer place where everyone is able to fulfil their potential and access the opportunities that living in Southwark presents.

- The need to work with the VCS to provide innovative solutions and high quality services that improve outcomes for people affected by complex social issues such as, mental health, domestic violence, and long-term health conditions. We need the sector to develop its work with particular population groups such as young people and elderly residents.

- The need for a thriving VCS that mobilises community action and makes best use of community resources, skills, knowledge and spaces and improves residents access to opportunities, services and buildings that meet their needs and ensure no-one is left behind, maximising our collective impact.

- The need to work strategically across the partnership and wider community to build the capacity of the partners, promote volunteering and support fundraising.

4. Notes the ongoing work on co-ordination of Commissioning both across the council and with the CCG and instructs officers to bring a report back to Cabinet for decision on the way forward in October 2016.

5. Agrees the proposal to extend the current Community Support Services grant programme totaling £660,900, subject to agreement of the council's budget to allow it to be brought into scope of the work on joint commissioning; and instructs officers to take the necessary actions to put this in place.

6. Notes the ongoing work in developing a Southwark Giving Scheme to maximize and co-ordinate business engagement with the VCS.

7. Notes the work that officers are undertaking to explore innovative models of social investment such as DERIC (Developing and Empowering Resources in Communities).

8. Notes the work that CCG officers are carrying out on a proposal to establish a VCS research challenge fund that aims to improve the way that statutory associations in Southwark engage with the VCS and improve pathways and use of VCS services in the borough.

9. Notes the good practice examples of early action across the council, CCG and VCS that are outlined in paragraphs 61 to 91 of this report and form a sound basis for

future action that meets the early action/preventative agenda.

BACKGROUND INFORMATION

10. The Southwark & Lambeth Early Action Commission responded to a commitment in the Council Plan to establish a commission to enhance the vital work of the voluntary and community sector.

11. In July 2014 the Southwark Health and Wellbeing Board approved the creation of an independent Early Action Commission. The broad aim of the Commission was to make a series of recommendations about how organisations such as the local council, NHS, police and voluntary sector can work together to prevent problems that damage people's lives and trigger future demand for services.

12. The commission was chaired by the Rt. Hon. Margaret Hodge MP and was composed of a range of experts in early action and intervention across a range of policy areas. The commissioners were Dr. Sue Goss (Office for Public Management); Carey Oppenheim (Chief Executive, Early Intervention Foundation); Dr. Jonty Heaversedge (Chair, Southwark CCG); Prof. David Colin-Thome (Trustee, Guy's and St Thomas' Charity); Helen Charlesworth-May (Strategic Director of Commissioning, Lambeth Council); and, David Robinson (Community Links).

13. On 21 October 2015 the Health & Wellbeing Board received the final report of the Commission. The Board agreed to note the report and to prepare a response for a future meeting in 2016.

14. The report (Local early action: how to make it happen) was formally launched on 16th November 2015 at the Coin Street Conference Centre and the speaker for Southwark was Dr Jonty Heversedge who was Vice Chair of the Commission.

15. The VCS in Southwark has been advocating for a stronger role and voice in the development of policy and strategy. As well as the request for the EAC, there has been the approach made to the Overview and Scrutiny Committee to examine commissioning, and the recent tender from Community Action Southwark (CAS) which set out desired areas for improvement in how engagement between the council and the VCS takes place.

16. There also appears to be a desire for greater recognition at a strategic level of the contribution the sector makes to meeting the needs of residents in the borough.

17. This perception is also prevalent at a London wide level. A recent report "The Change Ahead, Creating a new future for civil society in London" funded by the Corporation of London's Charity, City Bridge Trust, stated that civil society is not part of a strategic plan for London. "At a local level there is a patchwork of approaches to involving and working with civil society organisations which fails to grasp the real potential of civil society to address many of London's entrenched problems and issues."

18. The report also states that "civil society is not consistent in how it "connects" with the communities it serves, which leaves it open to challenge in terms of the legitimacy of what it says and does."

19. The report also highlights the lack of a consistent up to date, single source of data on the most basic of issues: the size, nature and structure of the civil society sector

in London and how this maps against need and notes that this is an impediment to strategic planning.

20. In Southwark, the council has a very strong and visible commitment to the VCS. The level and structure of engagement is well established and the confidence with which demands are articulated indicates that there is a strong relationship. The level of financial investment in the infrastructure organisation demonstrates the council's recognition of the key role that a strong leadership body can make to the economic wellbeing of Southwark by fostering a vibrant VCS.

KEY ISSUES FOR CONSIDERATION

21. The Commission identified four goals for early action in Southwark and Lambeth. These were designed to reverse the balance of spending and to address problems as far upstream as possible. They focused on what can be done locally in the context of extreme budgetary constraints. They interact with dynamic effect and are intended to be mutually reinforcing and sustainable over time.

- ***Resourceful communities*** where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections and control.

- ***Preventative places*** where material conditions have a positive impact how people feel and enable them to lead fulfilling lives and to help themselves and each other.

- ***Strong, collaborative partnerships*** where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.

- ***Systems geared to early action***, where the culture, values, priorities and practices of local institutions support early action as the new 'normal' way of working.

22. The Commission noted that effective early action depends on changing whole systems, not just launching new initiatives. The Commission pointed out that these recommendations build on good practice already underway in Southwark, Lambeth and elsewhere. To make a real difference, they must be placed at the heart of policy and practice in both boroughs and pursued forcefully and consistently over time. Taken together, they contribute to the four goals as stated above: resourceful communities, preventative places, strong, collaborative partnerships and systems geared to early action. Action to change systems should not wait until resources are found, nor should changes in practice wait for systems to be geared to early action.

23. The Commission's Summary and key recommendations are set out in Appendix 1.

24. The report concluded that the local VCS should be encouraged and supported to strengthen its focus on upstream measures, and to adopt an inclusive and participative approach to their activities. Funding should be better co-ordinated and directed at early action.

25. The council has a significant commitment to a partnership approach with the VCS and to maximising the use of all community resources to improve the borough.

Having said this, the context in which the council works has shifted radically not least because of the current resource constraints imposed by reductions in central government funding. These changes have necessitated a transformation in the way that the council and its statutory partners are able to go about their business but also demand a new relationship with our residents, and with the VCS.

26. A harsher financial climate has meant the council and other partners being forced to reduce spending dramatically. Within this context we need to continue to meet our statutory obligations, protect essential frontline services and respond to the changing and in some areas increasing needs of residents. This makes the voluntary sector an even more significant partner in making a real difference in areas that are most important for local people. Budget reductions on the level we have seen inevitably mean reductions in grants and procurement opportunities.

27. The VCS continues to have an essential role to play in Southwark and VCS organisations are a key partner in working with the council to ensure that our most vulnerable residents and communities are protected. In facing the challenges of the financial climate, the council, the CCG and the VCS will continue to have to change and modernise the way we work becoming more efficient, reducing costs and diversifying our income sources.

28. Despite the resource constraints the council investment in the VCS is £25million in the current financial year. Further funding in the form of personal budgets is also channelled to the VCS to meet the needs of residents eligible for care.

29. A significant part of these resources (£4m) is in the form of grant funding. The grant funding is for services which are more flexible in responding to community needs and are less tightly defined.

30. These services, broadly speaking, fall within a social action/preventative definition in that they seek to enable service providers within the VCS to respond to the needs of communities.

31. The council also supports the VCS in a range of other ways including the use of mandatory and discretionary rate relief, use of council premises and partnership working with local organisations to develop and deliver new services.

32. Establishing evaluation frameworks that could track the impact of preventative spending over time might help build a stronger evidence base but would reinforce a top-down approach to service provision and meeting community needs. It would mean that resources are spent on monitoring and evaluation rather than on enabling resident empowerment and independence.

33. A more productive use of resources would see the council and the VCS focus on projects that enable and empower residents who are economically disadvantaged or reliant on council and VCS services to track and monitor their own well-being, particularly for health. The Healthy High Streets initiative is one such project that supports this approach.

34. It is recognised that of the £25 million, £6m is for Anchor Trust for older people residential care and £11 million for Supporting People services. Given that these services are for specific identified needs the remaining pot shared amongst the VCS is £8m.

35. Many of the commissioned services even in the form of contracts are not meeting a statutory requirement – some exceptions include Healthwatch and advocacy services relating to mental health issues. Each council department currently commissions services that support a thriving VCS in Southwark but as the resources are diminishing then there is a strategic challenge for the sector to respond to.

36. It is welcome that the EAC report highlights many examples of good practice across Southwark and Lambeth. The report however gives less attention to ways in which the VCS itself can address the current challenges and what the sector itself needs to make this a reality. One of the recommendations is for a dedicated Change Fund to support systems change. The council has already fulfilled this recommendation by funding 5 rounds of a VCS Transition Fund for the sector to change and modernise. The challenge for the sector is to continue to modernise, reduce duplication and ensure that organisations are evolving to meet the changing needs of communities and the changing face of the borough. Southwark has gone from being the 17th most deprived borough in England in 2001, to the 26th most deprived in 2007, to the 41st most deprived in 2015. To what extent has the VCS considered what this means and what new fresh challenges this poses?

37. There are many examples of successful partnerships and pooling of resources both across the council and with our partners, including neighbouring boroughs. This includes the work across Lambeth, Lewisham and Southwark councils on the Better Placed project which helps people who are struggling to find employment get into sustainable jobs.

38. The south London community budget is one of several projects around the country being supported by the Public Sector Transformation Network, a government programme which encourages organisations to work together to deliver place-based services. Ultimately the projects should reduce the cost of services to the public purse by spending money more effectively; in this case, getting people into sustained employment will reduce the need for benefits, as well as helping the individual and their family.

39. A number of key headline changes are already underway or in development that address key recommendations. These are set out in paragraphs 40 to 63.

40. The prime development is that council officers, CCG officers and representatives of the VCS locally have expressed a strong interest in developing more joined up services and better integration of VCS activities with statutory provision to improve the quality of life of local communities. This provides an opportunity to work together on a new joint voluntary sector strategy that sets out the vision and direction of travel for the partnership going forward. The key principles on which to build this strategy could be:

    - A recognition of the significant financial challenges across the partners meaning that we must reduce duplication between services, commission efficiently and reduce demand on more intensive interventions such as hospital based services and care homes. The approach is to invest in enabling people to remain healthy and independent in their own homes and communities.

    - The need to focus on outcomes for our residents and work that integrates services to improve the quality and experience for users. The need to work

together across the council, CCG and VCS on services that best support our residents and communities and provide services that offer all residents support appropriate to their needs in their local area so that Southwark is a fairer place where everyone is able to fulfil their potential and access the opportunities that living in Southwark presents.

- The need to work with the VCS to provide innovative solutions and high quality services that improve outcomes for people affected by complex social issues such as, mental health, domestic violence, and long-term health conditions. We need the sector to develop its work with particular population groups such as young people and elderly residents.

- The need for a thriving VCS that mobilises community action and makes best use of community resources, skills, knowledge and spaces and improves residents access to opportunities, services and buildings that meet their needs and ensure no-one is left behind maximizing, our collective impact.

- The need to work strategically across the partnership and wider community to build the capacity of the partners, promote volunteering and support fundraising.

41. As noted in paragraph 31 above there are many other ways in which the council and its partners support the VCS. A key part of a new modernised relationship is to take an approach that strengthens the resilience of the sector by finding new or better ways of supporting our local VCS that go beyond financial support. These other forms of support need to be within the scope of the strategy including reviewing the VCS premises strategy to look at how we use our property portfolio to support the VCS to achieve self-sustainability and take advantage of regeneration and development opportunities to find new ways of improving and providing community spaces that are efficient and fit for purpose.

42. The council also supports preventative activity through its procurement activities and the work on the procurement strategy includes a focus on ensuring social value and community benefits through our commissioning, taking into account the Public Services (Social Value) Act 2012.

43. To ensure a co-ordinated and more strategic whole council and CCG approach to the VCS, officers have been exploring the potential of bringing together commissioning from across the council into a single unit to include a significant part of services currently commissioned by the Clinical Commissioning Group. The intention is that it will result in improved co-ordination, reducing duplication and transactional costs and give a better understanding of the totality of services that are provided both statutory and discretionary. The intention is that this informs the 2017/2018 budget round.

44. This makes 2016/2017 a transitional year. A number of actions are being taken to prepare the ground for this initiative, for example the current proposal to extend advice service commissioning within the Communities Division so that the current contract expires at the same time as the advice and advocacy that is commissioned by Children's & Adults Services so that officers and the sector can then explore the opportunity to bring these two together where it makes sense. We need a sector that can combine its capacity to reach more vulnerable residents to link them with professional advice services and mainstream provision.

45. Within Children's & Adults Services the current grant funded model that is known as Community Support Services was established in April 2012 to support older people and people with disabilities with the objectives of maintaining independence, health and wellbeing and effective personalised services. The programme currently funds the following 9 organisations as follows:

Information, access and advice	
Leonard Cheshire Disability	£90,000
SDA	£47,500
Age UK	£40,000
Southwark Pensioners Centre	£40,000
TOTAL	£217,500

Wellbeing	
Lambeth Mencap	£41,000
Lambeth Family Link	£28,300
Blackfriars Settlement	£28,300
Age UK	£28,300
Southwark Pensioners Centre	£28,300
Age UK – Yalding	£110,000
TOTAL	£264,200

Social Interaction Support	
SDA	£32,500
Lambeth Family Links	£16,700
Dulwich Helpline and Southwark Churches Care (now known as LinkAge Southwark)	£65,000
Time and Talents	£32,500
Blackfriars Settlement	£32,500
TOTAL	£179,200

OVERALL TOTAL	£660,900

46. The services within the community support structure generally were developed as a response to the challenges faced by Adult Social Care in terms of personalisation and budget reductions. The model was developed to respond to these twin challenges and to support the council's efforts to improve the resilience and support networks of residents of the borough.

47. The services have been in operation for almost 4 years and are due to cease at the end of March 2016. All current funding for these services sits within the Better Care Fund (BCF).

48. There is recognition that future services must take account of and complement the wider prevention offer commissioned by the council and the NHS Clinical Commissioning Group and therefore are part of the work in consolidating and co-ordinating commissioning.

49. There are other potential sources of funding that could be pooled into this budget. All sources are listed in the table below. Final agreement on the total amount for this grant process will be determined prior to launch. These are set out in the table below:

Source of funding		Lead Commissioner	Amount (per annum)
Community Support Services Grant	BCF	LBS	£780,000
Prevention and Inclusion budget	ASC	LBS	£500,000
Mental Health budget	CCG	SCCG	£55,471
	ASC	LBS	£44,529
Carers Support Services	BCF	LBS	£660,000
Self Management	BCF	SCCG	TBC
Other Preventative services	CCG	SCCG	TBC
		TOTAL	**£2,040,000**

50. The inclusion of the budgets assigned to the two contracts that were not successfully awarded through the Carers Support Services tender allow the inclusion of support for Carers to be included in the broader preventative services programme.

51. There are a number of projects that fit under the banner of community based preventative services that are not funded through recurrent budgets and would benefit from being brought into a more secure funding process (see table below).

Services funded from time limited budgets that could be aligned	Lead Commissioner	Amount (per annum)
SAIL	LA / CCG	£100,000
Weathering Well	CCG / LA	£75,000
SWiSH	LA	£260,000

52. The SAIL (Safe and Independent Living) project is delivered by AGE UK Southwark and Lewisham as part of the COPSIN Collaboration. This project was funded through a two year grant from the Council ending at the end of March 2015, and has recently been supported by the Council and Southwark CCG by receiving a one off payment of £48,000 from the BCF allocation.

53. The SWiSH (Southwark wellbeing at home service) is a pilot project funded through the Prevention and Inclusion budget (historic Supporting People floating support funding) for 1 year to support people at risk of admission into hospital without a low level of support to support them to remain at home.

54. Aligning all of these budgets and funding sources creates a pooled budget in the region of £2,000,000 per annum. This fits within the remit of the work on co-ordination of commissioning and it is therefore recommended that the Cabinet agree to continue the current grant provision for one year as set out in paragraph 45 above to allow these services to be brought within the scope of the commissioning review so that it can be considered alongside the wider prevention offer commissioned by the council and the NHS Clinical Commissioning Group. The finance and governance arrangements for future pooling will be decided at a later date in a separate report.

55. The council is working in partnership with Southwark Funders which brings together local charitable funders in the borough to identify and deal with common issues and ensure that our respective funding stream priorities reflect local understanding of

the greatest needs. Building on this initiative, officers are now meeting with VCS representatives to consider the establishment of a Southwark Giving scheme similar to those in operation in other boroughs like Islington. These schemes aim to maximise resources and increase business engagement and community connectivity. Southwark is well placed to make this an effective initiative with its major business hub in the north of the borough and is also home to a thriving SME business sector. While there are already some examples of good practice, there is considerable potential in developing relationships between SMEs and community organisations to benefit local residents.

56. In October 2015 the Health & Wellbeing Board received a presentation on a draft council and CCG five year plan (Southwark Five Year Forward View) to be presented to the January 2016 meeting of the Board. The Plan relates to a shared approach to transforming the commissioning of health and social care services.

57. The Board endorsed the following key messages for this new plan which among other things aims to create a much stronger emphasis on early action:

- Commissioners in Southwark are committed to improving the health and wellbeing of local people. The experience of staff, service users and carers suggests that the existing system does not consistently deliver the best outcomes for people, and that there could be significant improvements if we worked together in new ways.
- This is a quality and value argument, it is not about cuts: if funding wasn't an issue we would still want to radically improve the system.
- This will mean commissioning based on people's holistic needs rather than traditional approaches which result in provider silos and historic service models. Our local ambition is to create a much stronger emphasis on early action as well as stronger integration across health and social care, and wider council services (including education).
- To support this transformation we will increasingly bring together commissioning budgets and contracting arrangements that incentivise system changes, focusing on assets and outcomes over inputs or activity.
- In addition, we will increasingly move away from contracting with lots of different institutions for specific services and towards inclusive contracts which cover funding for the total health and care needs of a population (or a specific cohort of people with similar needs).
- These contracts will be made available to providers that can demonstrate that they can bring together the various skills needed to meet the needs of the population, for example by working together as a network or consortium. Our aim is to support the development of multi-specialty community providers serving populations of 100,000-150,000 people.

58. Council, CCG and VCS officers are currently scoping models for social investment such as DERIC (Developing and Empowering Resources in Communities) which has a focus on developing, incentivising and empowering communities – building towards investment in a variety of platforms for collaboration and partnership. This model involves identifying cashable savings through new partnerships and commissioning processes. DERIC is a community interest company that operates as a Social Investment Finance Intermediary raising funding from a variety of public and private sources and investing these to achieve:

- The development of new and innovative forms of community owned social enterprises

- Deliver outcomes that improve peoples' lives and enhance community control and engagement
- Better use of public funding
- Innovative use of commercial funding.

59. DERIC is currently working in Leeds (4 programmes), Belfast (1 programme) and Sandwell (1 programme) on a programme called Combining Personalisation and Community Empowerment (CPCE) that provides incentives for communities to deliver support to vulnerable people, delivering an enhanced quality of support, over time reducing the cost of providing social support that enables some savings to be reinvested in communities and reduces reliance on statutory services commissioned by local authorities and the NHS. The Leeds Local Links initiative has been in place since 1994 and established 37 Neighbourhood Networks supported by the City Council and NHS. The Networks are run and owned by local people and add extra services using community volunteering and other resources. Through CPCE Leeds has been able to develop this model gaining national recognition and developing a wide range of community support initiatives. While DERIC may not turn out to be the right model, officers will continue to explore the potential offered by initiatives of this kind.

60. CCG officers are currently working on a VCS Research Challenge Fund that awards small grants of between £5,000 and £20,000 per year to support targeted research that enhances understanding of informal care provision in Southwark with the intention of stimulating innovative work with local communities, improve engagement between statutory and community sectors and inform future commissioning strategy.

61. The Public Health Directorate is working with partners to carry out a council housing health needs assessment (CHNA) to identify key health issues among Southwark's tenants. The CHNA will inform the implementation of principle 4 of the Southwark housing strategy which states that Southwark wants to be more than a landlord by better connecting residents to the services they need to lead independent lives. Different data sources, for example, the housing database Iworld, information from tenancy management organisations, and yearly returns to the DWP on newly signed leasers (core data) will be combined and used to create a picture of the tenant's health. Engagement with tenants will round off this picture, and the results of the analysis will then inform the development of a range of services to better support people with housing health needs.

62. This initiative is one example of how the transition of public health responsibilities to local government in 2012-2013 can contribute to more integrated working across professional boundaries that aligns with local priorities and seeks better outcomes for our residents. Public Health staff will inform and support commissioners in putting the principles of early action into practice.

63. On 20 October 2015 the Cabinet agreed a response to the Healthy Communities Scrutiny Sub-Committee's report on the Health of the Borough and noted the progress in taking forward the recommendations. This report concerned how the partnership between the council, NHS and voluntary and community sector is addressing the issue of health inequalities and improving the health of residents. The scrutiny review and responses covered financial health, environmental health and physical health and focused on actions relating to Public health that are part of the early action/preventative agenda.

64. The key areas of action for the partnership that were included in this response were:

- Working with the VCS on supporting financial health including access to good quality advice on financial management.
- Giving eleven year olds in Southwark a helping hand with their finances with the council Smart Savers initiative.
- Agreeing an action plan for working with the CCG, local GP practices and CAB services to provide financial health services in health centres in Southwark.
- Continuing to invest in our Parks and Green Spaces.
- Putting pressure on TfL to reconsider the scope for the ultra-low emission zone to include Southwark.
- Working to stop adults smoking in any of the 68 playgrounds in Southwark.
- Working on a major cycling marketing campaign that will be promoting the priorities in the cycling strategy.
- Promoting walking, cycling and more use of green spaces.
- Actively encouraging developers to consider interim use projects that contribute to improving the environment for Southwark residents during their schemes.
- Developing outdoor gyms in parks and open spaces throughout the borough.
- Extending the play street scheme that provides an ideal opportunity for engaging children in safe play near their homes.
- Review of the Statement of Licensing Policy to consider incorporation of public health related issues for example the sale of low cost high strength alcohol. Consulting Public Health on licensing applications and use by Public Health of a data tool that allows the geographical location of licensing applications to be assessed in relation to alcohol related violence and crime, hospital admissions, A&E attendances and ambulance call outs.
- Development of a Southwark Tobacco Control strategy. The strategy is being informed by local intelligence that is being gathered through data analysis, engagement with partners including the CCG, as well as deep dive community insights with residents. The strategy will also identify commissioning priorities for the council as well as the NHS. The Lambeth and Southwark Tobacco Control Alliance facilitated by Public Health continues to promote an evidence based tobacco control approach locally.
- A review of smoking across Southwark led by Public Health.
- Work with schools to discourage young people from taking up smoking.
- Tackling illegal tobacco in partnership with Lambeth, Lewisham, Greenwich, Bexley and Bromley including the launch of a joint South East London illegal tobacco campaign, “Keep It Out”.
- The commitment to the London Living Wage and the Southwark Ethical Care Charter for homecare workers and their positive impact on the health and wellbeing of staff.
- Encouraging local employers including the voluntary sector to sign up to the Workplace Health Charter. The Charter provides a systematic process to improve the health of staff. This has also been negotiated with Public Health input into the tendering specifications for Southwark’s leisure centres.
- Work on health impact assessments and mental health and wellbeing assessments as part of decision making.

65. The Troubled Families initiative is incorporated within the Families Matter approach to service delivery with vulnerable children and families. The Department for Communities and Local Government has given Southwark a target of working with

over 3,000 families between 2015-2020. This could potentially bring in funding of £7.2million to support service delivery and service transformation. Currently this programme commissions approximately £600,000 per annum from the Voluntary Sector to support families.

66. In spring 2014 the council selected the Multi-Agency Working and Alternative Delivery Models initiative as one of four projects for a Strategic Savings Programme which will contribute to meeting the council's significant target for budget reductions in 2015/16 onwards. The proposed Multi-Agency Working (MAW) team is part of the work stream for the corporate Strategic Savings Programme. Senior officers across a wide range of council services have now established a multi disciplinary team which aims to prevent individuals from ending up in high cost social care due to a lack of joined up working. From October 2015- October 2016 the pilot will work with 50 people who have been assessed as being on the fringe of high care cost with potential significant costs to the council, CCG and partner agencies. The cohort is drawn from council tenants who have a range of complex needs including: antisocial behaviour, mental health, substance misuse, disrepair, hoarding, high rent arrears. The pilot is exploring alternative therapeutic interventions which can be delivered through voluntary sector or community health care services. This aims to reduce costs via early intervention, bringing coordinating partnership responses to clients with complex needs and provide the council with an opportunity to evaluate the impact of tailored local interventions.

67. In July 2014 Cabinet adopted the Southwark Ethical Care Charter, and the council commenced negotiations with current homecare providers to, as of 1st August 2014, pay homecare workers for their travel time and, as of the end of October, to offer all home care workers a guaranteed level of working hours each week as an alternative to zero hours contracts.

68. By treating care workers in an ethical manner, care workers themselves are better equipped to provide the quality, personalised services and help which, in turn, enables those in receipt of care to live more independent lives.

69. In March 2015 Cabinet agreed a Gateway 1 report to procure all Home Care services in line with the Southwark Ethical Care Charter. In addition, the intention is to move towards locality working with health, through Local Care Network arrangements, to deliver better outcomes.

70. The council is currently concluding an extensive engagement programme (in partnership with Healthwatch and the VCS) which has included both care workers and people who use the service.

71. There is considerable support for the objectives of the council and a shared understanding of the need to distinguish Southwark's unique approach from traditional home care and work towards "care@home" being a kite mark to good quality and responsive support for an increasingly frail user group.

72. The council is seeing an improvement in quality since the Ethical Care Charter has been introduced in the directly contracted services and the engagement work undertaken to date has enhanced the council's relationship with the spot provider sector.

73. The council will soon be advertising for new home care contracts that will ensure that all spot purchased and children home care is fully covered by the SECC by the end of the next financial year.

74. The CCG have also been working to set up Local Care Networks (LCNs) within Southwark. LCNs bring together providers from across health and social care (including the VCS), to work together to address common challenges. By coming together, providers can look at the range of services that they provide for our populations and see how they can work better together to improve and integrate them.

75. Working as part of LCNs represents a culture shift in the way that providers collaborate. Traditionally providers have been paid to deliver services by commissioners and have been rewarded for the amount of activity (e.g. appointments, operations, home visits) they have undertaken. Whilst this approach has advantages, it does not reward providers for working together and can unintentionally lead to a situation where providers concentrate on the individual's immediate needs, without seeking to understand the underlying health and social issues that may be impacting on their wellbeing. Instead of paying for activity, commissioners would like to move to a model where providers are paid on the basis of the outcomes. This means that they will be rewarded for helping people to live happier, healthier and more independent lives – and this can only be achieved by working more closely together with each other and our local populations.

76. By having the VCS as a core member of LCNs, it will help facilitate improved working between the statutory and the voluntary sector, and ensuring that VCS services are integrated as part of patient and customer pathways.

77. Through LCN meetings, CAS have been exploring potential options regarding asset mapping and simple points of access to the VCS (building on the experience of the SAIL model) to make it easier for both statutory providers and for citizens to find out about, and make use of, the range of VCS services available in the community. This work will continue through 2016/17 and help inform the Voluntary Sector Strategy.

78. As part of its new approach to domestic abuse (DA), the council is expanding its prevention work. The overall aim is to promote healthy relationships and ensuring that potential victims, abusers and their family and friends are able to spot early warning signs of abusive behaviours and seek support before it escalates. There will also be a strand around abusers, talking about their behaviour, impact on others, the consequences and how they sought help.

79. This approach takes into account the fact that psychological and emotional abuse, as well as controlling and coercive behaviours, are more prevalent than, and usually precede, physical violence.

80. There are three strands to the prevention work currently being undertaken by the council:

    a) Building community leadership
    b) Work in schools
    c) Building survivors' resilience.

81. In terms of building community leadership the council and partners have embarked in a DA awareness campaign branded #oktotalk.

82. This campaign taps into the idea that most people have experienced difficult relationships, whether directly or through a friend or family member, and it is by

talking to people they trust that they can find the strength and support they need to identify potentially damaging relationships before the risk escalates.

83. It also emphasises that DA can happen to anyone and that it is not necessarily physical. Officers have identified survivors to act as case studies and talk about their experiences, for example of being with a coercive partner or watching a friend treating their partner badly.

84. The campaign will use a combination of social media, council media and face to face community engagement to get these messages across, engaging with community leaders to spread these messages and advocate them as their own within their communities.

85. A domestic abuse strategy launch event was held in October 2015. A wide range of community leaders and representatives who reflected Southwark's diverse population attended. The subject was explored through a play and workshops. This ended with a call for action to sign up to a DA community champions programme. These volunteers will receive training in the coming months to become DA champions in their communities so that they can:

- Recognise members of their community experiencing abuse or at risk of experiencing abuse
- Give the right advice and signpost to specialist services for those who disclose experiencing abuse
- Challenge cultural norms in their communities which may condone abusive behaviours
- Increase chance of early intervention
- Increase awareness of support available
- Signpost individuals displaying abusive behaviours to the perpetrator programme and encourage change.

86. With regard to work in schools the council funds Insight to deliver the SHER (Safe Equal and Healthy Relationships) programme in Southwark secondary schools.

87. SHER is an educational toolkit to promote awareness of healthy relationships and combat domestic and dating abuse. It was developed by the council alongside with international partners as part of an EU funded project.

88. The pilot evaluation showed that SHER:

- Increased awareness of what is and isn't a healthy relationship and that dating
- violence is not acceptable
- Prevented young people from becoming victims or perpetrators of DA in the future
- Enabled self-assessment/examination of their relationships
- Promoted understanding that they have choices about making positive changes and how to access advice on how to do it
- Provided help and support if they are in abusive relationships or witnessing DA at home.

89. This year, the programme is on track to deliver target outputs and outcomes, with 117 pupils having already participated in the programme a further 200 pupils planned by the end of 2015/16.

90. The third strand of preventative work focuses on building survivors' resilience and takes the form of empowerment structured workshops and peer support groups which the SASS service offers to its clients. These programmes come under the banner WRAP (Women's Resilience Awareness Programme). The aim is to improve their understanding of domestic and sexual abuse and provide longer term practical and emotional support in order to build resilience. It also aims to prevent clients from having abusive partners in the future and prevent repeat victimisation.

91. The EAC report gives a number of examples of good practice working across the VCS, council and CCG partnership in both boroughs. The Southwark examples are set out in Appendix 2 of this report and demonstrate how the sectors are putting early action into practice. The case studies include:

- Community development by Pembroke House in Walworth
- Southwark Healthy High Streets (SHHS)
- Paxton Green Time Bank
- Southwark and Lambeth Integrated Care
- Safe and Independent Living
- Local care networks
- Local Area Co-ordination
- Knee High Design Challenge.

92. As these initiatives progress and are evaluated they form a strong basis for work on Early Action across the partnership moving forward.

Policy implications

93. In addition to the policy initiatives set out above, the recommendations of this report support a number of council policies and strategies, including:

- Health and Wellbeing Strategy
- Public Sector Equality Duty
- Economic Wellbeing Strategy
- Children and Young People's Plan
- Homelessness Action Plan and Homelessness Prevention Protocol.

Community impact statement

94. The initiatives and recommendations of this report have a significant positive impact on the community and are intended to raise standards of community support across the three partners.

95. A full community impact assessment will be carried out on the development of the new VCS strategy which is a key recommendation of this report.

Resource implications

96. There are no additional resource requirements arising from the implementation of the recommendations within this report.

Financial implications

97. This document is a strategy and as such does not carry any immediate cost or

savings implications. However, it introduces future initiatives that form part of Multi-Agency Working and Alternative Delivery Models work stream as one of four projects for the Strategic Savings Programme which will contribute to meeting the council's significant target for budget reductions in 2015/16 onwards.

Consultation

98. One of the key recommendations of this report is the creation of a Joint VCS Strategy that will be "co-produced" by the council, CCG and VCS partners.

99. The Early Action Commission conducted research and consultation that included dialogue with local residents and community-based organisations, through a series of workshops, to tap into their wisdom and experience; interviews with experts working with local authorities and with VCS organisations, to explore ways of turning ideas for change into practical local action; and discussions of emerging findings with Health and Wellbeing Board members.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Director of Law and Democracy

100. The decision maker should consider section 149 Equality Act 2010, which requires the council, in exercising its functions, to have due regard to the need to eliminate discrimination and other prohibited conduct and advance equality of opportunity and foster good relations between people who share a relevant protected characteristic and those who do not.

101. A full community impact assessment will be conducted on the development of the VCS strategy.

Strategic Director of Finance and Governance

102. The Strategic Director of Finance and Governance notes the strategy set out in this report, and the financial implications set out in paragraph 97.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Local early action: how to make it happen – report of the Southwark & Lambeth Early Action Commission	Housing & Modernisation, Communities Division, 160 Tooley Street	Stephen Douglass 020 7525 0886
Link: http://b.3cdn.net/nefoundation/a5845188d1801a18bc_3nm6bkn3b.pdf		
Response to Recommendations from the Scrutiny of the Health of the Borough	Housing & Modernisation, Communities Division, 160 Tooley Street	Stephen Douglass 020 7525 0886
Link: http://moderngov.southwark.gov.uk/ieListDocuments.aspx?CId=302&MId=5140&Ver=4		
Southwark Council and Clinical Commissioning Group - Joint Five Year Strategic Plan: Key Messages	Housing & Modernisation, Communities Division, 160 Tooley Street	Stephen Douglass 020 7525 0886
Link: Five Year Plan - Key Messages		

APPENDICES

No.	Title
Appendix 1	Local early action: how to make it happen – Summary and Key Recommendations from the report of the Southwark & Lambeth Early Action Commission
Appendix 2	Southwark Good Practice Examples from the Early Action Commission Report.

AUDIT TRAIL

Cabinet Member	Councillor Michael Situ, Communities and Safety
Lead Officer	Gerri Scott, Strategic Director of Housing & Modernisation
Report Author	Stephen Douglass, Director of Communities
Version	Final
Dated	28 January 2015
Key Decision?	Yes

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	Yes	Yes
Strategic Director of Finance and Governance	Yes	Yes
Strategic Director of Children's and Adults Services	Yes	Yes
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		28 January 2016

APPENDIX 1

Early Action Commission Summary and Key Recommendations

5 Local early action: how to make it happen

Summary

Many of our biggest societal challenges – from childhood obesity to violent crime – are preventable. The Southwark and Lambeth Early Action Commission aims to find ways of taking local early action to improve people's quality of life and reduce the strain on public services.

Local authorities are under increasing pressure both to maintain essential services and to cut their spending.

A shift towards investing in upstream preventative measures, rather than spending downstream on treatment and care, is an effective use of public funds – particularly at a time when resources are severely restricted.

Southwark and Lambeth Councils recognise the potential benefits that a preventative approach can bring. In 2014 they set up the Southwark and Lambeth Early Action Commission to reduce demand for acute services and maintain wellbeing for all residents.

The Commission has examined local conditions in Lambeth and Southwark, especially the immediate and underlying causes of pressing local problems, and what works best to prevent them. It has carried out a review of local strategy, policy and practice; explored more than 30 examples of good practice in the two boroughs and further afield; and engaged with local residents and community-based groups and with other experts, through workshops and interviews.

The underlying causes of most social problems can be traced to the same set of social and economic challenges. Some of these, such as poverty and inequality, are linked with national policy, making it hard to tackle them locally. But there are plenty of opportunities for local early action to prevent problems by improving local conditions and social relationships.

The Commission has identified four goals for early action in Southwark and Lambeth. These are designed to address problems as early on as possible and focus on what can be done locally in the context of extreme budgetary constraints. To help achieve these goals it will be important to find additional resources.

• *Resourceful communities*, where residents and groups are agents of change, ready to shape the course of their own lives. To achieve this people need actual resources (but in the broadest sense), connections, and control.

• *Preventative places*, where the quality of neighbourhoods has a positive impact on how people feel and enables them to lead fulfilling lives and to help themselves and each other.

• *Strong, collaborative partnerships*, where organisations work together and share knowledge and power, fostering respectful, high-trust relationships based on a shared purpose.

• *Systems geared to early action*, where the culture, values, priorities, and practices of local institutions support early action as the new ‘normal’ way of working.

Recommendations

Effective early action depends on changing whole systems over a sustained period of time. To make a real difference, these recommendations must be pursued together and placed at the heart of policy and practice in both boroughs, building on the good practice that's already taking place.

We hope they are useful not only for Southwark and Lambeth but also for others trying to move towards local early action.

Stage 1: Prepare the ground

• *Establish senior leadership and commitment.*
Health and Wellbeing Boards must ensure that early action is a central feature of their strategy, with Board members firmly committed to implementing it. The Department of Public Health should play a key role in driving the changes.

• *Map assets across both boroughs.*
Asset mapping, already practiced in both boroughs, identifies human and social resources, which are abundant in every locality and play a vital role in early action. This should be strengthened to locate, develop, and connect local assets.

Stage 2: Find resources

• *Co-ordinate charitable funding for early action.*
Bring together independent funders across both boroughs to share knowledge about early action and work together to offer grants for activities that tackle problems systemically and further upstream.

• *Set up a dedicated Change Fund to support systems change.*
This could be financed partly or wholly by a suitable local grant-giving foundation and dedicated to stimulating profound changes in the way local systems are designed and operated.

• *Review and strengthen community returns from regeneration.*
Opportunities to generate funds through the sale of redevelopment sites, Section 106 negotiations and the Community Infrastructure Levy should be maximised, with funds used to prevent problems, for example through housing and spatial planning.

• *Pool budgets between organisations and departments.*
This can help to support early action and make resources go further, by consolidating existing funds and focusing them on early action, as well as strengthening collaboration between the boroughs, and sharing risks and rewards.

• *Tap in to community-based assets.*
Unlock human and social assets in the community, by working more closely with voluntary and community sector (VCS) organisations, and by applying the principles of co-production.

• *Make strategic use of social finance models, including Social Impact Bonds.*
These involve raising investment from the private sector to finance service provision (usually by the VCS). Social Impact Bonds are useful in limited conditions, especially as a tool for experimenting with new initiatives in the transition to early action.

Stage 3: Change systems

• *Classify spending to distinguish early action from downstream coping.*
Spending bodies should know whether the money they spend is allocated to coping with problems or to preventing them. Spending should be loosely classified – as a rule of thumb – adapting guidance from the Early Action Task Force.

• *Establish a long-term plan, across 5–10 years, with specific milestones.*
To avoid local systems defaulting to downstream coping, leading decision-makers and budget holders in Southwark and Lambeth should commit to a step-by-step transition to early action, over the longer term, with specific milestones.

• *Commit to shifting a significant % of spending each year to early action.*
Both boroughs should commit to shifting a specific – and significant – proportion of total spending each year towards early action. Targets should be subject to yearly revision but we suggest 5% as an initial goal.

• *Establish clear oversight arrangements, with regular monitoring and reporting.*
Health and Wellbeing Boards should oversee the shift to early action, supported by Public Health, with a shared evaluation framework and regular progress reports, with the first no later than November 2016.

• *Transform the commissioning process to support early action.*
Decisions about what services and other activities are required should be taken in partnership with local people, with commissioning focused on assets, on how to prevent problems and on outcomes, and encouraging collaboration.

• *Develop a shared evaluation framework.*
For use by VCS grant-holders and contractors, and public sector bodies, this would establish a theory of change reflecting a shared understanding of early action, and shared criteria for monitoring progress, including wellbeing indicators.

• *Assess community assets alongside needs.*
Asset assessment should be integrated with the Joint Strategic Needs Assessment (JSNA), changing the focus of data collection to generate a more rounded view of the local community and higher priority to early action.

Stage 4: Change practice

• *Improve connections, co-ordination and knowledge-sharing.*
This involves linking people and organisations, improving communications between them, and enabling them to exchange information, build a shared sense of purpose and complement rather than duplicate each other's efforts.

• *Forge stronger partnerships and more integrated working.*
Stronger partnerships, promoted through information-sharing and the commissioning process, as well as by pooling budgets and more integrated working, should strengthen the momentum towards early action.

• *Create and support more spaces for people to get together.*
There should be more opportunities for people in Southwark and Lambeth to use parks, open spaces, schools, underused public buildings and empty properties for meeting each other, building networks and doing things together.

• *Make more use of 'place-shaping' powers to support early action.*
Councils should use their powers to create the conditions that help to prevent problems, working with local people and building on existing good practice in the two boroughs.

• *Devolve more power to neighbourhoods.*
Local councils and their partners should look for ways of devolving more power and resources to communities and community groups, and transferring community assets to residents.

• *Promote and support local early action.*
Health and Wellbeing Boards and their constituent bodies should support local preventative initiatives and draw out lessons that can stimulate similar action elsewhere and contribute to wider, systemic changes.

• *Increase participatory budgeting.*
This aims to deepen public engagement in governance by empowering citizens to decide on how public funds are spent, engaging citizens in democratic deliberation and decision-making.

• *Promote and apply the principles of co-production.*
Co-production, already applied in some programmes and initiatives in both boroughs, should become the standard way of getting things done, encouraged through commissioning and adopted by choice in all sectors.

• *Strengthen the focus and funding of the VCS in Southwark and Lambeth.*
The local VCS should be encouraged and supported to strengthen its focus on upstream measures, and to adopt an inclusive and participative approach to their activities. Funding should be better co-ordinated and directed at early action.

APPENDIX 2

Early Action Commission Southwark Case Studies

Case Study 1: Community development by Pembroke House in Walworth

Pembroke House is a community centre in Walworth that has recently adopted an innovative asset-based community development approach to engaging local residents. In an attempt to reach deeper into, and activate, the local community, Pembroke House complemented asset-mapping exercises by hiring a trained community organiser. Resourced by United St Saviour's Charity and a government grant, this community organiser is tasked with building 'face-to-face' relationships with local residents and, in turn, providing opportunities for these residents to build relationships with one another. In the first few months, the organiser held more than 300 individual conversations with local residents, exploring their needs, priorities, and concerns with a view to supporting them to take action with others who have similar ideas. This produced some swift results.

An individual living opposite the community centre initiated a new Co-Dependents Anonymous meeting, while residents who were concerned that there was not enough local youth provision took it upon themselves to establish a bi-weekly ' community fun club' for young people and their families to eat, talk, and play together. This was born out of a series of meetings of local residents. First, parents and other concerned adults met to discuss options for new local youth programmes. Recognising that there were no young people at the meeting, however, they invited their children to join the discussion. At this second meeting, the families enjoyed the opportunity to be together so much that they began meeting on a regular basis. Between sessions a core group of volunteers young and old – meet to plan the following week's activities.

Organisers at Pembroke House see this approach to community development as a first step in strengthening the local social fabric to develop local residents' resourcefulness and ability to organise and engage in collective action. They show that asset-based community development has potential to improve the lives of people, and how the public sector can play an enabling and supportive role.

Case Study 2: Southwark Healthy High Streets (SHHS)

SHHS aims to bring together public health, planning, licensing, trading standards, and transport, as well as work with local communities, to explore ways of changing Southwark's high streets to help make people's lives healthier. Its key objectives include promoting a healthier eating and living environment through restrictions on the number and distribution of fast food and licensed outlets, betting shops, and pay day loan companies; promoting active travel through high street design – including a good cycling infrastructure, bike hire, and walking opportunities; supporting communities to make use of underused public spaces; and supporting the high street revitalisation programme in Southwark.

These work-streams are a good example of upstream ambitions because they look at the high street holistically. SHHS illustrates place-shaping ambitions in that it moves beyond an understanding of problems arising from decisions of

individuals, to the local conditions that shape their behaviours and choices. It is also an example of partnership working and building on assets: the initiative brings together and co-ordinates people and organisations from different sectors and provides funds for community organisations to develop and implement ideas for healthy high streets.

As such, SHHS place-shapes by bringing together the regulatory power of local bodies (e.g. in restricting certain shops) and creativity of the community through funding local initiatives.

Case Study 6: Paxton Green Time Bank

Paxton Green is one of the largest GP practices in South East London, which uses time banking as a way to complement clinical services with peer support and skill sharing. People who live in the area, whether they are registered patients or not, can get involved in the mutual exchange of activities that are delivered by members of the time bank. These range from simply providing transport to health and other services, to a variety of social and cultural activities – all depending on the skills and desires of members. Time banking generates connections between residents and helps to enrich the social fabric of a community, so that people become less isolated and less dependent on state services. The approach is no panacea: it relies on people's participation and people can let each other down – sometimes seriously. But when successful, it can transform people's lives for the better and in doing so prevent problems from arising. There is much evidence suggesting that community-based approaches such as time banking improve people's self-confidence and wellbeing – thus avoiding ill health and social harm.

Case Study 9: Southwark and Lambeth Integrated Care

The Southwark and Lambeth Integrated Care (SLIC) programme aims to join up care services and agencies in ways that help to improve the health of people in Lambeth and Southwark. Launched in 2014, SLIC was one of the first major integrated care schemes in the UK. The programme includes general practices, community healthcare services, mental healthcare services, local hospitals, and social services, and aims to integrate and co-ordinate the services offered by each in person-centred ways, enabling people to take a more active role in their own health. SLIC also aims to enable joint commissioning through pooling health and social care budgets, and forms an important part of Southwark and Lambeth's 'Better Care Fund' plan – the NHS's national programme to integrate health and social care. SLIC works with Lambeth's Citizens Board to mobilise a 'citizens' movement' to raise awareness about why services need to change, to get more people involved in co-designing better local services, and to play a central role in co-producing better outcomes.

Case Study 10: Safe and Independent Living

In Lambeth and Southwark, Safe and Independent Living (SAIL) is a social prescribing scheme delivered in partnership with Age UK. It aims to build and maintain a list of activities and services offered by the local voluntary and community sector (VCS). SAIL works through a simple yes-or-no questionnaire, which acts as a guide for anyone working in the community to quickly identify an older person's needs. Each question is associated with a partner agency, so a

'yes' to any question operates as a flag to bring that person to the attention of that particular organisation.

All partner agencies have agreed to accept all referrals through SAIL and to contact the client within two weeks of being notified. Age UK acts as the hub for the scheme across both boroughs, receiving completed SAIL questionnaires, forwarding them to the appropriate partner agency within 24 hours of receipt, and following up the referral with the older person to ensure their needs are met. In this way, SAIL integrates health activities and services offered by the public and voluntary sectors. It is a good example of how partnership working can contribute to early action through signposting and communication.

Case Study 11: Local care networks

Local care networks (LCNs) integrate health and wellbeing services and activities provided by the public and voluntary sectors in order to shift from a clinical to a more holistic and person-centred approach to local health.

At the time of writing, LCNs are being implemented in Lambeth and Southwark. They encourage greater collaboration between GP practices and form the basis for integration between primary care and other services – particularly community nursing and social care and elderly and early years services. LCNs are an example of ambitions for improved asset-based and partnership working in health. They also aim to embed approaches recommended in this report within their service delivery such as 'every contact counts', social prescribing, pooled budgeting across public agencies, and co-production. The networks are expected to increase personal resilience and reduce dependency on downstream services. Much energy across both boroughs is being focused on developing LCNs. Although it is too early for evidence of success, they have real promise as a vehicle for early action.

Case Study 12: Local Area Co-ordination

Local Area Co-ordination (LAC) is an asset-based approach to empowering people with disabilities and other needs, improving their lives, and preventing them from developing worsened conditions. Local workers – known as Local Area Coordinators – act as a single point of contact for people with disabilities and their families in a defined area.

Their role is to enable people to develop their own skills and capabilities, to help them access existing local resources and networks and, where these do not exist, work to build them. Co-ordinators work as capacity builders and sign-posters, and help to integrate public services with voluntary and community activity in ways that are shaped around the needs and aspirations of people who use these services. Crucially, the starting point is to identify with the individual what they can do to improve their own wellbeing and achieve their own aspirations with support from within their local community. In Lambeth, the model already forms part of the Living Well Partnership's plans to personalise recovery and support plans for those suffering from mental and physical disability. This approach is an important feature of plans to develop Local Care Networks (Case Study 11) in both boroughs.

The process was pioneered in Australia, where it focused on people with disabilities and special needs. In the UK it has been most fully developed in Middlesbrough, where it has included people with lower-level needs. Because it seeks to build on people's strengths and to develop community capacity, it can help to prevent people from developing more complex needs. The LAC model yielded impressive results in Australia, where it was seen to have delivered a 30% reduction in costs by keeping people from using more acute services. The greater universality of coverage in Middlesbrough could multiply these savings, by picking up a wider range of people with multiple low-level challenges before they trigger demand for acute services. It has been recommended that Local Area Co-ordination is rolled out throughout the UK.

Case Study 13: Knee High Design Challenge

The Knee High Design Challenge is a partnership between Guy's and St Thomas' charity and Lambeth and Southwark Councils. It sets out to find, fund, and support people with new ideas for raising the health and wellbeing of children under five. The programme aims to address problems that public health has failed to address by reducing inequalities in children's development when they start school. It offers an opportunity for local people, whether residents, social workers, parents or others, to propose ideas and provides support to turn these into investable ventures.

Children and families are involved at every stage in the development and testing of new products, services, and initiatives that are beginning to be used throughout Southwark and Lambeth. Launched in 2013, the initiative received 190 initial applications, out of which 25 'design teams' were funded with £1000 each to further develop their ideas. After testing ideas with families, six teams receive a larger grant (£41,000) to deliver the project and develop a sustainable business model. Since the autumn of 2014 these six project teams have been developing projects.

One example is the 'pop up parks' project, which arose from the Design Challenge. This seeks to engage local communities in the creative use of open public spaces to design and install temporary park facilities where children and families can spend time playing. Although 'pop-ups' usually last for one day, the aim of the initiative is to transform attitudes to urban public spaces and make greater use of them.

APPENDIX 2

Community Action Southwark's (CAS) Response the Southwark and Lambeth Early Action Report

Local Early Action: how to make it happen

1. Overview

1.1 We warmly welcome the opportunity to respond to the Southwark and Lambeth Early Action Commission (SLEAC) on behalf of Southwark's voluntary and community sector. Community Action Southwark (CAS) was the catalyst for the Southwark and Lambeth Early Action Commission[1], kick-starting its inception through our '*Value the VCS'* campaign. The campaign sought to highlight, amongst other things, the preventative power of the voluntary and community sector (VCS) in the borough. One of the key asks of the campaign was the establishment of an independent commission to look at how early action principles could be embedded into policy and practice across the borough. We believed that it was important to consider how early action, as a needs reduction strategy, could promote greater individual and community readiness, lessen future liabilities for statutory services, generate long-term savings across traditional service boundaries and foster greater multi-agency working.

1.2 We were clear from the beginning that the focus of the Commission should have not been limited to the voluntary and community sector. Nevertheless the sector is a champion of early action and we welcome the important role the voluntary and community sector has been given in delivering the recommendations of the Commission.

1.3 We welcome the report produced by the Commission and we would encourage Southwark Council, NHS Southwark CCG and Southwark's VCS to be real, motivated agents of change and not just tweaking existing practice. From CAS's perspective the role of Commission has shown how the voice of the voluntary and community sector has grown from an 'outsider' perspective to being increasingly embedded in core business and providing solutions to large scale social problems. We believe the Commission, through its recommendations, has laid the ground work for a new settlement between the local authority, the NHS and the voluntary and community sector in relation to early action and preventative work.

[1] Although we recognise that the Southwark and Lambeth Early Action Commission (SLEAC) was a cross-borough initiative, this response is focused primarily on how the recommendations should be implemented in Southwark, as that is our main area of operation.

2. Recommendations

2.1 We welcome and agree with many of the recommendations in the report but we have focused on giving our views, potential solutions and challenge with respect to the four main areas identified by the Commission.

2.2 We strongly endorse and support the Commission's main goal of building resourceful communities. We believe that this offers a new opportunity to give residents more control over their own circumstances which has been shown to impact positively on a person's quality of life and addressing wider social determinants of health.

3. Prepare the ground (stage 1)

3.1 It is clear that for change to occur there needs to be **senior leadership and commitment** to delivering the recommendations of the Commission. The Health and Wellbeing Board (HWBB) has been a vital sponsor of the SLEAC, and will need to continue to push the early action agenda forward. Members of the HWBB will need to play a leadership role in ensuring the implementation of preventative working. We would encourage the HWBB to develop a small implementation team, drawn from partners, to help oversee and drive forward the recommendations detailed in the report.

3.2 We fully endorse the recommendation around **mapping assets**, and agree that recognising assets and strengths, rather than just focusing on problems, is a positive way forward when identifying need and designing services. We believe that the Commission's focus on building resourceful communities where local people are agents, not victims, of change and are able to shape the course of their own lives is of fundamental importance.

3.3 We believe this ambition of the Commission is a key component in creating a new way of approaching current problems whilst managing demand on the system in the future. However, we feel the ambition and scale the Commission articulated could have gone further and made a more explicit challenge to the local system about giving people more control and agency over their lives and where they live. There are programmes that focus on self-management and peer support but none that deal with the wider social context; an important factor in enabling people to become more in control of their health and wellbeing[2]. There is increasing evidence that community cohesion, resilience and social capital can contribute to improving health and wellbeing, reducing rates of depression and preventing falls, as well as enhancing life-skills, increasing rates of employment and higher education and improving social relationships[3,4].These factors largely lie outside the control of any one part of the system, so the challenge is how can the world of

[2] NESTA (2016) 'At the heart of health Realising the value of people and communities'. Available from: http://www.nesta.org.uk/sites/default/files/at_the_heart_of_health_-_realising_the_value_of_people_and_communities.pdf
[3] Marmot Review (2010) 'Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010.' Available from: www. instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[4] Aked, J. et al. 'Five Ways to Wellbeing: the evidence'. London: New Economics Foundation. Available at: www.fivewaystowellbeing.org

formal care and provision align to build stronger communities. The answer does not necessarily lie in just mapping community assets. We believe that putting people and communities genuinely in control of their lives requires a wider shift that will bring about the change hoped for by the Commission.

3.4 We would ask the Health and Wellbeing Board to consider the behavioural, cultural and systemic change needed to achieve person- and community-centred approaches. Research[5] has shown that these approaches can and do lead to significant benefits for individuals, services and communities. They can improve individuals' health and wellbeing; reduce demand on formal services such as reducing unplanned hospital admissions, and address health inequalities by contributing to wider social outcomes such as employment and school attendance.

3.5 There is emerging research that demonstrates that engaging individuals and their communities in health and wellbeing can contribute to reducing the burden of preventable disease and ease the pressures of increased demand on the health service by developing people's knowledge, skills and confidence to manage their own care. There is a range of development approaches that are relevant to working with communities for health and wellbeing. For example, asset-based community development (ABCD) is a specific framework used to steer processes for community building. It starts by making visible and explicitly valuing the skills, knowledge, connections and potential in communities and neighbourhoods. The aim is to mobilise local people to act on the things they care about and want to change. The asset-based approach places high value on promoting a sense of belonging, a capacity to control and finding meaning and self-worth, not specifically to promote individual wellbeing and health, but rather to connect individuals and enable flourishing communities. By way of illustration, research conducted by the New Economics Forum estimated, using the Social Return on Investment model, that for every £1 a local authority invests in community development activity, £15 of value is created[6].

3.6 We believe this recommendation goes beyond integrating VCS activities with statutory provision and we would urge all partners around the Health and Wellbeing Board to consider carefully how we develop this asset-based community approach in relation to early action.

4. Find resources (stage 2)

4.1 We fully support the recommendation that **independent funders should be brought together to share knowledge about early action** and offer grants in a more systematic way. Local independent funders have a very important role to play in the prevention agenda, particularly at a time when public sector funding is being squeezed. At the moment, co-ordination of charitable

[5] NESTA (2016) 'At the heart of health Realising the value of people and communities'. Available from: http://www.nesta.org.uk/sites/default/files/at_the_heart_of_health_-_realising_the_value_of_people_and_communities.pdf

[6] Nef (2010) 'Catalysts for Community Action and Investment: A Social Return on Investment analysis of community development work based on a common outcomes framework.' London: Nef. Available from: www.cdf.org.uk/wp-content/uploads/2011/12/SROI-ReportFINAL1.pdf

funding is not joined up and it could be more logical, in order to reduce duplication and focus on where the return on investment will be greatest. CAS currently chairs a group of Southwark Funders and will endeavour to discuss strategy, emerging need and where grant giving can take a more co-ordinated approach to tackle a problem holistically.

4.2 We would welcome the introduction of a **Change Fund to support system change**. The Change Fund should be used to kick-start systems change across both the public sector and the VCS. The Change Fund should test new approaches to public social partnerships designed to test and review prevention and early action activities. We believe applications should be led by the voluntary sector in partnership with the public sector. The development of the Change Fund should be informed by the experiences and outcomes achieved by the Scottish Early Action Change fund. We will be proactive in seeking out external funding sources to support the creation of a Southwark and Lambeth Early Action Change fund.

4.3 However, it must be pointed out that the benefits of preventative working can only be reaped over the long-term, and systems change is an ongoing process –it cannot be done quickly, and ways of working are continually evolving. If the Change Fund is used to fund innovation to embed early action – funded through charitable or philanthropic sources - it must be recognised that ongoing funding may be needed to keep these initiatives going.

4.4 In relation to **making strategic use of social finance models, including Social Impact Bonds we acknowledge the use of different models of finance but we would offer a world of caution.** It should be recognised that social impact bonds (SIBs) have very limited application especially where cashable savings and a return on investment can be clearly articulated. Our experience of new social finance models often transfers significant risk to the voluntary sector provider and the estimated returns on the initial investment are not always achieved thereby creating significant liabilities for the provider.

5. Change systems (stage 3)

5.1 We would encourage the **classification of spending to distinguish early action from downstream coping** within statutory services and VCS organisations. We would like to see an assessment of preventative spend analysis built into the annual budget challenge process as a means to embed this classification into normal practice.

5.2 What is important is to distinguish what is truly meant by ‘upstream, midstream and downstream’ spending. There needs to be a shared understanding of this across the council, CCG, and VCS in order for any spending classification exercise to be truly useful. This is because savings from early action are generally spread across more than one partner – for example, investment by the council in early action may have a positive effect on the CCG’s budget in future years.

5.3 We agree with the importance of **establishing a long-term plan, across 5-10 years, with specific milestones.** The difficulty of implementing this recommendation lies in the fact that funding cycles, are in general, a maximum of three years. It is difficult to agree long-term plans without being sure that the corresponding investment will be available to put plans into place. This logic applies to both the public sector and the VCS.

5.4 However we would support the creation of high level strategic documents which lay out long-term plans for moving towards early action, both within the statutory sector and the VCS. We would recommend that a cross-sector 'early action' strategy, outlining steps to be taken by all partners with expected outcomes, so that high-level outcomes can be monitored and measured. This strategy would hold all partners to account and drive forward early action in a high-level strategic way.

5.5 We welcome the recommendation to **establish clear oversight arrangements, with regular monitoring reporting.** We believe this role should lie with the HWBB, in order to give strategic leadership to early action.

5.6 We welcome the recommendation to **transform the commissioning process to support early action.** The commitment of the council and CCG to develop a Commissioning Partnership Team provides a significant opportunity to build in early action to commissioning processes. We believe the commissioning process should be transformed, where possible, in order to incentivise preventative work, and to understand the holistic nature of many of the services the VCS provides.

5.7 **A shared evaluation framework** for prevention and early action would be very welcome if it were possible. However, we question its applicability and feel that the idea of one evaluation framework to measure success rates for the whole of 'prevention' is too conceptual and unrealistic. The question we would ask is – prevention of what? If we do not identify what social problem we are preventing, it is hard to devise an evaluation framework to measure how successful its prevention has been.

5.8 For example, one evaluation framework to measure the success of prevention initiatives for youth crime, for example, would have different indicators than a framework to measure child obesity. It may be difficult for the frameworks to be closely aligned, given the different types of data which will need to be measured, the different time-frames for the two problems, and the different outcomes we want to see. Additionally, evaluation frameworks will need to be proportional to the piece of work being carried out, and may need to be tailored if they involve more than one partner, for example, if the framework was to be applied to an alliance contract.

5.9 We would encourage the joint creation of specific evaluation frameworks for preventative work whenever a programme is being commissioned or grant funding is awarded. Evaluation frameworks should be co-produced to ensure a good understanding by all parties of what is expected. However, the

creation of a ‘standardised’ framework, as described by the Commission, seems unrealistic.

6. Change practice (stage 4)

6.1 We found the recommendation to **improve connections, co-ordination and knowledge sharing** to be a little simplistic, and would like to offer some practical recommendations as to how organisations should form better links around their service users to deliver holistic services.

6.2 For example, we would like to suggest the idea of ‘living noticeboards’ – volunteers in each area, people with a strong base of local knowledge, who would be willing to take time to sit in local places such as doctor’s surgeries, post offices etc. and chat to people about what is available on going on in their local area. These people could be identified during the asset-based community development process and would build on the community navigators programme delivered by Age UK’s SAIL programme.

6.3 There also needs to be stronger engagement with local people who might not be seen as the typical contributors to wellbeing, but who have the best relationships with some of the most vulnerable in our society – pub landlords, staff in gambling shops, receptionists in doctor’s surgeries. If they are willing to engage, these people should be informed about the assets that exist around them, so they can spread this knowledge to those they interact with and increase resourcefulness in the community. CAS is developing a borough wide Community Action Network that has building resourcefulness in communities as a long-term ambition.

6.4 In order to improve knowledge sharing between VCS organisations, we are establishing Provider Led Groups for a range of policy areas (children’s services, safeguarding, communities etc.). These groups will be independent of the council and the CCG and will allow VCS organisations to discuss issues they are facing and to develop solutions to emerging need. This is a new way of working which should raise awareness amongst groups of the services they are offering, and lends itself to improved signposting, partnership working and collaboration.

6.5 There needs to be a joint understanding across both the council and the VCS of what **‘co-production’** actually means and what it looks like in action. At present, it seems that it can be used to mean engagement and consultation – when in truth; co-production means the actual co-design of policies, right from the beginning, with partners. It should not be done when there is already a predetermined notion in mind of the outcome that needs to be achieved. This is just enhanced consultation. All partners should be permitted to have ideas that will be genuinely considered, regardless of how much change they may represent. We hope that the forthcoming Voluntary Sector Strategy will be underpinned by co-production principles.

6.6 **In relation to strengthening the focus and funding of the VCS in Southwark and Lambeth,** we would disagree with the idea that promoting 'inclusive' VCS services through funding decisions is the best way forward. VCS organisations may have different ways of working and different models of service delivery – but this does not always make a difference to the quality of their services, or their success in improving outcomes for service users. Essentially, just because a service is 'inclusive', it does not necessarily follow that it is high quality, meets local need and is well run.

7. Conclusion

7.1 The work of the Commission focussed on processes, structures and cultural changes that could enhance upstream working. Although the Commission took a whole system approach it is our contention that the voluntary and community sector is at the centre of the report and will act as a key partner in delivering many of the recommendations in the report. Many of the recommendations in the report require buy-in and leadership from the VCS in order to get them off the ground; they will require a commitment and genuine partnership working with the VCS at every step of the way. We particularly welcome the Commission's focus on empowering residents and communities to have greater control over their lives.

7.2 We welcome the recommendations of the SLEAC and we look forward to working closely with our partners to transform how we work together with the shared aim of supporting and empowering people to take more care of themselves and to prevent problems from escalating to a level at which statutory services have to intervene.

APPENDIX 3

NHS Southwark Clinical Commissioning Group

Southwark CCG's Response to 'Local Early Action: How to make it happen- Report from Southwark & Lambeth Early Action Commission' (March 2016)

Purpose

This paper notes and responds to the recommendations within the Lambeth & Southwark Early Action Commission, Local Early Action: How to make it happen. This paper sets out how the CCG intends to act on the commission and takes the key recommendations, notes the CCG's work in progress to date, outlines our further medium term plans and our longer term intentions.

Background

The commission, published in November 2015, responded to a commitment from Lambeth & Southwark's Health & Well Being Boards (H&WBB) to enhance the work of the voluntary and community sector in building resilient communities within Lambeth & Southwark within the current budgetary restraints. In July 2014 the Southwark Health and Wellbeing Board approved the creation of an independent Early Action Commission. The aim of the commission was to make a series of recommendations about how local health & social care partners can work together to take a more preventative approach and shift investment towards upstream preventative measures as opposed to downstream treatment and care.

Our commitment to early action

NHS Southwark CCG welcomes the commission and views the recommendations as helpful in the delivery of Southwark's Joint Five Year Forward View (5YFV). The 5YFV sets out our local ambition to create a much stronger emphasis on prevention and early action as well as deeper integration across health and social care, and the wider voluntary and community sector (VCS). The CCG is committed to creating resourceful communities and services that respond to the wider social determinants of health are embedded in local communities and deliver system wide value.

The commission recognises the work to date that has begun to transform Southwark's health and social care economy to be more proactive, preventative and act early. This includes the development of Local Care Networks (LCNs), strengthening partnership working with the VCS with projects such as Safe and Independent Living (SAIL) and system wide approaches to prevention such as Southwark Healthy High Streets. The CCG welcomes the recommendations identified by the commission which gives the CCG and its partners a clear framework to take this work further and take system wide approaches to early action.

The CCG, in partnership with the Council, are committed to strengthening the commissioning of integrated, proactive and holistic services across our priority populations; children, those living with severe mental illness, and adults with frailty/complex needs. We are currently working with the Council to align into one Commissioning Partnership Team (CPT) which will further bring together the health & social care commissioning agenda for these populations. This development will help us to achieve greater equity and better outcomes for Southwark people by addressing the social as well as the physical determinants of health and wellbeing. The CPT will support the pooling of resources and the alignment of decision-making so that we achieve progressively more integrated health and social care commissioning, and the development of increasingly population-based provider contracts. This new team will begin work in 2016/17.

The commission identifies four priorities, which the CCG recognises, supports and holds central to our commissioning approach:

- **Resourceful communities** where residents and groups are agents of change, ready to shape their lives
- **Preventative places** where neighbourhoods have a positive impact on how people feel and enable them to help themselves and each other
- **Strong, collaborative partnerships** where organisations work together on a shared purpose
- **System geared to early action** where culture, values, priorities and practice support early action as the new 'normal' way of working

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How we intend to take forward the commission's recommendations

The CCG is committed to ensuring that the recommendations from the commission are taken account and acted upon through it's commissioning remit. This work is currently being driven by the Building Resilient Communities & Prevention Programme Board (under review) which brings together partners across health, social care and the VCS. The CCG views the Local Authority's Public Health Department as a key partner of this board and has engaged in discussions to ensure that the CCG commissions services that are evidence based and utilises both universal and targeted approaches to prevention where most appropriate.

The CCG intends to act on the commission recommendations as outlined below:

Stage 1: Prepare the ground

- **Establish senior leadership & commitment**

The CCG is an active partner within Southwark's Health & Well Being Board (H&WBB) with Jonty Heaversedge (CCG Chair) as Vice Chair. Both Clinical & Executive CCG Governing Board members are engaged and committed to ensuring that early action and evidenced based preventative approaches are taken to the public health needs of Southwark residents.

Further to the H&WBB, the CCG is in the process of reviewing the governance and programme boards of the organisation. Currently, the Building Resilient Communities and Prevention Programme Board has been responsible for driving early action, resourceful communities and preventative approaches throughout the CCG's commissioning intentions and work plans. This will be replaced by a programme structure for each of the priority populations; children, complex adults and serious mental illness. 'Early Action' will be a key objective across all of these programmes, and will be driven by an 'Early Action Challenge' group. As these programmes

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develop the CCG will commit to ensuring each programme develops an 'Early Action Implementation Plan' by September 2016 which will outline the priority deliverables for the next 3 years that will build resourceful communities and shift investments upstream for these populations.

- **Map assets across both boroughs**

Work to map local assets within Southwark has been ongoing through a number of forums including Southwark Lambeth Integrated Care (SLIC), Pembroke House, the commissioning of self-management programmes and the Southwark Wellbeing Hub. However, it is recognised that more work is required and the CCG will continue to invest in this work for two key benefits; to develop and strengthen relationships across local care networks, and provide a foundation for effectively supporting individuals to self manage and support professionals to increase social prescribing. We acknowledge that the mapping of assets cannot be a static process, we will work with the Local Care Networks to ensure we have organic systems that can enable communities to broadcast and navigate communities as assets evolve and change. These asset maps will enable us to better align resources and investment when taken alongside the ongoing Joint Strategic Needs Assessment.

Stage 2: Find Resources

- **Set up a dedicated change fund to support system change**

The CCG recognises the need to resource local change appropriately, and have subsequently identified a Research Challenge Fund to learn more about how the voluntary and community sector work with specific local populations to support positive behaviour changes and improvements in wellbeing. This work will provide a valuable piece of research for participant organisations and it will inform the way the CCG understands and commissions these wellbeing and early action services. This will be an initial project, which will be followed by a further grant based fund to support local innovation. The CCG will take the learning from these work streams and continue to consider opportunities to support system change going forward.

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- **Pool budgets between organisations and departments**

The CCG acknowledges the value of consolidating budgets to ensure investment in early action and a strong focus on prevention. Southwark were one of just six boroughs nationally to be given full unqualified approval for its Better Care Fund (BCF) plan, a pooled budget between the CCG and council which shifts resources into social care and community services with the aim to help people stay out of hospital if they don't need to be there by providing better services closer to home. Making resources for early action go further does remain a challenge however, particularly with the current financial challenges of social care and health funding and will only happen if our organisations continue to operate within the clear framework as set out in the Joint FYFV.

- **Tap into community based assets**

The CCG values the importance of approaches which recognise, identify and harness existing community based assets as a way of strengthening communities and promoting resilience. The CCG and Council have agreed to develop a Joint Voluntary & Community Sector Strategy that sets out the vision for stronger partnership working with the VCS. This strategy will be co-produced with the VCS and completed by October 2016, which will layout the CCG & Council priorities for strengthening our VCS partnerships going forward.

Stage 3: Change Systems

- **Classify spending to distinguish early action from downstream coping**

As outlined in Southwark's 5YFV, the CCG is committed to shifting investment to early action and preventative measures. The Early Action Task force classification of spend provides a useful and consistent tool for establishing current investment in early action. The CCG is committed to undertaking a review of current spend, which will utilise this approach and use this information as a baseline of investment into upstream preventative measures going forward.

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- **Establish a long term plan, across 5-10 year, with specific milestones**

Southwark's 5YFV sets out the main aspects of the CCG's strategy for transforming health services and strengthening our focus on prevention and early action. However, we recognise that we must continue to develop this into a specific action plan. The CCG will develop an action plan and highlight the investment necessary to deliver the ambitions set out in this local Five Year Forward View. We will publish this detailed plan 'Southwark's Forward View: Into Action', by June 2016.

- **Commit to shifting a significant percentage of yearly spend to early action**

Our 5YFV commits us to changing contracting mechanisms with a shift from payment based on episodes of care to investing in improved outcomes for our citizens. This work will enable us over time to set targets for shifting resources from downstream services to fund early action that can be incorporated into future planning cycles. Specifically we are working with the Local Authority to look at effective joint planning for Children and Young People's Services. We are supporting the development of a joint commissioning approach for Mental Health Services and will be working jointly on older adults.

- **Establish clear oversight arrangements with regular monitoring and reporting**

The CCG support the recommendation for the H&WBB to monitor and report Southwark's shift to early action across the partnership. We are committed to making this happen and will work with partners to set up systems to report to the H&WBB by providing information and resources as necessary.

- **Transform the commissioning process to support early action**

Establishing the CCG & Council Commissioning Partnership Team will enable us to transform the commissioning process to support early action. Over time, and with a jointly agreed remit, the CPT will become the vehicle for developing and delivering joint strategic intentions across

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health and social care with strong links to education, public safety and public health that will enable a system wide commissioning approach to support early action and commissioning for outcomes. By contracting for outcomes and not activity, with integrated networks or alliances of providers, across whole pathways of care, we will incentivise providers of health and social care to increase value by focusing on intervening early to reduce utilisation of health services.

- **Develop a shared evaluation framework**

The CCG recognises the need for a shared evaluation framework to enable consistent monitoring of the system wide shift to early action. We view this as a central role of the H&WBB, supported by public health. The Commissioning Partnership Team, will provide the opportunity for such an evaluation framework to be central to the local commissioning of health and social care and used to inform future planning.

Stage 4: Change Practice

- **Improve connection, co-ordination and knowledge sharing**

Ensuring that local people and organisations are connected and informed is central to building resilient communities. The CCG will work in partnership with the local Authority to enhance the local self-management offer and support voluntary and community sector to empower people and communities. Ensuring that people are aware of the services and support available in their local area is a key challenge to address in Southwark. We continue to explore and pilot different models of empowering people with the information required to successfully navigate local services. These models include community patient champions, directories of wellbeing services and care navigators. We will utilise innovative approaches to improving connections, co-ordination and knowledge sharing which will empower patients with information about local services which can improve their lives and facilitates collaboration between organisations.

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The CPT provides opportunity to coordinate these models more widely across the breadth of public sector and VCS organisation, ensuring a seamless service for the people of Southwark. This will also facilitate wider sharing of information across organisations to breakdown the artificial boundaries that exist between these services and facilitate greater collaboration.
The CCG and Council's commitment to coproducing a Voluntary Sector Strategy intends to further strengthen the local VCS to mobilise community action and makes best use of community resources, skills, knowledge and spaces. It will be a priority for the CCG to work with the council during 2016/17 to agree a joint approach to ensure that we appropriately resources communities with information, sign posting and navigation services that empower citizens to take early action of their lives, supported by appropriate health and social care services and the VCS.

- **Stronger partnerships and more integrated working**

The CCG have also been working to set up Local Care Networks (LCNs) within Southwark. LCNs bring together providers from across health and social care (including the voluntary sector), to work together to address common challenges. We expect that these Local Care Networks (LCNs) will bring together doctors, nurses, social workers, therapists, housing support workers, home carers and voluntary sector groups to work together with a shared ambition to support the needs of individuals and improve health outcomes for the population.
By coming together, providers can look at the range of services that they provide for our populations and see how they can work better together to improve and integrate them. By having the VCS as a core member of LCNs, it will help facilitate improved working between the statutory and the voluntary sector, and ensuring that VCS services are integrated as part of patient and customer pathways

- **Devolve more power to neighbourhoods**

LCNs are an example of our ambition for improved asset-based and partnership working in health. The networks are expected to increase personal resilience and reduce dependency on downstream services. These networks will share accountability for the outcomes of their local

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population, and they will use evidence and experience to plan and organize the local delivery system.

In addition, we are embedding a Population Health Management approach that will allow all parties to share data and risk stratification tools so that we can better understand, anticipate and respond to the needs of our populations. By embedding this at a Local Care Network level we can ensure that we are responsive to the needs of our population on a highly localised basis.

- **Promote and apply the principles of co-production**

We recognise that to successfully transform commissioning we need to further strengthen the role of our citizens in the commissioning process. The CCG has many good examples of effective engagement and co-design of services, such as the recent co-design of an integrated weight management service with our local citizens, for which our public and patient engagement lead won the Guy's and St Thomas' Involvement to Impact award for patient and public engagement. However, we need to ensure that there is a shift in expectations so that such good practice become the norm across commissioning programmes rather than being considered a gold standard example. We will build on our award winning approach to partnership working with local people and ensure that the service user voice is at the centre of the commissioning process going forward.

- **Strengthen the focus and funding of the VCS in Southwark & Lambeth**

We will continue to have a vibrant and diverse voluntary and community sector, working closely at the heart of communities with general practitioners and social workers as central professionals. An example of this is the pilot currently underway between Safe and Independent Living (SAIL) and the GP Federations within Southwark. SAIL Navigators are now working within General Practice to support the holistic needs of local residents and work collaboratively across the voluntary and health sectors to better integrate services.

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We further recognize that funding streams for the VCS have tended to be relatively short-term which has compromised planning and investment. By working with the Council to develop a joint strategy we would aim to award funding on a long term basis to help ensure the sustainability of the VCS sector.

Conclusion

In summary, the CCG welcomes and supports the recommendations outlined in the Early Action Commission. As noted by the commission, we have already begun to make significant steps to shifting our focus to prevention and early action and we are committed to acting upon the recommendations outlined by the EAC and further transforming the local health and social care system to bring about better outcomes for Southwark Citizens. The CCG's immediate steps to doing this will be the transformation of our commissioning structures through the formation of the CPT for specific populations, the implementation of *Southwark's Forward View: Into Action',* and the development of Local Care Networks as the foundations for collective and cohesive action to improve the health and wellbeing of our citizens. This response outlines the key steps that the CCG will take to implement these changes in 2016/17.

The CCG looks forward to working with the H&WBB and local partners in implementing the commission's recommendations and transforming Southwark's communities to focus on preventing social problems and ill health.

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Agenda Item 7

Item No. 7.	Classification: Open	Date: 31 March 2016	Meeting Name: Health and Wellbeing Board
Report title:		NHS Southwark CCG Operating Plan 2016/17	
Ward(s) or groups affected:		All wards	
From:		Andrew Bland, Chief Officer, NHS Southwark CCG	

RECOMMENDATIONS

1. The board is requested to:

   - Review the attached Operating Plan document and comment.
   - Note the section on the *CCG's Forward View into Action*, which describes our joint approach to transforming the local health and care system.
   - Note the mandatory requirements of the CCG, which are addressed in the plan. A briefing on the national requirements was presented at the January 2016 Health & Wellbeing Board.
   - Note the Board's assurance that the document sufficiently constitutes a credible plan, which ensures Southwark patients receive the services they are entitled to; that we are planning appropriate interventions to improve the outcomes of Southwark's residents; and that our plans are aligned with the objectives of the Health & Wellbeing Strategy and Better Care Fund in Southwark.
   - Endorse the CCG Operating Plan 2016/17.

EXECUTIVE SUMMARY

2. In December 2015 national health and care bodies in England published *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21*, setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

3. As part of the planning process, all NHS organisations are asked to produce two separate but interconnected plans:

   - a local health and care system 'Sustainability and Transformation Plan (SPT)', which will cover the period October 2016 to March 2021; and
   - a plan by organisation for 2016/17. This will need to reflect the emerging Sustainability and Transformation Plan. This is known as a CCG Operating Plan.

4. The CCG Operating Plan 2016/17 sets out the CCG's plans to improve local health services over the course of the year from April 2016. It sets out our approach to system transformation and also summarises the approach to ensuring delivery of nine nationally-mandated 'must-do' requirements.

5. Health & Wellbeing members should note that the Operating Plan is an assurance document focused on addressing the 'must do' aspects of CCG business and also the work we are leading to transform local services and improve the quality of care commissioned in Southwark.

6. This final draft version of the CCG Operating Plans is written to describe how over the course of the next year we will:

    - Begin implementation of a programme of transformation across the local health and care system.
    - Commission services in a way that improves outcomes and access and addresses health inequalities.
    - Ensure key programmes and headline commissioning intentions for 2016/17 are delivered.
    - Commission high performing services and secure patients' NHS Constitution rights and pledges
    - Commission high quality and safe services
    - Support local financial sustainability, delivering value for money and invest to improve health outcomes.
    - Develop our structures of governance to support the delivery of our plan.

7. The plan also demonstrates how our major work programmes have been developed to align with the Health & Wellbeing Strategy and Better Care Fund for Southwark.

8. The CCG will submit a final version of the Operating Plan 2016/17 for approval at the CCG's Council of Members on 30 March 2016.

BACKGROUND INFORMATION

9. The CCG presented the national planning guidance to the Health and Wellbeing Board in January 2016.

KEY ISSUES FOR CONSIDERATION

Policy implications

10. A continued strong emphasis on increasing investment in prevention and public health.

11. The continued development of the Better Care Fund as a mechanism to support integration and reduce rates of hospital admission

12. National support for local areas to test new approaches to contracting and commissioning.

Community and equalities impact statement

13. The CCG will complete an equalities impact assessment as part of its work with south east London partners as we develop the local STP (see page 1, above). We will do this in order to determine the extent of any differential impact of proposed strategic changes on various groups in Southwark.

Legal implications

14. None at this stage

Financial implications

15. Details are summarised as part of the Operating Plan 2016-17.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Southwark JSNA Southwark CCG Operating Plan 2015/16 Southwark Health and Wellbeing Strategy	www.southwarkccg.nhs.uk	Kieran Swann Head of Planning & CCG Assurance 0207 525 0466
NHS Forward View	http://www.england.nhs.uk/ourwork/futurenhs/	Kieran Swann Head of Planning & CCG Assurance 0207 525 0466
Link: http://www.england.nhs.uk/ourwork/futurenhs/		

APPENDICES

No.	Title
Appendix 1	NHS Southwark CCG: Operating Plan 2016/17

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Southwark CCG	
Report Author	Kieran Swann, Head of Planning & CCG Assurance	
Version	Final	
Dated	17 March 2016	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		17 March 2016

NHS
Southwark
Clinical Commissioning Group

NHS Southwark CCG Operating Plan 2016/17

– FINAL DRAFT –

Southwark Health & Wellbeing Board

31 March 2016

Operating Plan 2016-17: contents

NHS Southwark Clinical Commissioning Group

NHS
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Clinical Commissioning Group

1. Introduction and context

What is an Operating Plan?

NHS Southwark Clinical Commissioning Group

The Operating Plan is an assurance document, which sets out how through the commissioning process, the CCG plans to improve the health and wellbeing of people living in our borough. The plan also sets out how the CCG will meet mandatory requirements set by NHS England in the annual planning guidance. The document sets out our locally-defined response to national requests and as such the Operating Plan can be read as a declaration of the CCG's commitment to meet national requirements; establish the extent of our ambition for the improvement of certain performance and outcome indicators; and provide a view of the programmes of work underway and planned to ensure these improvements happen.

The Southwark Operating Plan 2016/17 describes the CCG's response to the requirement included in planning guidance published in December 2015: *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.*

Both the CCG Council of Members and NHS England are responsible for assuring and endorsing CCG plans and the CCG submits detailed planning templates to NHS England. These templates include the CCG's detailed financial plans; monthly activity and performance trajectories; quality and outcome indicator trajectories; and details of the borough's Better Care Fund plan. This document summarises these detailed submissions and supplements this information with further description of the key actions and activities the CCG plans to complete in 2016/17 to deliver an improved NHS in Southwark.

Planning guidance stipulates nine 'must dos', which CCG operating plans should address. These are:

1. Develop a high quality, agreed Sustainability and Transformation Plan, achieving key identified milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
2. Return the system to aggregate financial balance.
3. Develop a local plan to address the sustainability and quality of general practice.
4. Meet standards for A&E and ambulance waits.
5. RTT: that more than 92% of patients on non-emergency pathways wait no more than 18 weeks.
6. Deliver the 62 day cancer waiting standard and improve one year survival rates.
7. Achieve the two new mental health access standards (50 % of people experiencing first episode of psychosis to access treatment within two weeks; and 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks).
8. Transform care for people with learning disabilities, improving community provision.
9. Improve quality and implement an affordable plan for organisations in special measures.

Introduction to NHS Southwark CCG

NHS Southwark Clinical Commissioning Group

NHS Southwark Clinical Commissioning Group (CCG) is a membership organisation of all general practices serving people in the London Borough of Southwark. The combined registered population of Southwark's 44 general practices is approximately 290,000 patients. The CCG operates with the strong clinical leadership of local practices to commission and improve local services.

Clinicians from member practices have been involved throughout the year in the development of the CCG's major programmes of transformational change. These programmes of transformation constitute a core component of this Operating Plan and have informed the development of a broader piece of strategic planning across health and social care in south east London. The CCG has run borough-wide clinical engagement events; monthly locality member practice meetings; the CCG's Council of Members as well as targeted multi-disciplinary focus groups to develop the content of the Operating Plan.

The CCG is also committed to understanding the views of local people about the NHS in Southwark. We have a well-developed network of local people, who help us to better understanding prescient issues in health and social care. This network is based on practice-based Patient Participations Groups, which feed the views of members through locality groups and into the CCG's Governing Body. The CCG also runs a wide range of engagement events and operates web-based interactions with people in Southwark and other community organisations.

Our Population:

- 288,300 patients registered with Southwark practices.
- Young and ethnically diverse population.
- Significant disparities in levels of deprivation across the borough and health inequalities.

Key health issues in Southwark include:

- Premature cardiovascular mortality.
- Preventable respiratory mortality and morbidity.
- Diabetes management and under-detection.
- Liver disease and alcohol related illness.
- High prevalence of patients with mental health problems.
- Very high levels of childhood obesity.

Our organisation and local context

- 44 GP member practices.
- 4 geographically coherent neighbourhoods (Dulwich, Peckham and Camberwell, Bermondsey and Rotherhithe, Borough and Walworth) served by two locality groupings (north and south Southwark).
- 2 GP provider organisations (north and south) covering every practice holding population based contracts for services including extended primary care access; integrated frail elderly care, access and population health.
- Vast majority of acute care provided locally by GSTT and King's College Hospital NHS FT (Denmark Hill) with even split between both.
- Community services provided from GSTT and acute and community mental health services by SLaM.

The health context in Southwark

NHS Southwark Clinical Commissioning Group

Life expectancy has continued to rise for people living in Southwark and over the last few years there has been a trend towards diminishing inequality in health outcomes between different socio-economic groups within the borough. Progress has been made on improving health outcomes in a wide variety of areas, including reductions in infant mortality; better, more comprehensive care for people at the end of their life; and improved outcomes for people living with HIV.

However, according to the JSNA in Southwark and across NHS there are a number of problems that we need to solve. And the longer we wait to respond to these challenges, the more difficult these problems become. In essence, we know that health outcomes here in Southwark are not as good as they could be:

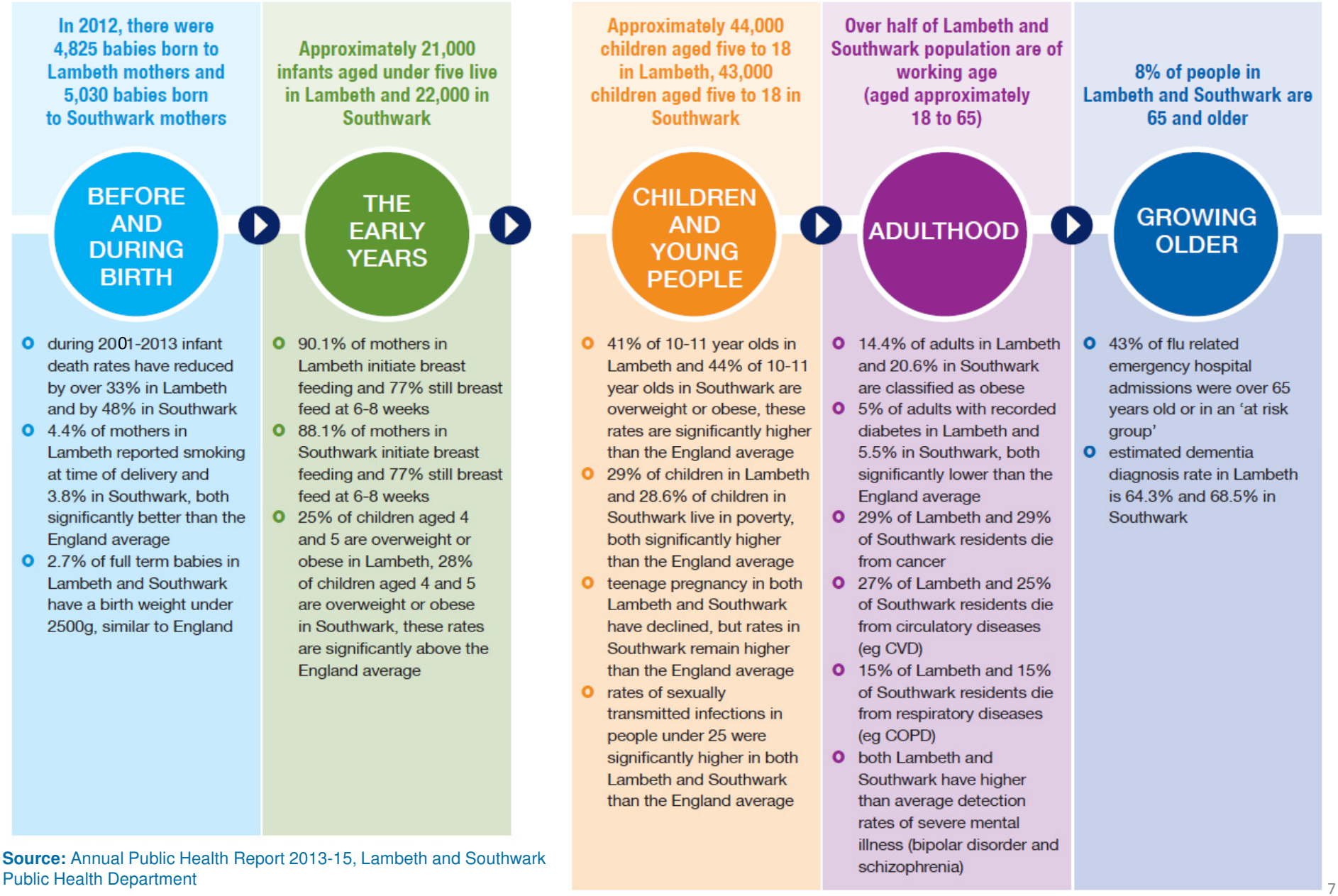
- Too many people live with preventable ill health or die early.
- The outcomes from care in our health services vary significantly and high quality care is not available all the time.
- People's experience of care is very variable and can be much better.
- We don't treat people early enough to have the best results.
- Patients tell us that their care is not joined up between different services.
- The money to pay for the NHS is limited and need is continually increasing.

These issues are challenges faced by health economies across London and the country. The response to these challenges is outlined in a number of regional and national strategic documents, which we need to reflect and implement where they are relevant for people in Southwark. We are an evidence-based commissioning organisation and as such work to accurately understand the health of our population and to ensure that solutions to key health issues are things that work.

Southwark JSNA: Key Health Issues
Southwark people are more likely to die prematurely from cardiovascular disease than people living in similar parts of London.
Chronic obstructive pulmonary disease (COPD) and lung cancer cause relatively high numbers of preventable early deaths and ill health in Southwark.
There is significant variation in the management of patients with diabetes in Southwark and a high number of people are living with undiagnosed diabetes.
Rates of preventable early deaths from liver disease and alcohol-related hospital admissions are significantly higher in Southwark than they are in similar London boroughs.
Southwark has a high prevalence and comparatively poor outcomes for people with low and medium-level mental ill-health. There is significant unmet need too.
Childhood obesity levels in the borough amongst the highest in England. Adult obesity is also higher than the London average.
Only about half of the predicted numbers of patients with dementia are diagnosed. Effective management of patients is highly variable.
Admission rates and health related quality of life for older people is higher than in similar areas of London with rates of falls-related admissions particularly high.
Patients and members of the public consistently tell us that they often find it hard to get an appointment with their GP.

The local public health context

NHS Southwark Clinical Commissioning Group



Source: Annual Public Health Report 2013-15, Lambeth and Southwark Public Health Department

The regional and national planning context

NHS Southwark Clinical Commissioning Group

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

NHS England, NHS Improvement (the new body which brings together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE published the national *NHS Five Year Forward View* on 23 October 2014. The *Forward View* set out a vision for the future of the NHS.

In December 2015 the same national health and care bodies in England published Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances. The planning guidance is backed up by increased NHS funding, including a new Sustainability and Transformation Fund which will aims to support the NHS achieve financial balance, the delivery of the Five Year Forward View, and enable new investment in key priorities, such as 7 day working and IT integration.

As part of the planning process, all NHS organisations are asked to produce two separate but interconnected plans: 1) a local health and care system 'Sustainability and Transformation Plan (SPT)', which will cover the period October 2016 to March 2021; and, 2) a plan by organisation for 2016/17, which needs to reflect the emerging Sustainability and Transformation Plan. This document constitutes the second of these requirements.

The operating plan process is overseen by NHS England. CCGs are required to make a number of detailed planning submissions (Excel templates, rather than narrative) over the time period from February to April 2016.

CCGs are each required to set clear and credible plans, forecasts and trajectories for levels of commissioned activity; performance standards; and finance. NHS England complete assurance of these submissions, reviewing assumptions against historic data, national expectations and plans submitted by provider trusts.

The first draft of Southwark CCG's Operating Plan was submitted to NHS England on 8 February 2016, with further submissions made on the 2 March 2016. A final submission of the CCG's Operating Plan templates is due on the 11 April 2016, at which stage it is expected that the plan should be fully aligned with signed provider contracts.

This document summarises the templates submitted to NHS England by the CCG. It provides further descriptions of the transformation work that the CCG will undertake in 2016-17 in order to improve local services, and it addresses the '9 must do' requirements required of CCG's under the planning guidance this year.

The local planning context

NHS Southwark Clinical Commissioning Group

NHS Southwark CCG Five Year Forward View

Southwark commissioners across health and social care are committed to improving the health and wellbeing of Southwark people. The experiences of people who use services, and their families and carers, shows that existing arrangements do not always deliver the best outcomes for people, and there can be significant improvements if we work together using new approaches. Improving the system requires fundamental changes in how we all work.

Building on the national Five Year Forward View, the CCG and Southwark Council have developed a local strategy to transform local NHS and care services in the borough. Both the CCG and Council together with local stakeholders agree that we should be working toward establishing a health and care system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements.

Our local ambition is to create a much stronger emphasis on prevention and early action as well as deeper integration across health and social care, and wider council services (including education).

To support this change we will increasingly join together commissioning budgets and contracting arrangements to incentivise system-wide improvement. We will focus on specific populations, including particularly vulnerable groups. We will put ever greater emphasis on the outcomes achieved in addition to the quantity of activity delivered.

This means moving away from a system with lots of separate contracts and instead moving towards inclusive contracts for defined segments of the population which cover all of the various physical health, mental health and social care needs of people within that group. These contracts will be available to providers who can bring together the skills required to meet these needs.

Our aim is to empower the development of multi-specialty community providers serving populations of 100,000-150,000 people, with access to excellent specialist networks when required.

We are confident we can enable this scale of system-wide transformation

Southwark Council and NHS Southwark CCG have been working on this agenda for several years with partners across Southwark, Lambeth and south east London. As a result there are exciting examples that demonstrate new ways of working between providers of services and with the wider community of service users, families, carers and local residents. There is also a growing sense of system leadership and a recognition of the scale of change required across all parts of the health and social care system.

We will develop an action plan and highlight the investment necessary to deliver the ambitions set out in this local Five Year Forward View. We will publish this detailed plan in March 2016.

The local planning context

NHS Southwark Clinical Commissioning Group

Lambeth and Southwark Strategic Partnership

We have committed to developing a strong local partnership to oversee and govern system-wide transformation. Working within the mission and constitutions of the CCG and Council, we will seek to enable the realisation of our plan by establishing a strategic partnership with citizens, commissioners and providers of health and social care services. This partnership will work together to develop, practically support, and oversee a programme to transform how care is commissioned and provided. In practice this means:

- Bringing together partners with a common vision and a desire to work together
- Aligning partners´ individual strategic intents to develop a shared partnership strategy for system-wide transformation in Southwark and Lambeth, changing the way we manage risks and coordinate various activities so that they happen in concert and are mutually reinforcing and collectively identifiable as a common programme
- Supporting and resourcing changes in the practice of commissioning and the practice of service delivery, including but not limited to leadership development, stakeholder engagement and 'on the ground' help to try new ways of working
- Holding each partner to account for doing what we said we would do
- Assuring ourselves that our collective actions are improving care for our local population.

Our general expectation is that this strategic partnership will, first and foremost, practically support the development of Local Care Networks (LCNs) within Southwark. In this model, LCNs will represent both a locus of activity and of accountability, and transformation investment will be made available where LCNs can demonstrate a joint-commitment to deliver on specific priorities.

Our Healthier South East London (OHSEL)

The south east London strategy has been developed across the region by building on the common elements of CCG plans with a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together.

The south east London plans seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. The south east London plan focuses on six priority pathways: long term conditions (physical and mental health); planned care; urgent and emergency care; maternity; children and young people; and cancer. The CCG is committed to support the implementation of the south east London strategy within the borough of Southwark.

A full description of the strategy can be found here: http://www.ourhealthiersel.nhs.uk

The local planning context

NHS Southwark Clinical Commissioning Group

Children's and Young People's Health Partnership

The Children and Young People's Health Partnership (CYPHP) is a large scale initiative to improve the quality of care and physical and mental wellbeing of children and young people in Lambeth and Southwark. This programme has a true partnership approach, based on the understanding that no single organisation is able to address all the issues needed to improve the health and wellbeing of children and young people. The programme was initiated, and has been strongly led, by clinician and public health professionals. Children, young people and families have been involved in all of the work through focus groups, advisory groups and surveys. The partnership is made up of Southwark and Lambeth clinical commissioning groups and councils; the Evelina London Children's Hospital; Guy's and St Thomas' NHS Foundation Trust; King's College Hospital NHS Foundation Trust; King's College London; South London and Maudsley NHS Foundation Trust; children, young people and families from Lambeth and Southwark.

The first phase of the programme involved identifying the needs of children and young people in Lambeth and Southwark through an 18-month programme of data gathering and discussions with stakeholders. In January 2016 the CCG's Commissioning Strategy Committee endorsed the CYPHP's bid to secure funding sources for the next phase of the programme. This phase will develop and test new models of care, redesigning services to improve the treatment of acute illnesses, promoting health and wellbeing, and managing long-term conditions more effectively.

Healthy London Partnership

Early in 2015 NHS England and London's 32 Clinical Commissioning Groups (CCGs) launched a plan to make London the world's healthiest global city. This followed on from the work of the London Health Commission, which was an independent review of health established by the Mayor, Boris Johnson and led by Professor the Lord Darzi. The Commission's report *Better Health for London* contained 10 aspirations for London and over 64 recommendations on how to make London the world's healthiest city.

The NHS is currently working with partner organisations to ensure improvements are made through the London Health Board. The Board is made up of Public Health England, NHS England, 32 CCGs, London Councils and the Mayor of London.

The work of Healthy London Partnership is focused on 13 transformation programmes. Each programme aims to solve a different health and care challenge faced by the capital. All aim to make prevention of ill health and care more consistent across the city.

NHS Southwark CCG has been a contributing partner in the Healthy London Partnership. Further information about the work of the HLP is included here - https://www.myhealth.london.nhs.uk/healthy-london/about-healthy-london-partnership.

NHS
Southwark
Clinical Commissioning Group

2. Delivering the CCG's *Forward View into Action 2016-17*

Southwark Forward View into Action: contents

NHS Southwark Clinical Commissioning Group

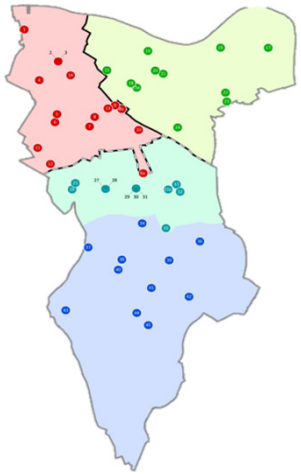
Our strategy is to maximize the value of health and care for Southwark people, ensuring our services exhibit positive attributes of care

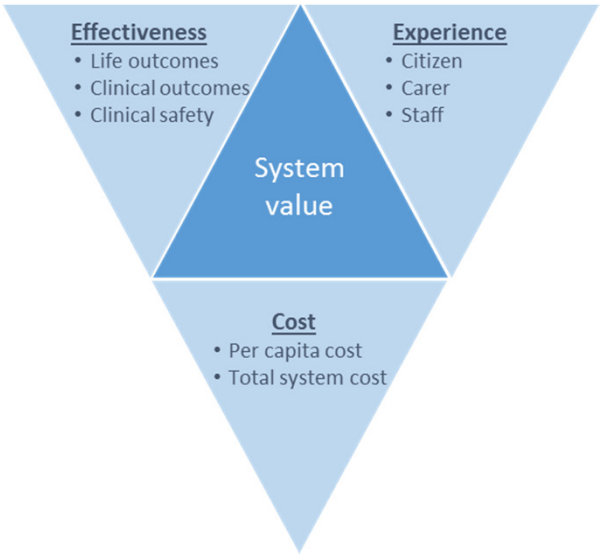
NHS Southwark Clinical Commissioning Group

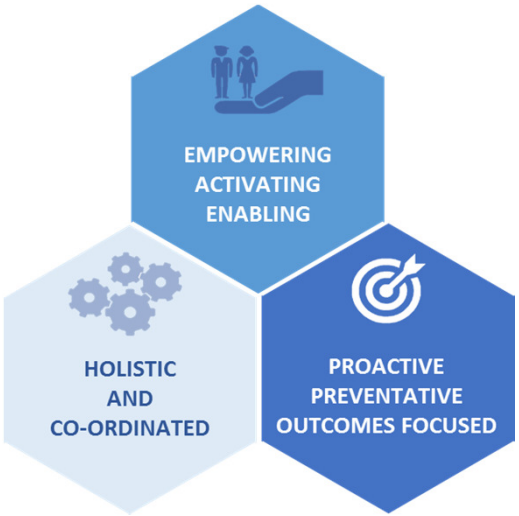
Strategic vision

We are changing the way we work and the ways that we commission services so that we:

Emphasize populations rather than providers	Focus on total system value rather than individual contract prices	Focus on the 'how' as well as the 'what'







Arranging networks of **services around geographically coherent local communities**	Moving away from lots of separate contracts and **towards population-based contracts that maximize quality outcomes** (effectiveness and experience) for the available resources	Focusing on commissioning services that are characterized by these attributes of care, **taking into account people's hierarchy of needs**

To fulfil our strategy we must address fragmentation in provision and contracting, and reverse the disempowerment of service users

NHS Southwark Clinical Commissioning Group

Strategic challenges

In order to maximize the value of health and care for Southwark people, whilst ensuring commissioned services exhibit positive attributes of care, we will need to address four root causes of complexity within the current system

1

The **fragmented contracting arrangements** can make it difficult to move resources to where they are needed to deliver what really matters to people

2

The **fragmented arrangement of organisations and professions** can reinforce boundaries and can make it too difficult to work together and to work consistently

3

The **disempowerment of service users** and carers can create confusion and risks making people passive recipients of care

4

There is not yet a strong mechanism for different agencies in the local system to align strategies and work together purposefully to implement a transformation plan

We are planning a variety of practical activities to put our strategy for change into action

NHS Southwark Clinical Commissioning Group

Strategic responses

In order to maximize the value of health and care for Southwark people, whilst ensuring commissioned services exhibit positive attributes of care, we will need to address four root causes of complexity within the current system

1 Addressing fragmented commissioning & contracting

a) Restructuring our internal programme boards

b) Creating a joint commissioning resource with the Council through the BCF

c) Creating a joint Commissioning Partnerships Team with the Council

d) Creating a formal alignment of all contracts through a system-wide shared incentive to develop and deliver coordinated care

2 Addressing fragmented organisations and professions

e) Supporting the development of multi-specialty models of service delivery through Local Care Networks

f) Supporting the development of at scale working in general practice

g) Supporting the development of new pathways and delivery models across South East London

3 Empowering residents and service users

h) Increasing the involvement of residents within the formation of commissioning intentions

i) Continuing to invest in self-management support

j) Ensuring that our commissioning requires providers to involve people in care planning and self-management

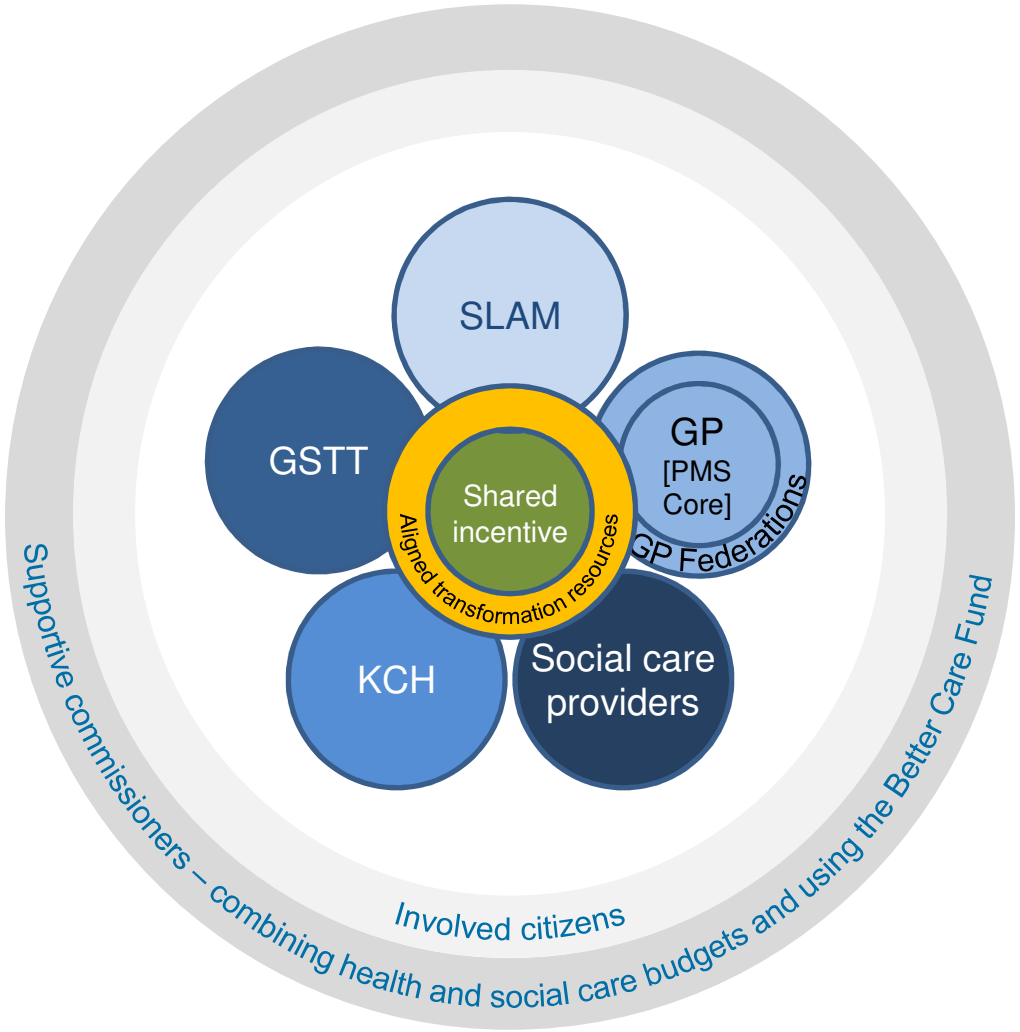
4 Establishing a local Strategic Partnership of commissioners, statutory providers and residents to ensure alignment of strategies and to coordinate and enable the delivery of our shared transformation programme

Addressing these challenges will move us towards a system which acts together to maximise the use of our shared resources

NHS Southwark Clinical Commissioning Group

Strategic responses

Overall this means working towards a future where we act as one system with one budget



Southwark Forward View into Action: contents

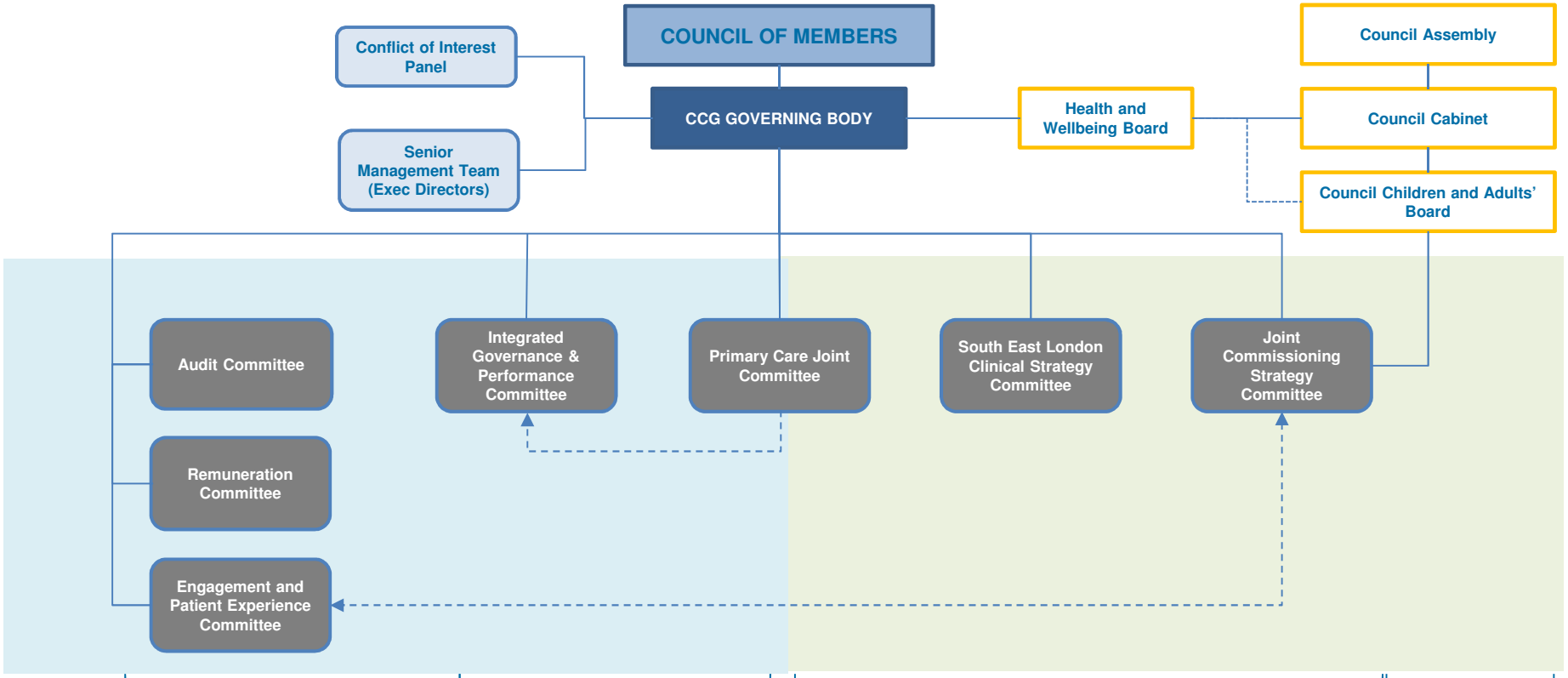
NHS Southwark Clinical Commissioning Group

To ensure we can deliver our vision we have undertaken a structured review of our internal assurance and commissioning arrangements…

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

a) Restructuring our internal programme boards



…we have made changes to support population-based commissioning and to emphasise the importance of the attributes of care

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

		Where do decisions get made and by whom?	How are ideas developed in advance of decision-making?
Understanding and assuring performance today	Are we set up properly and do we run a good organisation?	• IG&P remains the place where the CCG's overall budget is monitored and any in-year variance agreed • Audit and Remuneration committees continue unchanged • EPEC continues to provide assurance about the CCGs approach to engagement and inequalities	• Reporting into IG&P is provided by the CCG corporate teams, and additional preparation is coordinated in advance of NHSE assurance meetings • The Quality Board reporting into IG&P should change so that its focus is on all aspects of quality including safety, effectiveness and patient experience
	Do the services we contract for perform as we expect them to?	• In-year performance of all of the CCG's contracts should be reported into the IG&P, covering quality, activity and operational standards, and financial performance. This should include primary care. • IG&P should receive updates on the performance of the Better Care Fund. This would require reports to be shared back with IG&P from the H&SC Partnership Board • IG&P should receive updates on the application of any funding to federations based on business plan objectives	• Integrated performance reports should continue to be provided by the CSU to cover relevant aspects of the performance of acute and community contracts • The Health & Social Care Partnership Board should also formally report into IG&P as the nominated committee to track in-year contracting performance • A provider development programme board should be established to oversee the federation business plans and other relevant work (e.g. HLP/OHSEL provider development tasks)
Shaping services of tomorrow	Do we know where we need to focus our commissioning resources in future?	• We should continue to have a prime committee to receive proposed commissioning intentions, but this should be changed to become a joint-committee with the Council. It would not make final decisions but it would agree shared recommendations to the GB and the Council's equivalent decision-making forum. • Both the CCG and Council would wish to see Part 2 meetings to receive proposals that affect each organisation individually and in isolation from the other	• The development of commissioning intentions should happen within given timeframes set out within our commissioning cycle; this task should be undertaken by designated Commissioning Development Groups based on three population groups (CYP, adults, SMI) • CDGs should be collaborative groups led by the JCU commissioning manager, but including representation from nominated clinical leads, public health, transformation, Healthwatch, other council depts. As a consequence of this, existing partnership groups (e.g. for LTCs and EoL) should be rolled into the commissioning development groups
	Have we supported the development of providers who can respond to our future commissioning intentions?	• Most of the provider development work will be based on agreed investment plans (e.g. federation business plans or HLP programme plans). As such oversight of their delivery should be by the IG&P committee	• A Provider Development Group should be established to oversee execution of the federation business plans (and other similar plans). This should replace the Primary Care Development Board • Executive directors from this group would participate in a quarterly board-to-board meeting with each federation • Monthly operational update meetings between the transformation team and federation teams will also be arranged

We will use the Better Care Fund to invest health and social care commissioning resources in services that offer the best value

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

b) Creating a joint commissioning resource with the Council through the BCF

- In the first round of the Better Care Fund Southwark was one of only six boroughs nationally to have our plans approved without amendments
- We will continue to use the BCF as a strategic vehicle to align health and social care resources to invest in services that can support better community-based care and to reduce the demand on acute services
- In 2016/17 our BCF investment will be £21.8m. The main themes of investment will continue to be:
  - Schemes that support the timely transfer of people after acute illness, for example investment in adult social care, hospital discharge teams, intermediate care packages and home ward services (@home)
  - Schemes that support the reduction of avoidable admissions, for example through the Enhanced Rapid Response and Night Owls services
  - Schemes to strengthen multi-disciplinary working in the community to prevent crisis admissions related to mental health
- For the CCG, the oversight of the BCF will be through the Health and Social Care Partnership Board, reporting into the Integrated Governance & Performance Committee

We will formalise joint working arrangements with the Council by establishing a Commissioning Partnerships Team

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

c) Creating a joint Commissioning Partnerships Team with the Council

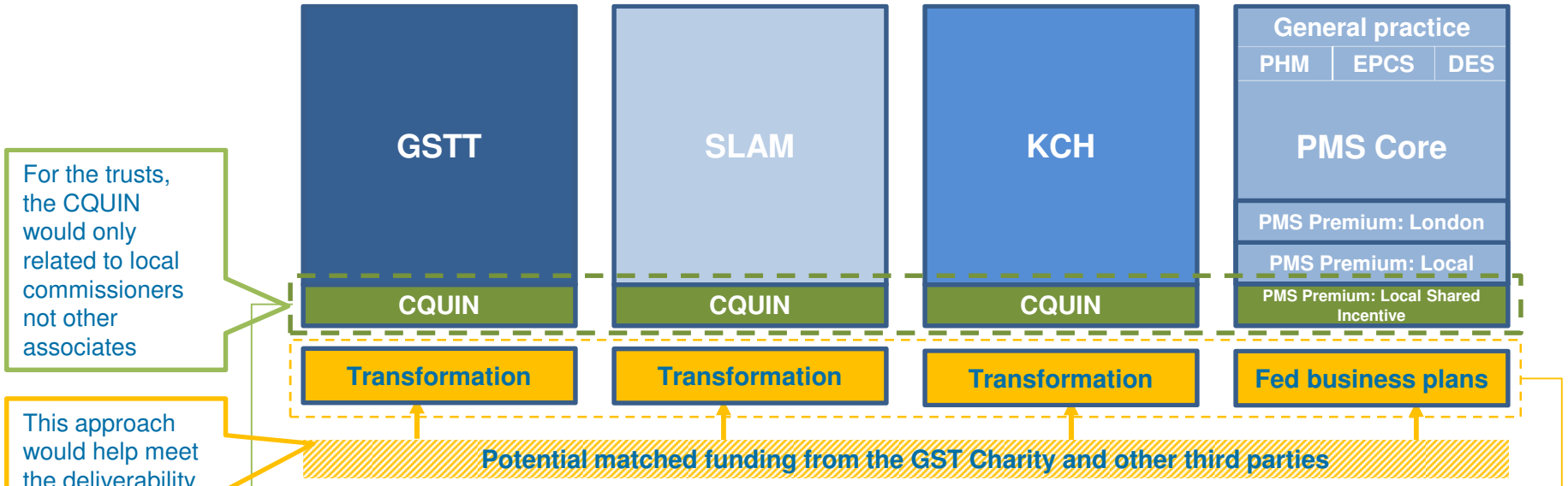
- To support the transformation described in this *Southwark Five Year Forward View*, the Council and the CCG will establish a Commissioning Partnership Team.
- Over time, and with a jointly agreed remit, this team will become the vehicle for developing and delivering joint strategic intentions across health and social care with strong links to education, public safety and public health.
- This development will help us to achieve greater equity and better outcomes for Southwark people by addressing the social as well as the physical determinants of health and wellbeing.
- The Commissioning Partnerships Team will support the pooling of resources and the alignment of decision-making so that we achieve progressively more integrated health and social care commissioning, and the development of increasingly population-based provider contracts.
- Planning for the unit is well underway, and the post of Head of Joint Commissioning will shortly be recruited to, with the Unit being formally established in Q3 2016/17. Its starting points will be commissioning for Mental Health, Older People and Children & Young People Services.
- Both the Council and CCG will retain other areas of commissioning, some of which may be included within this Joint Commissioning arrangement at a later date.
- A Joint Reference Group has been established oversee the design and delivery of the Joint Commissioning Unit to ensure that a Project Implementation Plan is initiated and followed and fully meets the responsibilities both organisations bear in relation to due diligence, formal staff consultation and all necessary governance and approvals.
- This new team will begin work in 2016/17.

In 2016/17 we will continue to contract with separate organisations but we will create clear alignment between these contracts…

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

d) Creating a formal alignment of all contracts through a system-wide shared incentive to develop and deliver coordinated care



For the trusts, the CQUIN would only related to local commissioners not other associates

This approach would help meet the deliverability tests set by the Charity to secure any additional funding

Shared incentive

- Separate contracts with each existing contract holder
- Acute contracts include an identical CQUIN component
- Primary care contracts to include a performance-based equivalent (i.e. a PMS premium payment for the implementation and use of agreed processes for care coordination and multidisciplinary working)
- Explore the use of the DES arrangements to support collective incentivisation of new models

Aligned transformation funding

- Investment of resources (money and people) is for collectively agreed priorities within contracts
- Priorities need to link directly to the wider Sustainability and Transformation Plans (STP) agreed by the SEL Strategic Planning Group (SPG)
- We would seek to access national STP funds through NHSE from 2017/18 onwards (or through mechanisms like the Primary Care Infrastructure Fund)

…a shared incentive will, in a phased transition, support multiple providers to develop and deliver an agreed model of coordinated care

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

d) Creating a formal alignment of all contracts through a system-wide shared incentive to develop and deliver coordinated care

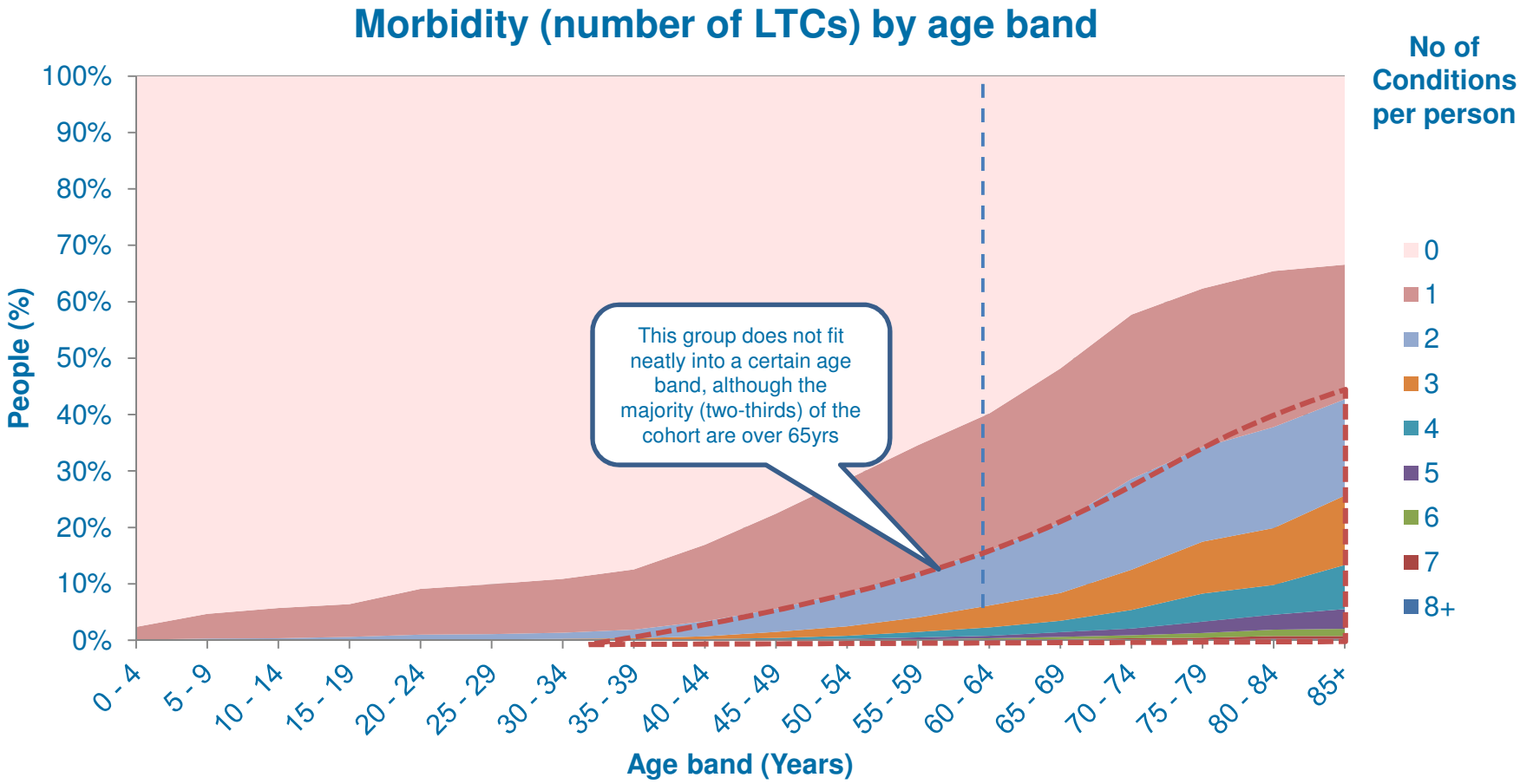
2016/17		2017/18
April-December	January-March	April-March
Payment for completion of defined project	Payment for delivering agreed processes and measurement	Payment for process with a proportion for achieving improvement in actual outcomes
Each LCN undertake a review to agree 'core operating model'. This should be set out in a business plan with an agreed approach to implement: • Case finding: specifying the finalised cohort definition • Named professional • Care planning • Self-management • Multidisciplinary working And propose an appropriate outcome measure to track	By the end of this period each partner in an LCN should be able to demonstrate that an agreed proportion (TBD) of the target cohort (defined in phase 1) are actually in receipt of the services proposed within the operating model Throughout this period each LCN should have been developing a baseline of the proposed outcome measure	In the second year the predominant focus (e.g. 90%) of the incentive would be on increasing the proportion of the target cohort in receipt of agreed services. However, a proportion of the payment (e.g. 10%) will be based upon an agreed improvement against the baseline of the proposed outcome measurement [KPI thresholds to be agreed as part of 2017/18 discussions] **Illustrative examples of outcome measures** – (for target cohort): • 5% increase in aggregate Patient Activation Scores • 5% increase in patient reported 'I' statement measure • 10% increase in time spent at home • 3-5% reduction in the number of emergency bed days (mental health and physical health); • 10-15% reduction in OP appointments

In the first instance our priority will be to support the development of coordinated care services for people with complex needs...

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

d) Creating a formal alignment of all contracts through a system-wide shared incentive to develop and deliver coordinated care



Base: People registered at practices that allow PHMCC access
Source: LTCs from acute inpatient data (11/12) & PHMCC

…we will work with clinicians to define the specific markers of complexity that will identify someone for care coordination services

NHS Southwark Clinical Commissioning Group

1 Commissioning & contracting

d) Creating a formal alignment of all contracts through a system-wide shared incentive to develop and deliver coordinated care

A joint scoping group proposed approach to identifying complexity that focuses on:

- knowing your whole population (e.g. have a shared list of all people with 3+ LTCs) as a basis to think about care gaps and opportunities for early action
- supplement analysis of the wider 3+ LTC population with routine reviews using markers of 'at-risk' residents within that population (to be defined but likely to include):

  - ❑ particular combinations of diagnoses (particularly comorbidities of physical and mental health)
  - ❑ 5+ LTCs of any sort
  - ❑ people in receipt of social care services or who have housing needs
  - ❑ people with low patient activation scores
  - ❑ systems for spotting and acting on other groups, for example
    - (i) anyone who is escalating rapidly in terms of need (e.g. signalled by a sudden increase in GP consultations, outpatient appointments, A&E attendances, or inpatient admission) and
    - (ii) anyone who requires specific follow-up actions, for example following discharge from hospital or re-ablement care (e.g. as indicated by a high Risk Score using a risk stratification algorithm).

Of the annual £8bn NHS spend on diabetes, £1.8bn is directly attributable to untreated comorbid mental health conditions

The precise approach will be co-developed with providers in the first six months of 2016/17

Southwark Forward View into Action: contents

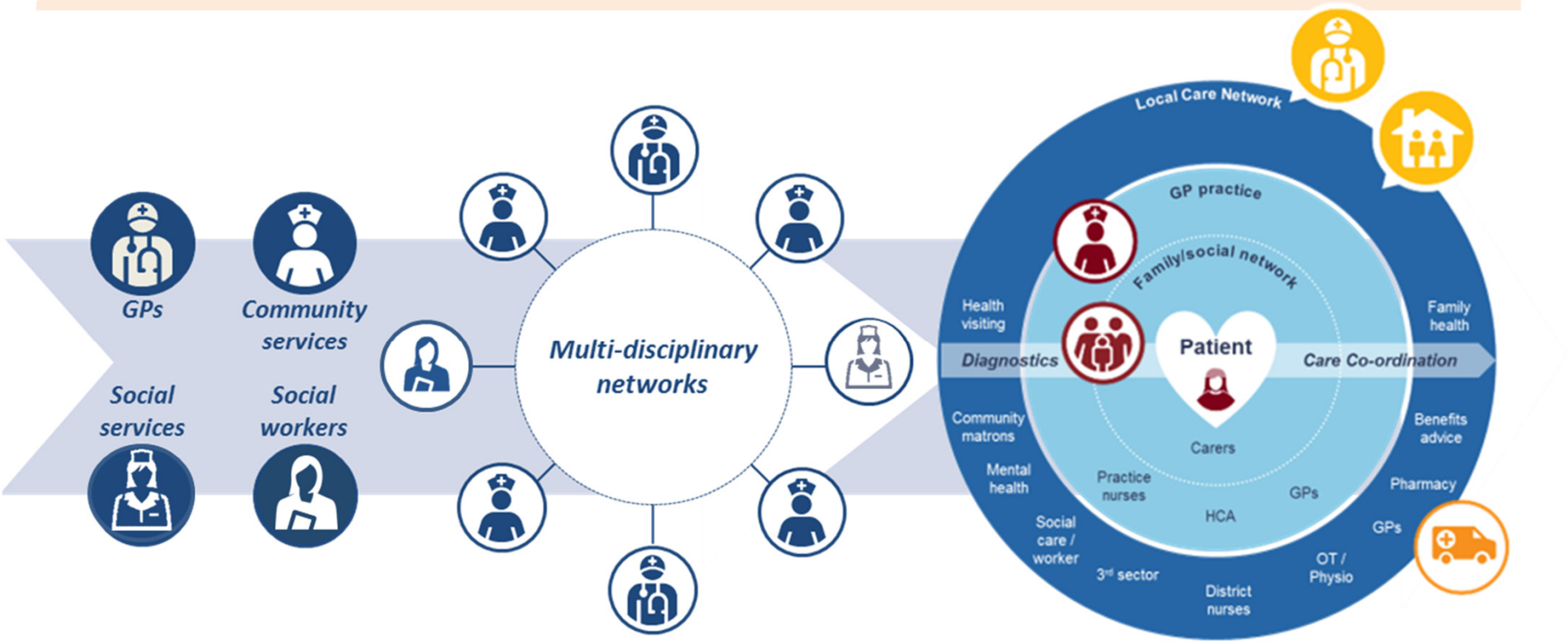
NHS Southwark Clinical Commissioning Group

We are developing better ways to work together at scale. LCNs will be multispecialty provider collaborations covering natural communities

NHS Southwark Clinical Commissioning Group

2 Organisations & professions

e) Supporting the development of multi-specialty models of service delivery through Local Care Networks



We think that Local Care Networks will only emerge if we prioritise a task that requires providers to work together, and which is in the interests of local residents and each provider organisation. Our shared system-wide incentive creates this and focuses local providers on working as part of a LCN to develop and deliver coordinated care services to people with complex needs.

A foundation of an LCN is sustainable general practice. We will invest in additional capacity and development support for local general practice

NHS Southwark Clinical Commissioning Group

2 Organisations & professions

f) Supporting the development of at scale working in general practice

- Through our Primary Care Development work with member practices we have heard from general practitioners just how hard it is to work within the existing model. Through discussion and co-development we have heard from practices that they see a route to sustainability by working together more formally within federations of practices.
- To support this new model of working within general practice the CCG has invested in the development of two new local GP federations that include all Southwark practices. Quay Health Solutions (QHS) and Improving Health Ltd (IHL) are now fully incorporated with CQC licenses.
- We will continue to invest in the federation to provide additional capacity in the system through the Extended Primary Care Service (EPCS). This £2.5m annual investment in two EPCS hubs will increase access for residents and it should free time within general practice to develop new ways of working (for example developing a standard approach to care coordination for people with complex needs).
- We will continue to work with federations and practices to develop new workforce roles, for example introducing clinical pharmacists in practice, and continuing our investment in three Population Health Management Fellows.
- We will make specific non-recurrent investment available to federations to support their practices to develop and mobilize the new care coordination service. This complements the investment already made through the Admissions Avoidance Direct Enhanced Service (DES), and in Holistic Assessments, care planning and CMDT working which is funded through our Population Health Management contracts.

At scale working in general practice can increase access for patients and also free up resources within individual practices

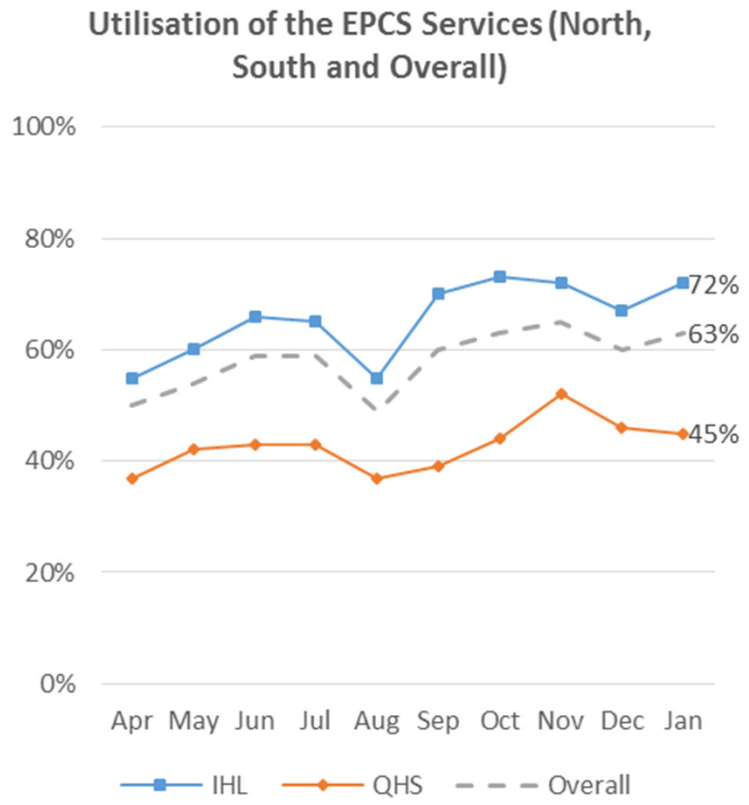
NHS Southwark Clinical Commissioning Group

2 Organisations & professions

f) Supporting the development of at scale working in general practice

Challenge Fund and 8am-8pm 7 Day Primary Care Access

- The Extended Primary Care Service (EPCS) improves access to general practice by delivering healthcare treatment and advice 8am – 8pm, 7 days a week.
- From April 2015 to January 2016, a total of 36,294 additional appointments have been offered through the two Extended Primary Care Access hubs, which operate from Bermondsey Spa Medical Centre in the north of the borough, and the Lister Primary Care Centre in the south.
- The south service is fully operational, while the north service is operating a reduced service on Mondays (12 – 8pm).
- Utilisation rates for both services have increased over the year. In January, utilisation rates for the north and south services were 45% and 72% respectively (% utilisation of appointments booked vs. offered).
- As the utilisation rates increase practices resources will be freed to focus on other tasks, for example on developing and then delivering new models of coordinated care for people with complex needs.



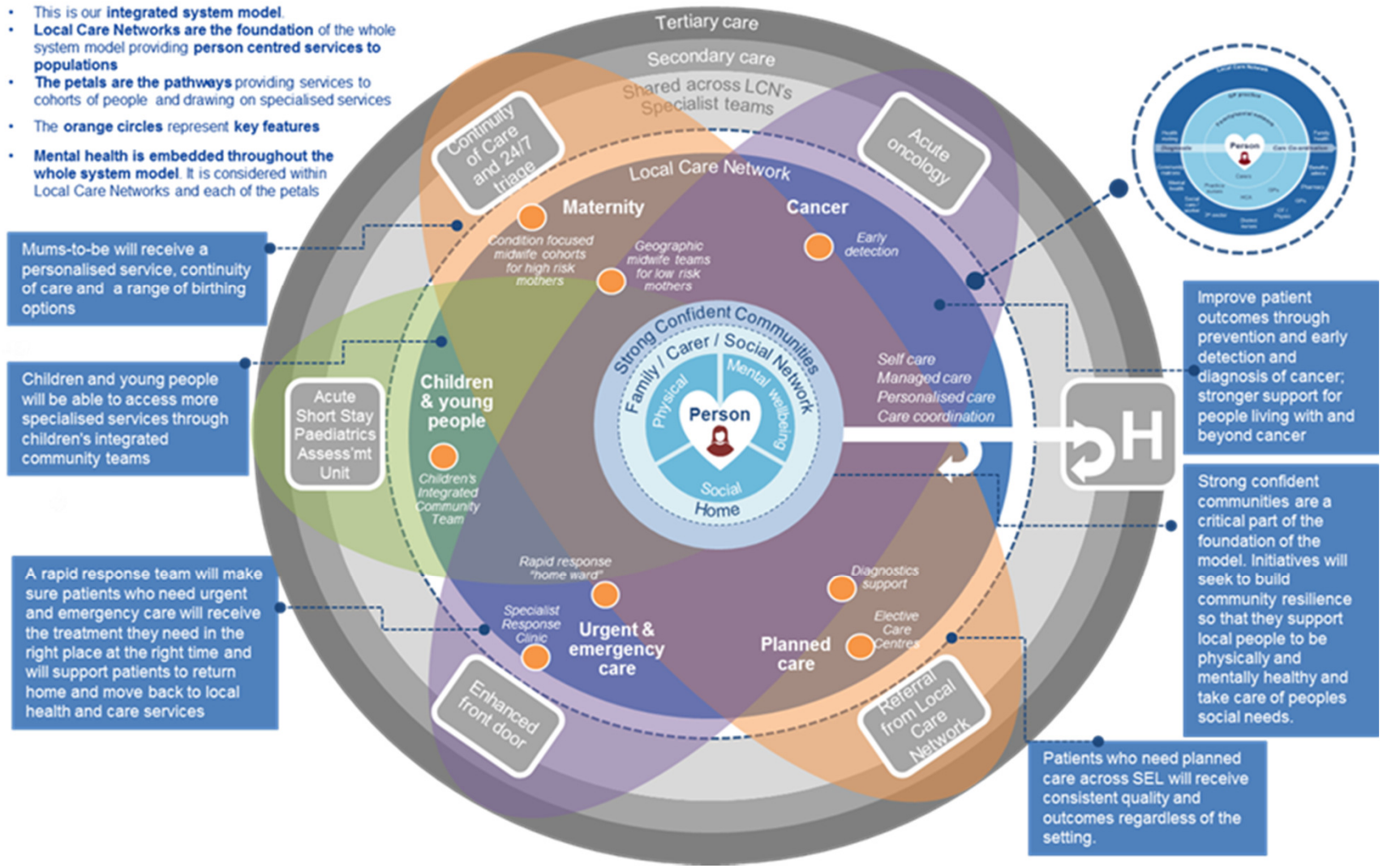
The LCNs will also need to ensure they can make best use of the improved patient pathways being developed across South East London

NHS Southwark Clinical Commissioning Group

2 Organisations & professions

g) Supporting the development of new pathways and delivery models across South East London

- This is our **integrated system model**.
- **Local Care Networks are the foundation** of the whole system model providing **person centred services to populations**
- **The petals are the pathways** providing services to cohorts of people and drawing on specialised services
- The **orange circles** represent **key features**
- **Mental health is embedded throughout the whole system model**. It is considered within Local Care Networks and each of the petals



Mums-to-be will receive a personalised service, continuity of care and a range of birthing options

Children and young people will be able to access more specialised services through children's integrated community teams

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services

Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer

Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

Southwark Forward View into Action: contents

NHS Southwark Clinical Commissioning Group

We will work to involve residents in the work of the CCG, and to commission services that work with and actively empower people

NHS Southwark Clinical Commissioning Group

3 Empowering residents & users

Empowering residents and service users

- Increasing the involvement of residents within the formation of commissioning intentions

- The introduction of Commissioning Development Groups provides a more structured approach to engaging people in the development of commissioning intentions for defined populations.
- A new engagement toolkit will help CCG teams plan engagement activities.

- Continuing to invest in self-management support and enabling personalisation

- We will continue to commission self-management support services
- We will continue to support the GP federations to pilot new models of connecting people to self-management resources and community activities
- We will use our VCS Research Challenges to understand more about how our local providers support self-management

- Ensuring that our commissioning requires providers to involve people in care planning and self-management

- Our focus on commissioning services that demonstrate positive attributes of care (for example addressing mental and physical health needs together) should support more active involvement of people in their own care.
- The development of structured care coordination services will emphasise joint care planning and user involvement

We are inviting our local residents to be an integral part of the Strategic Partnership we are establishing. This will mean participation in all aspects of the work of the partnership.

Southwark Forward View into Action: contents

NHS Southwark Clinical Commissioning Group

We need to work in partnership if we are to be successful in making the system-wide change we have described

NHS Southwark Clinical Commissioning Group

4 Strategic Partnership

Establishing a new strategic partnership of commissioners, providers and residents across Southwark and Lambeth

We began a journey towards greater integration of services and system-wide working several years ago. The SLIC programme supported us all to develop new ways of working together as organisations across Lambeth and Southwark. This has enabled us to deepen our understanding of how we can most effectively work together to improve outcomes for local people. However, it has become clear that, if we are to deliver the kind of radical system-wide transformation that is necessary to integrate care and improve system value, we will all need to commit to change in our individual organisations and as a partnership. We need to make a clear commitment to each other and the population we serve and we need to hold each other more effectively to account for delivering on our pledge. Each individual organisation will need to play its part, and invest in the development of our own staff to make lasting change.

The new Strategic Partnership represents an important transition towards a more formal, system-wide, programme-oriented and accountable way of working that will help build on the new models of care and network of relationships that have been developed through SLIC. Over the last few years we have learnt a lot about the things that need to be in place to genuinely transform the local health and social care system across Southwark and Lambeth. The Strategic Partnership we have created will provide the explicit commitment, direction and energy needed to enable change in the way we all work because:

- **Identity**: We will be clear in all of our communications that the Strategic Partnership means **us**, all of us, and not a separate programme of work. It will become a part of what we do, as commissioners and providers of care in Lambeth and Southwark. It is something that we all have to be involved in and take ownership of if it is to be a success.
- **Sovereignty**: This does not mean that partners will not continue to have their own individual identity and commitments. The Partnership is a group of sovereign organisations and decisions will, therefore, need to be approved by each individual board . This means that the commitment partners make to one another will be demonstrated in part through the alignment of our own organisational plans. It also means that partners will be able to be clearer with one another about the commitments we are not able to make. In this way our collective efforts will be invested in areas where we all agree progress can be made, and where staff have the internal organisational authority to participate.
- **Accountability**: We will make sure that where there is agreement across the partnership to work together, we have corresponding plans within each partner to mobilise our own staff (giving them time, space and a mandate to act). In this way our staff can feel ownership and clear responsibility for delivery, and remain accountable to our individual boards (as well as across the partnership).
- **Priorities**: We will set up a limited number of specific system wide programmes of work, and agree to follow them through. These commitments will, in some instances, be enshrined in our current contracts so that staff within our organisations and partners know that we are prioritising these programmes of work as part of our day jobs.
- **Sustainability**: We will ground our approach to change in Local Care Network programme boards that are led by our staff and our citizens so that people at the front line feel involved. This approach will ensure that our resources are spent on developing our workforce across Southwark and Lambeth, to develop new roles and relationships that lead to more effective services, more fulfilling and motivating careers and more sustainable change.

We have developed the outline arrangements and identified a common programme in order to establish a formal Strategic Partnership

NHS Southwark Clinical Commissioning Group

4 Strategic Partnership

Establishing a new strategic partnership of commissioners, providers and residents across Southwark and Lambeth

Working within the mission and constitutions of the CCG and Council, we will seek to enable the realization of our plans by establishing a strategic partnership with local residents, commissioners and providers of health and social care services.

The Strategic Partnership's shared vision is to increase the value of care for the people of Lambeth and Southwark by

- **improving health and wellbeing** through effective prevention at all stages of life, including strong interventions on risk factors such as alcohol, depression, smoking and obesity;
- **enabling individuals and communities** to feel well and be well, to identify their aims and needs early and respond quickly, and to enable people to manage their health, both mental and physical and taking into account important connections with other services, such as employment, housing and financial advice;
- **significantly improving people's experience of care** and ensure more consistent quality, reflecting the diversity of different groups in our population to ensure fair access, personalised care and choice; and
- **living within resources available**, which will mean addressing the fierce operational and financial pressures in the local system

The specific purpose of the partnership is to align the respective strategies of members and to provide shared strategic oversight for projects across Southwark and Lambeth that promote and enable the shared vision of integrated care for people of Southwark and Lambeth. We will achieve this by:

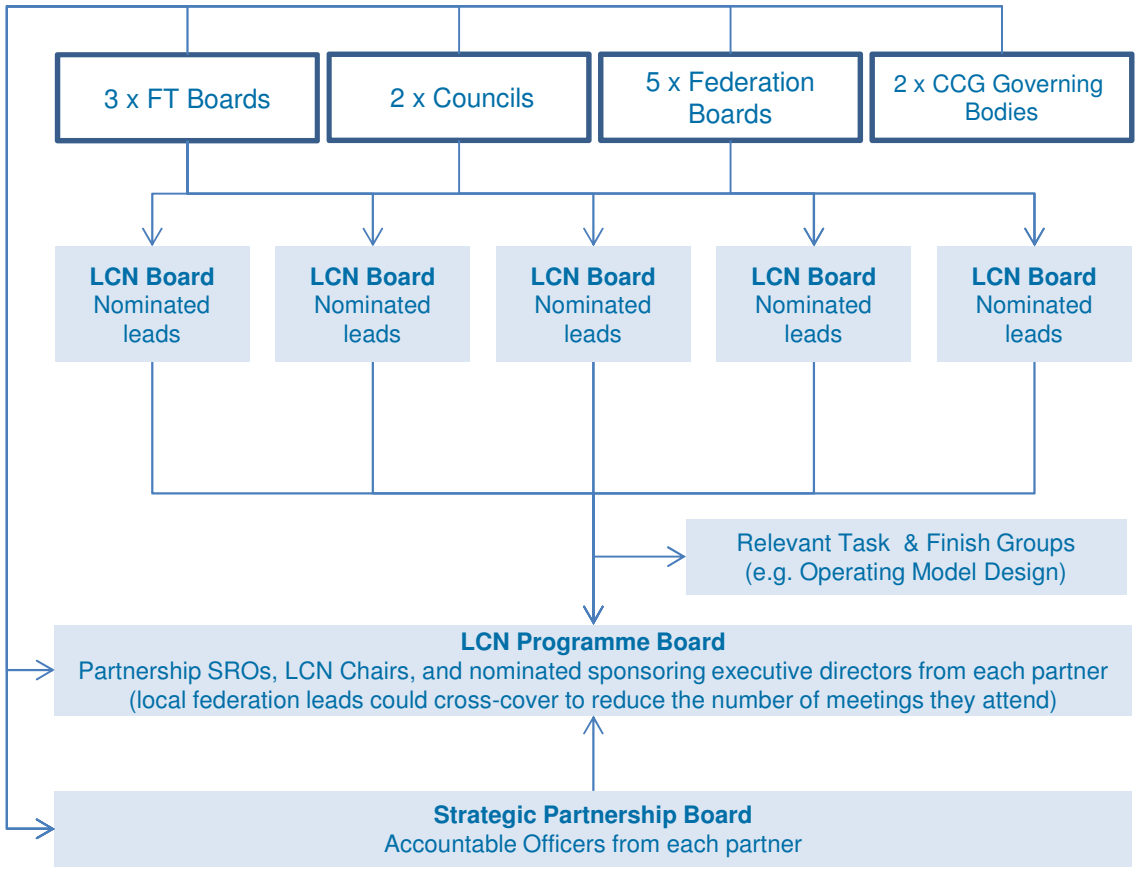
- Building a shared vision of integrated care that is focused on people and populations.
- Sharing key strategies and plans for health and social care across Southwark and Lambeth.
- Sharing strategic learning and best practice across all of our workforce, paid and unpaid.
- Ensuring we listen to the voice of people using or working in health and social care services in Southwark and Lambeth on matters of cross-borough relevance.
- Overseeing at a strategic level significant transformation projects that the strategic partners wish to include in the partnership on a voluntary basis.

The development of LCNs and coordinated care will be a major priority of the Strategic Partnership

NHS Southwark Clinical Commissioning Group

4 Strategic Partnership

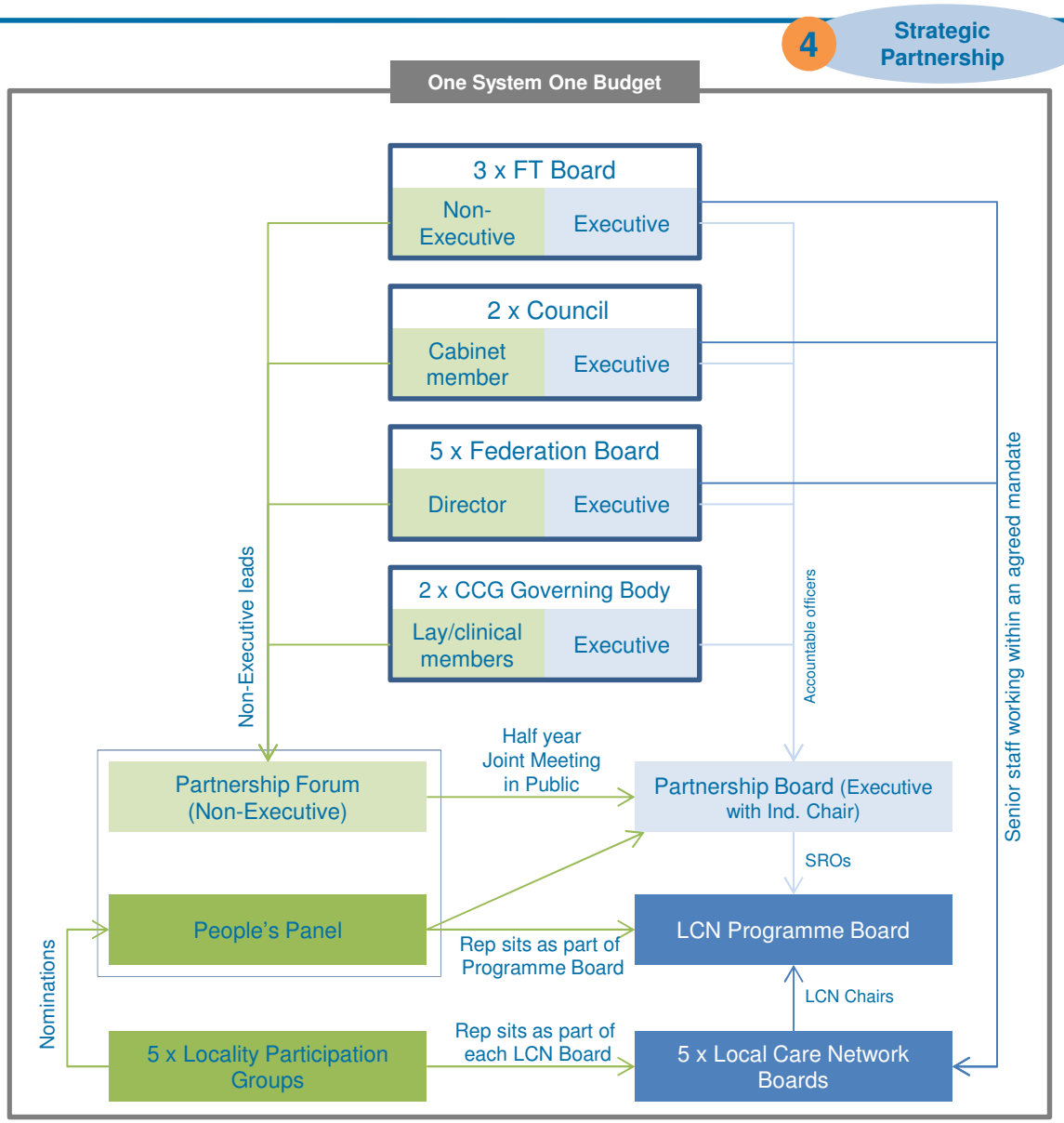
- In the Strategic Partnership organisational boards remain sovereign. Partners make clear commitments to develop and implement coordinated care, underpinned by organisational contracts that are aligned around a system-wide incentive
- Boards hold their own executive to account for fulfilment of commitments to develop LCNs. They nominate appropriate representatives to be part of a Local Care Network Board to deliver against these shared organisational commitments
- LCN Boards act as the main point of local co-ordination, planning and implementation. In addition there is the ability to run shared task & finish projects where that is agreed to be useful (e.g. to coordinate design of a shared core 'operating model')
- Through the Strategic Partnership Board our accountable officers will nominate one or two CEO-level SRO(s) to establish an LCN Programme Board. LCN Chairs and sponsoring exec directors from each organisation should attend that board to coordinate LCN activity and provide a means of escalation to resolve difficult issues



Accountability will be exercised through sovereign boards whilst enabling collaboration, transparency and citizen involvement

NHS Southwark Clinical Commissioning Group

- Partners make mutual commitments to align their strategies and policies in agreed work areas, and then coordinate and resolve issues through a Partnership Board
- Organisational boards remain sovereign. They hold their own executive to account for fulfilment of organisational strategies and commitments
- Non-executives from each sovereign organisation convene with a local 'People's Panel' who are themselves nominated from their locality participation groups to get a 'bottom up' understanding of progress, successes and challenges

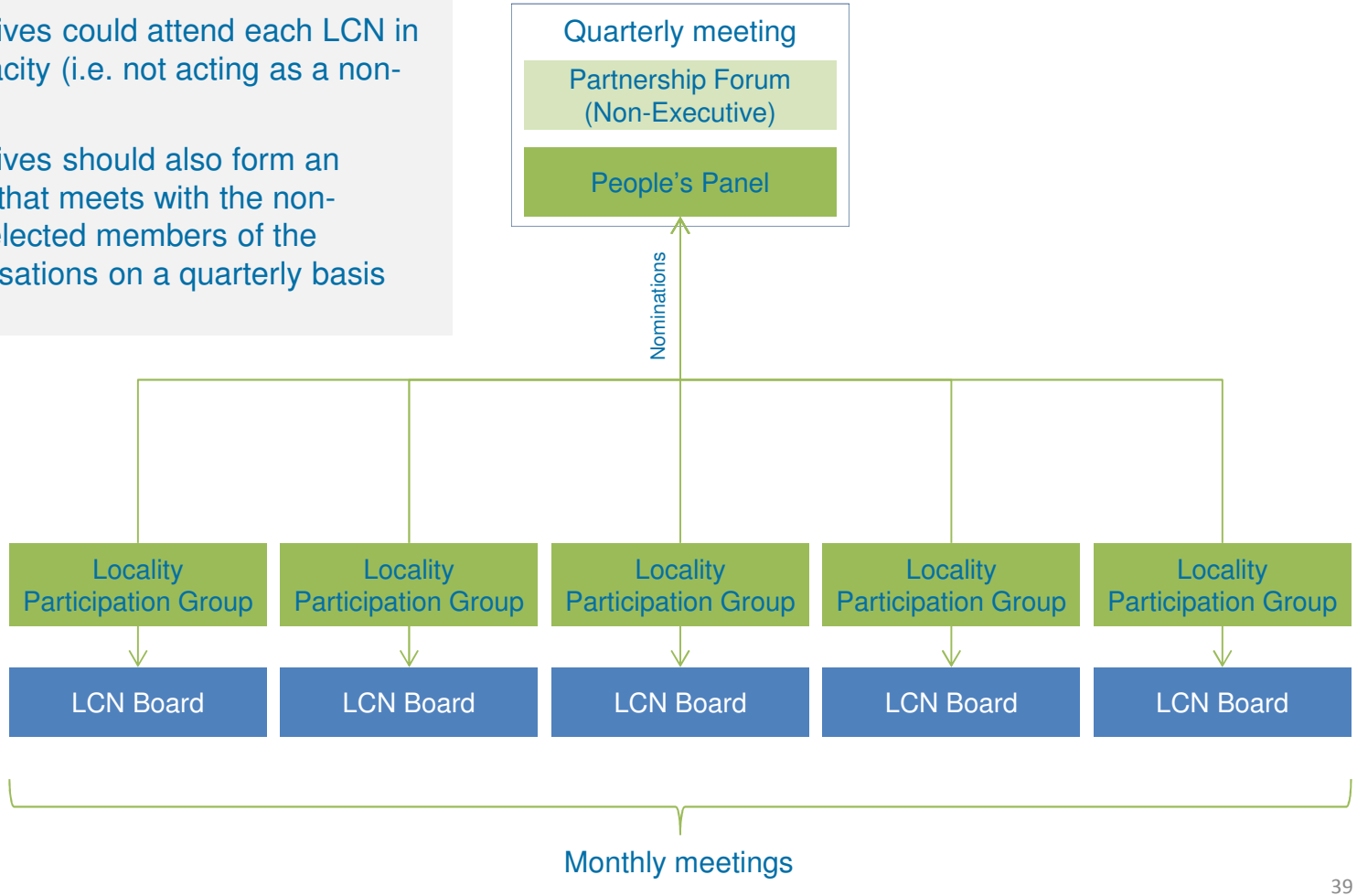


Structures will support elected representatives and non-executives to create organisational accountability, informed by citizen participation

NHS Southwark Clinical Commissioning Group

4 Strategic Partnership

- In each locality we should establish a Locality Participation Group (built around the existing PPG networks), meeting on a monthly basis.
- LPG representatives could attend each LCN in an advisory capacity (i.e. not acting as a non-executive)
- LPG representatives should also form an 'People's Panel' that meets with the non-executives and elected members of the sovereign organisations on a quarterly basis

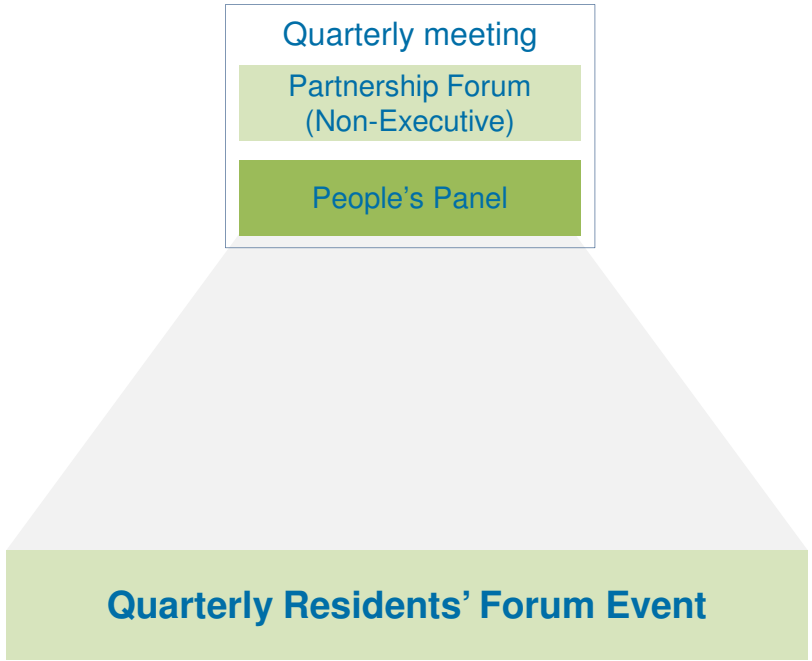


These arrangements will support the Partnership Forum and a 'People's Panel' to engage with and update a wider group of local residents

NHS Southwark Clinical Commissioning Group

4 Strategic Partnership

- Quarterly events could seek to engage the wider residents of Southwark and Lambeth, including:
  - general citizens and service users
  - the local FT membership
  - members of FT Council of Governors
  - the local ward councillors
  - CCG member practices
- This should be seen as part of the existing public engagement activities of the statutory organisations and draw resources from those teams



Developing estates and premises

NHS Southwark Clinical Commissioning Group

All CCGs have been tasked with the development of Strategic Estates Plans by the end of March 2016. This is work set in the context of the London-wide estates programme and the delivery of a south east London estates strategy, which would form part of the local Sustainability and Transformation Plan.

In Southwark this is being developed through the Southwark Strategic Estates Group, which has representation from the CCG - at both officer and clinical lead level, NHS England (London), all the local provider trusts, the GP Federations, the LMC, OHSEL, the two NHS property companies – CHP and NHS Property Services, the local authority – public health, regeneration and service delivery and HUDU.

The strategy development process is currently looking at each of the four localities in turn, reviewing the analysis of the current estate across all providers, and considering the current capacity against future need. At the end of January 2016 the group reviewed Borough and Walworth. At the next two meetings the other three localities will be reviewed.

In support of this process NHS England (London) are funding survey work in GP premises – considering two or possibly three facets of the usual six facet survey – building condition, utilisation and quality – which includes consideration of the potential for expansion and reconfiguration.

Developing estates and premises

NHS Southwark Clinical Commissioning Group

Dulwich

The Dulwich Project is a major development of a health centre on the site of the old Dulwich Hospital. This has been the subject of a detailed engagement and consultation process and is now at the design stage. This will form one of the Community Hubs referred to in the Primary and Community Care Strategy, and will be able to accommodate primary and community services, some more specialist services for people with long term conditions, some diagnostics and the reprovision of the renal dialysis unit.

The health centre development process is being overseen by the Dulwich Programme Board, which is accountable through to the Governing Body. Planning applications for both the health centre and the school which is to be located on the rest of the site are scheduled to be submitted in June 2016.

This will be a LIFT building, and as such the delivery of the new centre will be led by Community Health Partnerships. The CCG is leading on the development of the business case, and the Stage 1 case is being drafted. This will be submitted to NHS England for approval at much the same time as the planning application is submitted to the Council.

The design team has been appointed and two workshops have been held with patient and clinician users to discuss and steer the development of the inside configuration of the building. Wider public meetings to consider the early ideas on the exact location of the health centre building on its plot of land and what the outside might look like are also being planned.

Developing estates and premises

NHS Southwark Clinical Commissioning Group

Aylesbury
The regeneration of the Aylesbury Estate will not only result in a significant increase in the population, but also the demolition of Taplow House, which accommodates the Aylesbury Medical Practice and the Aylesbury Health Centre. The council are reproviding these services in an enlarged health centre building which will accommodate services for the expanded population as well as allowing a wider range of primary and community health services to be delivered.

The building is being delivered by Notting Hill Housing Trust on behalf of the council, and the future occupants (the practice and GSTT) and the CCG are members of the steering group.

Albion Street
The regeneration of the Surrey Docks area will result in 10-12,000 additional residents. The new Surrey Docks health centre was sized to be able to accommodate an additional 5000. The Albion Street Practice is working with the local council on a project which would reprovide and expand its existing services. It is in the process of working up a business case for submission to the CCG and NHS England.

Next steps

1. The completion of the Strategic Estates Plan is a priority, as this will provide the criteria and strategic direction for investment.

2. The 'significant projects' identified above already have clear cases for change, and both the Dulwich and Aylesbury projects have had Project Initiation Documents approved by the IGP and NHS England. In the case of Dulwich there have been other documents also approved.

3. The CCG is preparing to submit bids in April 2016 to the Primary Care Transformation Fund, which will be available for the next 3 years. Successful bids will need to meet the criteria set out in the guidance with an emphasis on projects which support integration and are truly transformational.

NHS
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3. Delivering the nine ‘must do’ standards in 2016/17

1: Developing a Sustainability and Transformation Plan (STP)

NHS Southwark Clinical Commissioning Group

One of the core asks included in NHS planning guidance is that organisations come together in a local area and develop a 'blueprint' for accelerating implementation of the *NHS Five Year Forward View*. Areas are required to develop a Sustainability and Transformation Plan (STP) to cover all areas of CCG and NHS England commissioned activity including: specialised services, primary medical care, better integration with local authority services, prevention and social care. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies. In Q4 of 205/16 local systems were first asked to focus on creating an overall local vision, thinking about three overarching questions:

1. How will you close the health and wellbeing gap?
2. How will you drive transformation to close the care and quality gap?
3. How will you close the finance and efficiency gap?

In January 2016 local health and care systems then made proposals on the geographic scope of their STP. 'Footprints' were to be locally defined, based on existing working relationships, patient flows and taking account of the scale needed to deliver the services, transformation and public health programmes required. The 'footprint' for Southwark is south east London, consistent with the geography for *Our Healthier South East London* (OHSEL).

South -East London CCGs and providers are well placed to develop and submit the STP plan as a result of the work that has been done to develop the *Our Healthier South East London* strategy and the governance structure and the financial modelling that supports it – see http://www.ourhealthiersel.nhs.uk/

The principle of subsidiarity that underpins the OHSEL strategy will continue. That is, the governing authority from commissioners derives from clinically-led CCGs and work is only undertaken at a south east London level where it makes more sense for patients to do so. All parties recognise that a complex health and social care system needs to operate at multiple levels, across a variety of geographies. There is recognition within the STP context of the importance of flows from other parts of London and Kent and partners across south east London will work with other STP footprints to account for this. Each of the CCGs in SEL will continue to work in partnership as a whole health and social care community with partners in social care, local government, residents, patients and other stakeholders.

The OHSEL strategy and governance processes map onto the STP and the programme's resources will be utilised to develop the STP. The development of the STP will proceed over Q1 and Q2 of 2016-17, with the CCG Commissioning Strategy Committee and Governing Body regularly appraised of progress.

2: Returning the system to financial balance in 2016-17

NHS Southwark Clinical Commissioning Group

The CCG is entering its fourth year, and faces a tough financial scenario for 2016-17 and future years. The CCG anticipates closing its accounts for 2015-16 having achieved its 1.9% surplus target, equivalent to c. £7.5m.

For 2016-17 NHS England is setting up a sustainability fund of £2.1bn, of which £1.8bn will be targeted at failing trusts who can demonstrate their plans to return to recurrent balance. Currently nearly all local trusts are in deficit, with King's being in the most severe position. The sustainability fund replaces the funding which was previously available via the Department of Health to trusts. There will be a clear process with NHS Improvement to access these funds and the CCG will work with King's to support this. The CCG endorsed the King's Five Year Recovery and Sustainability Plan.

The CCG is finalising its plans to invest more in mental health services. The *Five Year Forward View* requires CCGs to demonstrate that they are investing an amount equivalent to the growth in their allocation (3% in Southwark). This can be shown in our work on IAPT and early intervention in psychosis, and in year 2 of our redesign of Adult Mental Health services, and investment in CAMHS services. These total over £2m in 2016-17.

For the coming year we will continue to invest in improving the quality of community and primary care services, and achieve safety and quality improvements in all our contracts. We are working closely with our local GP Federations, and also in negotiating a PMS review jointly with NHS England, to deliver improved quality and consistency of services to all residents on a population basis.

We have had two Urgent Access 8am-8pm centres in operation for the past year. These are dealing with patients referred from other practices in their patch, and ensuring people get seen the same day, rather than using other parts of the health system. These are an investment of over £2.5m recurrently.

2: Returning the system to financial balance in 2016-17

NHS Southwark Clinical Commissioning Group

The CCG has had significant cost pressures to deal with in the past few years, most significantly the growth in acute activity. The current envelopes include an assumption of funds being set aside for acute growth, for 2015-16 outturn, unwinding non recurrent funding, and demographic growth, and meeting Referral to Treatment targets (RTT). The CCG has determined that it will need a net QIPP saving programme of circa £7m in the year comprising both new schemes, and the full year effect of some mental health schemes from 2015-16.

The CCG will therefore maintain a significant level of contingency and earmarked reserves. At this stage of negotiations, some of these may need to be utilised to reach better contract agreements that reduce our in year risk exposure. The outcome of this will not be known until March, when all contracts are agreed, or whether we will need to find further QIPP to mitigate these calls on reserves.

Financial balance and the delivery of the CCG's planned financial position is a core priority and a statutory requirement for NHS Southwark CCG.

The financial position is reviewed regularly by CCG's Governing Body and the Integrated Governance & Performance Committee (IG&P). The committee is accountable for: overseeing a robust organisation-wide system of financial management, including QIPP delivery; ensuring that budgets are set in an appropriate and timely manner and that the Governing Body is fully aware of any financial risks which may materialise throughout the year. The annual budget and operating plan are approved by the Council of Members in March, and they receive updates throughout the year.

he CCG has a key role as the lead commissioner of King's NHS Foundation Trust, in working with partners, and the Trust, on the delivery of their Financial Recovery Plan. This involves regular discussions and agreement of targets for the recovery plan with all parties, including NHS Improvement.

2: Returning the system to financial balance

NHS Southwark Clinical Commissioning Group

The three largest contracts for Southwark remain Guy's and St.Thomas', King's, and SLAM, which between them account for over 60% of our resources. We are working with approximate contract values at this time, and aiming to sign contracts by the national late March deadline.

Negotiations are being held regularly with all major Trusts and offers have been received from the Trusts. The CCG's have made a contract offer to mental health Trusts, and are evaluating the offers received from Guy's and King's NHS Foundation Trusts.

In addition the CCG has an important role, in signing off the internal Cost Improvement Programmes (CIPs), for the Trusts, and the commissioner led QIPP programmes as well, to ensure quality of services is not compromised by the changes made to stay within available resources. As we have a lead commissioner role for King's, we will undertake this for the whole of London CCGs, and also be part of a joint 4 CCG lead commissioner group for SLAM. Lambeth CCG will lead this work with Guy's and St.Thomas'.

We are working closely with King's, NHSE, and the NHS Improvement, to take forward the recovery plan for King's Foundation Trust.

The table sets out the high level opening budget envelopes for NHS Southwark CCG for 2016-17.

The CCG's full financial plans are set out in NHS Southwark CCG Budgetary Framework 2016-17.

Budget area	2015-16	2016-17
Acute services	209,724	219,145
Mental Health services	53,663	55,313
Community services, primary care and transformation	34,185	35,786
Primary care prescribing	32,485	34,063
Continuing Care / FNC	15,650	17,115
Better Care Fund	20,478	20,682
Corporate costs and property costs	5,838	6,193
Total Budget envelopes	372,023	388,297
Reserves and Contingencies	10,331	8,370
Total Programme Budget excluding running costs, net of QIPP savings	**382,354**	**396,667**

2: Returning the system to financial balance in 2016-17

NHS Southwark Clinical Commissioning Group

The CCG takes all reasonable steps to manage risks in order to protect the Southwark population, patients, staff and assets and to ensure appropriate protections are in place benefits realisation of appropriate risk-taking. The CCG's Governing Body sign-off a Risk Management Framework on an annual basis. The framework document describes the systems and processes in place to that enable the CCG to:

- Ensure all risks are identified and managed through a robust Board Assurance Framework and accompanying Risk Registers. These include corporate, strategic, operational, clinical, financial, information and reputational risks,
- Integrate risk management alongside quality and governance issues and established local risk reporting procedures to ensure an effective process flows throughout the CCG's activities and business,
- Ensure that the Governing Body and its delegated committees are kept care kept suitably informed of significant risks facing the organisation and associated mitigation plans.

The Governing Body is responsible for setting the strategic direction for risk and overseeing the integrated risk management arrangements across the organisation and the Integrated Governance Committee (IG&P) is responsible for the oversight of all risk and for implementing the strategic direction for risk within the organisation. The IG&P assists the Audit Committee in assuring the Governing Body in this respect.

NHS Southwark CCG has adopted the Australia/New Zealand (AS/NZS 4360/1999) standard which is internationally recognised standard providing a generic model for the identification, analysis, prioritisation, treatment, communication and monitoring of risks across clinical and non-clinical services and activities at local and corporate level.

The Board Assurance Framework consists of principal strategic and corporate risks directly affecting the corporate objectives as well as those risks escalated from CCG's Risk Register by the Governing Body, the Audit Committee, IGP or other committees. Directorate Risk Registers capture operational risks are supported by individual team/project Risk Registers. Monthly risk reports from the Directorate Risk Register and quarterly review of the Board Assurance Framework (BAF) will be presented to the Integrated Governance & Performance Committee and also the CCG's Governing Body.

The CCG Board Assurance Framework for 2016/17 will be developed ahead of April 2016 following sign-off of the CCG's Corporate Objectives and Business Plan 2016/17, which happened at the CCG's Integrated Governance & Performance Committee, 25 February 2016. The Board Assurance Framework will be published monthly on the CCG's website as part of the Governing Body meeting papers - http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/governing-body/Pages/default.aspx.

3: Develop a local plan to address the sustainability and quality of general practice.

NHS Southwark Clinical Commissioning Group

This is **described in full on slides 29 and 30** of the Operating Plan and is summarised below:

- Invested in the development of two new local GP federations that include all Southwark practices. Quay Health Solutions (QHS) and Improving Health Ltd (IHL) are now fully incorporated with CQC licenses.
- The Extended Primary Care Service (EPCS) improves access to general practice by delivering healthcare treatment and advice 8am – 8pm, 7 days a week.
- Commission additional capacity in the system through the EPCS and work with federations and practices to develop new workforce roles, (e.g. introducing clinical pharmacists in practice).
- Work with practices and King's College Hospital to increase the utilisation of EPCS capacity, freeing capacity at Denmark Hill A&E / UCC and freeing GPs to focus resource on other priority patient cohorts (e.g. proactively managing patients with multiple LTCs.
- Specific non-recurrent investment available to federations to support their practices to develop and mobilize the new care coordination service.

4: Meet standards for A&E and ambulance waits.

NHS Southwark Clinical Commissioning Group

The following pages set out the activity and performance trajectories for Southwark CCG for the year 2016/17. Plans are forecast from actual performance in 2015/16 (forecast year end) and is aligned to provider plans; the CCG's financial and QIPP plans; the Southwark BCF plan and to the contracts in place with providers for 2016/17 (subject to final agreement). Please note: current data are subject to revision and are pending final acute contract agreements.

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Number waiting > 4 hours	2255	2098	1967	1843	1538	1495	1390	1267	1297	1199	1113	1241
	Total Attendances	25056	26222	26232	26331	23663	24914	25266	25353	25940	23992	22264	24824
	% < 4 hours	91.0%	92.0%	92.5%	93.0%	93.5%	94.0%	94.5%	95.0%	95.0%	95.0%	95.0%	95.0%

The above data is for all patients attending King's College Hospital emergency department (both at Denmark Hill and PRUH sites). Southwark CCG is the co-ordinating commissioner for King's and so is required to submit this trajectory. The CCG will take action to support improved A&E performance in 2016-17 by undertaking the following actions.

- In partnership with South East London CCGs, procure an integrated urgent care service delivering high quality clinical assessment, advice, (formerly 111) and treatment (including Out of Hours GP services).
- Ensure local commissioned urgent care services are achieving the London Quality Standards and meeting to the pan-London Facilities Specifications for Urgent & Emergency Care System.
- Deliver of provider recovery plans and Southwark's Out of Hospital plan to improve performance against NHS operational standard of 95% of patients seen and discharged by A&E within 4 hours.
- Review access pathways for unscheduled care including Primary Care Access, Extended Primary Care Access, and Primary Care streaming in emergency departments.
- Re-specify Urgent Care Centre at Denmark Hill with King's College Hospital.

5: Meeting NHS Constitution standards for RTT

NHS Southwark Clinical Commissioning Group

Diagnostic waiting times		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Number waiting > 6 weeks	73	55	46	39	45	41	39	39	41	39	37	45
	Total Number waiting	4163	4163	4361	3965	4559	4163	3965	3965	4163	3965	3766	4559
	%	1.8%	1.3%	1.1%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

The performance trajectory above is for Southwark patients receiving diagnostic tests at any hospital site. The above trajectory shows achievement of 1% target from the end of June for King's College Hospital and from the end of July for GSTT. This has fed through into CCG position showing achievement from July onwards for Southwark CCG.

Incomplete pathways		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Incomplete Pathways < 18 weeks	8968	8968	9395	8541	9821	8968	8541	8541	8968	8541	8114	9821
	Total Incomplete Pathways	9747	9747	10211	9283	10675	9747	9283	9283	9747	9283	8819	10675
	%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

The above trajectory refers to the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period. It relates to Southwark CCG patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2016/17.

6: Deliver the 62 day cancer waiting standard and improve one year survival rates.

NHS Southwark Clinical Commissioning Group

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Number waiting < 2 weeks	617	617	646	587	675	617	587	587	617	587	558	675
	Total number waiting	663	663	694	631	725	663	631	631	663	631	600	725
	%	93.1%	93.1%	93.1%	93.0%	93.1%	93.1%	93.0%	93.0%	93.1%	93.0%	93.0%	93.1%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2016/17.

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Number waiting < 31 days	67	67	70	63	72	67	63	63	67	63	59	72
	Total number waiting	69	69	72	65	75	69	65	65	69	65	61	75
	%	97.1%	97.1%	97.2%	96.9%	96.0%	97.1%	96.9%	96.9%	97.1%	96.9%	96.7%	96.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2016/17.

6: Deliver the 62 day cancer waiting standard and improve one year survival rates.

NHS Southwark Clinical Commissioning Group

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 Plan	Number waiting < 62 days	28	28	29	27	31	28	27	27	28	27	26	31
	Total number waiting	34	34	35	32	37	34	32	32	34	32	31	37
	%	82.4%	82.4%	82.9%	84.4%	83.8%	82.4%	84.4%	84.4%	82.4%	84.4%	83.9%	83.8%

The CCG is working with local trusts to secure improvement in the cancer waiting times of local trusts. 85% target assumed to be met for Southwark patients by all providers for all months, apart from GSTT. For GST, the trust wide performance of 83.1% is assumed for all months in 16/17. This is inline with the local recovery trajectory and the 83.1% trajectory position at March 2016. The GSTT under-performance has meant that CCG performance is below the target in all months and is variable throughout the year.

The CCG will also take further action locally to support the delivery of trusts' improvement trajectories, The CCG will commission early diagnosis for cancer and increasing rates of screening and detection of cancer in Primary Care. Ensure that NICE guidance for 2 week wait pathways are implemented, including equitable provision of imaging and endoscopy services.

7: Achieve the two new mental health access standards

NHS Southwark Clinical Commissioning Group

IAPT - Access		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2016-17 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral	820	820	820	820
	The number of ended referrals that finish a course of treatment in the reporting period.	980	980	980	980
	%	83.7%	83.7%	83.7%	83.7%
2016-17 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral	950	950	950	950
	The number of ended referrals who finish a course of treatment in the reporting period.	980	980	980	980
	%	96.9%	96.9%	96.9%	96.9%

CCGs are required to ensure that 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. This standard applies to adults. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2016/17.

7: Achieve the two new mental health access standards

NHS Southwark Clinical Commissioning Group

IAPT		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2016-17 Plan	The number of people who receive psychological therapies	1,573	1,573	1,573	1,573
	The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	41,929	41,929	41,929	41,929
	% per quarter	3.75%	3.75%	3.75%	3.75%
2016-17 Plan	The number of people who completed treatment having attended at least two treatment contacts and are moving to recovery	300	300	300	300
	The number of people who finish treatment having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	750	750	750	750
	%	40.0%	45.2%	47.4%	50.3%

The CCG uses the results of the Psychological Morbidity Survey to estimate a prevalence of IAPT-eligible patients in the borough. We are required to commission services so that 15% of these patients access IAPT services each year. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet the access target for its patients throughout 2016/17.

The CCG has identified the recovery rate of current IAPT as high risk in 2016-17 and is planning to achieve the recovery rate target by Q4 2016/17. Commissioners and the provider (South London and Maudsley NHS Foundation Trust) reviewed the current pathway and have implemented an in-year action plan from Q3 2015-16.

The CCG completed a procurement of IAPT services this year, with the new service model being delivered from April 2016. The new service model is designed to improve recovery rates for patients by changing service access, capacity and clinical skill mix to enable: a shorter waiting time from assessment and subsequent treatments; a higher mean number of sessions per patient; a reduced attrition rate from refining referral pathways.

7: Achieve the dementia access standards

NHS Southwark Clinical Commissioning Group

Dementia diagnosis		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2016-17 Plan	Number of People diagnosed (65+)	1,170	1,170	1,170	1,170	1,170	1,170	1,170	1,170	1,170	1,170	1,170	1,170
	Estimated dementia prevalence (65+ Only (CFAS II))	1,499	1,499	1,499	1,499	1,499	1,499	1,499	1,499	1,499	1,499	1,499	1,499
	%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%	78.05%

A national dementia tool provides the CCG and each general practice member with a predicted number of people on lists estimated to have dementia. The CCG is to commission sufficient capacity from specialist providers to see that a minimum of 66.76% of those thought to have dementia are referred for diagnosis, diagnosed, and then added to their registered practice's dementia register for on-going management and care planning. Building on strong performance and significant investment made in 2014/15 and again in 2015/16, the CCG is aiming to meet this target again in 2016/17.

8: Transform care for people with learning disabilities, improving community provision.

NHS Southwark Clinical Commissioning Group

NHS Southwark CCG will continue to work with partner organisations to implement NHS England's Transforming Care Programme. This will include:

1. Minimising inappropriate admissions to inpatient services but ensuring:
    - pre-admission Care Treatment Reviews are implemented as soon as a client becomes at risk of an admission
    - Risk registers in place to identify both adults and children and young people at risk of an admission or readmission

2. Timely discharging of those patients who are clinically ready to move from an inpatient setting, achieved by ensuring:
    - Robust case management
    - 2 weekly reviews and reporting of all inpatients
    - Care Treatment Reviews for all inpatients within 2 weeks of admission and monitoring of resulting action plans

3. NHS England's recent publication 'Building Better Support' sets out three key changes to support the shift to from inpatient to community based care:
    - local councils and NHS bodies will join together to deliver better and more co-ordinated services
    - budgets will be shared between the NHS and local councils to ensure the right care is provided in the right place
    - National guidelines will set out what support people and families can expect, wherever they live.

4. NHS Southwark CCG will continue to work with CCGs and local authorities across south east London to develop its Transforming Care Partnership programme which will include:
    a. setting up joint commissioning arrangements, to enable commissioning and planning of services for people with complex LD/ autism across South East London
    b. working with local areas to develop community-based support
    c. working with providers of inpatient services to improve the quality of those services, including training and support for the workforce
    d. working with health justice and criminal justice systems to ensure that their workforce has a better understanding of LD/ autism and that appropriate services are commissioned for people with LD/ autism who are involved with the criminal justice system.

9: Implement an affordable plan to improve quality

NHS Southwark Clinical Commissioning Group

CCGs have a statutory duty to deliver safe, effective services for its residents. One of the ways Southwark CCG will ensure this happens is via a comprehensive quality work plan, with oversight from the CCG's Quality and Safety sub-Committee, and an allocated Governing Body Clinical Lead for quality.

To assure quality the CCG will continue to meet monthly with the medical and nursing directors, and senior teams at each provider to review the quality of care delivered in the services we have contracted. This will be supported by information from the programme of clinical site visits we run to improve knowledge of services, better understand patient experience and safety aspects of care, and from tracking quality alerts received from practices. The information from all areas is used to liaise with providers and achieve sustainable systemic change. The CCG also agrees quality priorities with each provider Trust via Quality Accounts.

Time-limited projects

In addition to its annual responsibilities the CCG will lead some quality projects which are time-limited. This includes implementing initiatives such as "Ban the Fax" to improve the reliability of data flows between hospitals and GP practices and consequently the patient's safety and experience, holding providers to account for delivery of their CQC Action Plans (resulting from CQC visits in 2015), identifying and contributing to thematic reviews on safety topics such as maternal deaths, misplaced naso-gastric tubes, and supporting GP practices to prepare for and improve following CQC inspections in order to gain assurance that the practice is safe, effective, caring and well-led

The CCG also plans to deliver "Achievement" status of the Mayor of London's Healthy Workplace Charter for its own staff, based on the premise that the organisation must promote health and well-being for its employees to enable them to deliver for patients and residents.

New areas of work

In early 2016/17 Southwark CCG will host a Quality Summit for stakeholders and patients in Lambeth and Southwark, jointly with Lambeth CCG and Healthwatch, focused on improving discharge experiences for patients.

Linked to and following this, Southwark CCG will also launch a new clinical network to advise and inform future CCG plans. The network will provide better connection for clinicians working on CCG projects, important to our aspiration of distributed leadership, and of extending clinical leadership beyond the Governing Body.

Agenda Item 8

Item No. 8.	Classification:	Date: 31 March 2016	Meeting Name: Health and Wellbeing Board
Report title:		Lambeth & Southwark Pandemic Flu Coordination Plan	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested:

   a) To agree the draft Lambeth & Southwark Pandemic Flu Plan (Appendix 1).

   b) To note that a multi agency Pandemic Flu Exercise was held in February 2016 to resilience assure the Pandemic Flu plan

   c) To note the multi agency roles and implications for the key local partners.

EXECUTIVE SUMMARY

2. Influenza (flu) is an acute viral illness that spreads rapidly from person to person when in close contact. Seasonal flu occurs every year, usually in the winter months, but a flu pandemic occurs when a new or re-emerging flu virus emerges which is:

   - markedly different from recently circulating seasonal strains,
   - able to infect people,
   - readily transmissible from person to person,
   - capable of causing illness in a high proportion of those infected, and
   - spreads widely because there is little natural immunity to it.

3. Pandemic flu is at the top of the UK National Risk register and one will occur at some point in the future. Until the event occurs the impact is unknown, so plans need to be flexible to address the breadth of possible scenarios.

4. The Lambeth & Southwark Pandemic Flu Coordination Plan outlines the local response to a pandemic; including actions to be taken and how the pandemic will be coordinated in the CCG and Southwark Council. It also provides an overview of the responsibilities of other key agencies.

5. During a pandemic NHS and Southwark Council commissioning and provider organisations will maintain their existing roles and responsibilities for the management of the local health and social care system. However, some pandemic specific activities and plans will also be required as the NHS and Southwark Council are likely to be particularly impacted due to an increase in demand for services coupled with a potential reduction in staffing and possible

supply chain disruptions.

6. The plan describes how the local coordination of the pandemic will be managed by Southwark Council by convening a Pandemic Coordination Group, under the leadership of the Director of Public Health.

7. A table top exercise to test local arrangements was held in February 2016 and involved representation from the CCGs, Southwark Council, Lambeth Council, SE London Surge Hub, PHE, NHSE and Kings. The overall aim of the exercise was to explore the coordination of and local response to an influenza pandemic, and had the following objectives:

- To exercise the Lambeth & Southwark Pandemic Flu Coordination Plan
- To understand command and control and coordination arrangements locally
- To clarify roles and responsibilities of CCGs, Southwark Council, Lambeth Council and partners at each stage of a pandemic
- To understand information and communication flows
- To educate participants about pandemic flu and national and London arrangements
- To consider business continuity arrangements

8. Participants at the exercise were keen to see the joint work between Lambeth and Southwark continue. The learning that arose from the exercise is being incorporated into the amended plan.

Policy implications

9. Department of Health guidance[1][2] recommends that multi-agency plans, covering the NHS, public health and social care need to be in place in each local health economy. The Lambeth & Southwark Flu Coordination Plan ensures we are compliant with recommendations from this guidance and other associated publications[3].

10. The Plan provides a framework for the CCGs and local authorities to use during a flu pandemic and complements plans and guidance developed by the acute trusts, PHE and NHSE.

Community impact statement

11. The Lambeth and Southwark Pandemic Coordination Plan provides a local framework to be followed to mitigate the effects of a pandemic on the public, staff and oorganisations in Lambeth and Southwark. It includes a section about vulnerable people and how we might access information to ensure we try and help those less able to help themselves during a pandemic.

Legal implications

12. The Civil Contingencies Act 2004 (the Act) places a series of duties on local bodies (known as Category 1 responders) to assess the risk of an emergency

[1] Health and Social Care Influenza Pandemic Preparedness and Response, Department of Health 2012
[2] UK Influenza Pandemic Preparedness Strategy 2011, Department of Health
[3] Preparing for Pandemic Influenza: Guidance for local planners, Cabinet Office, 2013

occurring and to maintain plans for the purpose of responding to an emergency. Local authorities are Category 1 responders. It also imposes duties on Category 2 responders (which includes CCGs) to provide information to and cooperate with other organisations during an emergency.

13. The Lambeth and Southwark Pandemic Flu Coordination Plan supports local compliance with the Act.

Financial implications

14. There are no financial implications contained within this report. However, in the event of a pandemic occurring, contingency funds may have to be found to cover any pandemic specific activities that need to be undertaken.

BACKGROUND PAPERS

Background papers	Held at	Contact
None		

APPENDICES

No.	Title
Appendix 1	Draft Lambeth & Southwark Pandemic Flu Plan

AUDIT TRAIL

Lead Officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Author	Sarah Robinson, Health Protection Manager	
Version	Final	
Dated	18 March 2016	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		18 March 2016

APPENDIX 1

Working together for the public's health

Lambeth

Southwark Council

NHS Lambeth Clinical Commissioning Group

NHS Southwark Clinical Commissioning Group

Pandemic Flu Coordination Plan

Lambeth & Southwark

Health & Wellbeing Board Draft (March 2016)
v1.0

Document approval and review process

The following groups and individuals have been consulted on during the development of this plan:

- Lambeth Borough Resilience Forum
- Southwark Borough Resilience Forum
- Director of Governance & Development, NHS Lambeth CCG
- Chief Officer, NHS Lambeth CCG
- Assistant Director Governance and Quality, NHS Lambeth CCG
- Interim Urgent Care Project/Service Transformation Lead, NHS Lambeth CCG
- Chief Financial Officer, NHS Southwark CCG
- NHS Southwark Senior Management Team
- Head of Primary, Community & Children's Commissioning, NHS Southwark CCG
- Chief Pharmacist, NHS Lambeth CCG
- Pandemic Influenza Resilience Manager, NHS England (London)
- NHS England (London)
- SE London Health Protection Team, PHE
- Director of Public Health, Lambeth and Southwark
- Consultant in Health Protection, Lambeth and Southwark
- Infection Prevention and Control Advisor, Lambeth & Southwark

Plan Author	Sarah Robinson, Lambeth & Southwark Public Health	
Approved by	Lambeth Borough Resilience Forum	Southwark Resilience Forum Health & Wellbeing Board
Date approved		March / April 2016 - tbc
Issue date		
Next review date		

CONTENTS

SECTION A: BACKGROUND

1. INTRODUCTION

New influenza (flu) subtypes emerge with unpredictable frequency and can result in a new pandemic strain that will spread rapidly throughout the world, affecting large numbers of the population with little or no immunity. However, until the event occurs, the impact, expressed as the severity of the illness and proportion of the population that will be most severely affected, will be unknown. As a guide, the impact could range from a 1918-type pandemic, where there was significant morbidity and mortality in young adults, to a 2009 pandemic, where the illness was mild in most groups of the population. Given the uncertainty and the potential impact of such an event on the UK, pandemic influenza has been classified by the Cabinet Office as the number one threat to the UK population.

Given the unpredictable nature and the potential severity of pandemic influenza, it is important that any response is flexible and proportionate. It is also important that our response builds on currently developed business continuity arrangements, while addressing the specific issues that might emerge during the pandemic. Lessons identified during the response to the 2009/10 flu pandemic caused by the A(H1N1) virus ('swine flu') and subsequent 2010/11 winter seasonal flu outbreak have informed ongoing preparedness activity.

In the event of a pandemic the Director of Public Health will coordinate the local response in Lambeth and Southwark via the Pandemic Coordination Group (PCG). NHS and local government commissioning and provider organisations will maintain their existing roles and responsibilities for the management of the local health and social care system. However, some pandemic specific activities and plans will also be required. Essential to all local plans are:

- A **sustainable community based response** – with effective arrangements for providing initial assessment, access to antiviral medicines and vaccines, treatment of complications, home care and access to hospital care;
- An **integrated approach to planning and response** that effectively employs all of the health and social care services in a local area, using flexible working across agencies;
- **Clear and comprehensive arrangements for admission, discharge and transfer** between appropriate levels of health and social care, based on established ethical frameworks to assist in managing local demand;
- **Effective monitoring and communications systems**;
- **Effective management of the increases in demand**, including a graded approach allowing local response to be proportionate to the severity of the pandemic and the continuation of essential non-flu care;
- **Psychosocial support** for all staff and patients/clients.

This plan outlines the response to the pandemic in Lambeth and Southwark including how the pandemic will be managed and coordinated in the CCGs and local authorities. It also provides an overview of the responsibilities of other key agencies and, as such, offers a broad overview of all aspects of response.

The principles, systems and processes contained within this plan are transferable to other types of pandemic.

2. WHAT IS INFLUENZA

Influenza is an acute, infectious viral illness that spreads rapidly from person to person when in close contact. It is characterised by a sudden onset of fever, chills, headache, muscle pain and usually cough with or without a sore throat – or other respiratory symptoms. These symptoms generally last for about a week, although a full recovery could take longer.

There are three broad types of influenza virus – A, B and C. It is influenza A that causes most winter epidemics and all pandemics and affect a whole range of animal species as well as humans. Influenza A has a marked propensity towards adaptation and change and this is what enables them to remain in circulation in slightly different forms, resulting in the virus having different impacts.

A flu pandemic occurs when a new or re-emerging influenza A virus emerges which is:

- Markedly different from recently circulating strains,
- Able to infect people,
- Readily transmissible from person to person,
- Capable of causing illness in a high proportion of those infected,
- Spreads widely because few, if any, people have natural or acquired immunity to it.

3. AIM OF THE PLAN

The aim of this plan is to provide operational guidance for a flu pandemic and to outline the roles and responsibilities of Lambeth and Southwark local authorities, CCGs and other key agencies and how the local response will be coordinated by the Director of Public Health.

The overall objectives of the UK's approach to planning and preparing for a flu pandemic[1] are to:

- **Minimise the potential health impact by:**
    - Supporting efforts to detect its emergence and early assessment by sharing scientific information.
    - Promoting individual responsibility to reduce the spread of infection through good hygiene practices and uptake of seasonal flu vaccine
    - Ensuring the health and social care systems are ready to provider treatment and support for the large number likely to be affected, while maintaining essential care.
- **Minimise the potential impact on society and the economy by:**
    - Supporting the continuity of essential services, including the supply of medicines and protecting critical national infrastructure.
    - Supporting the continuation of everyday activities.
    - Upholding the law and democratic process.
    - Preparing to cope with significant numbers of additional deaths.
    - Promoting a return to normality and the restoration of disrupted services.
- **Instil and maintain trust and confidence by:**
    - Ensuring health and other professionals, the public and media are engaged and well informed in advance of and throughout the pandemic and that professionals receive information and guidance in a timely way so they can respond appropriately.

[1] Department of Health. UK Influenza Pandemic Preparedness Strategy 2011

4. ASSOCIATED DOCUMENTS

Pandemic plans should be based on existing systems and processes as far as possible. Routine processes, including those for managing seasonal flu outbreaks each year, and business continuity plans for responding to other pressures, such as winter illness or major incidents such as flooding are well established, tried and tested. Building on these familiar procedures provides a robust foundation for responding to fluctuation in demand for capacity that may occur in a flu pandemic.

This plan has been developed using, and therefore should be considered in conjunction with, the following documents and guidance:

Internal (CCG or local authority)	External
CCG Business Continuity Plans	NHSE Operational Guidance
Council Business Continuity Plans	PHE Pandemic Flu Response Plan
L&S Pressure Surge Management Plan	DH 2012. Health and Social Care Influenza Pandemic Preparedness and Response
Council Emergency Plans	NHS England (London) Operational Guidance Jun 14
SEL CCG Director On call handbook and supporting documents	Cabinet Office Preparing for Pandemic Influenza. Guidance for local planners. July 2013
	UK Pandemic Communications Strategy 2012
	London Resilience Partnership. Pandemic Influenza Framework. Feb 2014
	UK Influenza Pandemic Preparedness Strategy 2011
	DH 2011. Scientific Summary of Pandemic Influenza and its mitigation

5. ACTIVATION OF THE PLAN

This plan will be activated on declaration of the Detect Stage by the Department of Health or Public health England. At this point the Lambeth & Southwark Pandemic Coordination Group will have been convened by the Director of Public Health to lead the response locally, and existing plans and processes will be reviewed.

Notification of a pandemic

The Department of Health (DH) will inform the Cabinet Office and PHE should the WHO declare a pandemic or if there is a significant change in the threat assessment. The Cabinet Office will alert other government departments and work with the DH to develop, update and circulate top line briefings via the News Coordination Centre. The DH will also alert health and social care organisations and professionals. The Department of Communities and Local Government (DCLG) will alert Local Resilience Fora (LRF) and LRFs will, in turn, cascade information to their members.

6. PLANNING ASSUMPTIONS

Influenza pandemic planning in the UK has been based on an assessment of the 'reasonable worst case' derived from experience and a mathematical analysis of seasonal influenza and previous pandemics.
This suggests that up to 50% of the population could experience symptoms of pandemic influenza during one or more pandemic waves lasting 15 weeks, although the nature and severity of the symptoms would vary from person to person.

Analysis of previous influenza pandemics suggests that we should plan for up to 2.5% of those with symptoms dying as a result of influenza, assuming no effective treatment was available. The *UK Influenza Pandemic Preparedness Strategy 2011* recognises that the combination of particularly high attack rates and a severe disease is also improbable, and consequently suggests planning for a lower level of population mortality is sensible. Therefore plans should be flexible and scalable for a range of impacts. While the profile of the next pandemic remains by its very nature unknown, it is prudent to continue to plan and prepare using modelling assumptions based on experiences of previous pandemics.

Although all parts of society will be affected by a pandemic, the NHS is likely to be particularly impacted due to an increase in demand for services from patients coupled with a potential reduction in staffing (due to a variety of factors including personal illness and caring responsibilities) and possible supply chain disruptions.

Planning at all levels needs to be comprehensive and flexible to address the breadth of possible scenarios. A proportional, graded response that can be adjusted as the threat alters, including cessation or commencement of certain functions, is required.

7. IMPACT IN LAMBETH & SOUTHWARK

The table shows the possible impact of a pandemic with Lambeth and Southwark, assuming a 50% attack rate and at varying levels of severity of disease. These assumptions are taken from the Department of Health UK Influenza Pandemic Preparedness Strategy 2011.

	Lambeth	**Southwark**
Resident population (2011 Census)*	303,300	288,300
Possible no. of symptomatic patients over first wave (50%)	151,650	144,150
Patients requiring assessment and treatment in usual pathways of primary care (30% of symptomatic)	45,495	43,245
Possible number requiring hospital care (4% of symptomatic)	6066	5766
Number of excess deaths (0.5% of symptomatic)	758	721
Number of excess deaths (1.5% of symptomatic)	2275	2162
Number of excess deaths (2.5% of symptomatic)	3791	3604
Up to 50% of the workforce may require some time off during the entire period of the pandemic, up to 20% on any given day		

** For CCGs, registered population may be more relevant. As at June 2014, Lambeth registered population was 372,709; Southwark 305,073.*

To assist local planners in their planning and preparations for an influenza pandemic central government has developed a tool to facilitate the application of National Planning assumptions to the local setting:
https://www.gov.uk/government/publications/pandemic-flu-national-planning-assumptions-assessments-tool

Staff absence
Up to 50% of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35-50% of the population, this could be even higher as some with caring responsibilities will need additional time off.
Staff absence should follow the pandemic profile. In a pandemic affecting 50% of the population, between 15 and 20% of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline.

Some small organisational units (5-15 staff) or small teams within larger units where staff work in close proximity are likely to suffer higher percentages of staff absences. In a widespread and severe pandemic, 30-35% of staff in small organisations may be absent on any given day.

Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools and nurseries closing, family bereavement, practical difficulties in getting to work and other psychological impacts.

8. NATIONAL STRATEGY

The *UK Influenza Pandemic Preparedness Strategy 2011* built upon lessons identified during the 2009 pandemic and 2010/11 winter season. This section summarises key aspects of the 2011 Strategy and includes references to a range of activities that will be undertaken by various health partners, including PHE, NHS England, providers of NHS funded care and other health and multi-agency partners.

The strategy recognises that the World Health Organization (WHO) pandemic alert phases were not ideally suited as a response framework within individual countries. In 2009, the UK was well into its first wave of infection by the time WHO declared the official start of the pandemic. The use of WHO phases as a trigger for the different stages of local response, as detailed in the 2007 National Framework, proved to be challenging and were ultimately confusing for the public as did categorisation of UK Alert Levels which were not used.

The 2011 UK Strategy recognised that a more flexible approach is required for pandemic preparedness and response. In June 2013, WHO revised its own pandemic preparedness arrangements and published interim guidance on pandemic influenza risk management that is also more flexible than previous guidance and reflects a continuum of influenza activity.

The overall objectives of the UK's approach to preparing for an influenza pandemic are to:
- minimise the potential health impact of a future influenza pandemic
- minimise the potential impact of a pandemic on society and the economy
- instil and maintain trust and confidence

Towards this, the Strategy identifies a series of stages, referred to as '**DATER':**
Detection, Assessment, Treatment, Escalation and **Recovery.** These stages are non-linear and have identified indicators for moving between them. The stages are not numbered as they are non-linear and may not follow in strict order; it is also possible to move back and forth or jump stages. It should also be recognised that there may not be clear delineation between stages, particularly when considering regional variation and comparisons.

Given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity:

Precautionary: the response to any new virus should take into account the risk that it could be severe in nature
Proportionality: the response to a pandemic should be no more and no less than that necessary in relation to the known risks
Flexibility: there should be a consistent, UK-wide approach to the response to a new pandemic but with local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection and the different healthcare systems in the four countries

The Strategy further elaborates on the proportionate aspect of the response by describing the nature and scale of illness in low, moderate and high impact scenarios, and further attributes potential healthcare and wider societal actions as well as key public messages.

SECTION B: COORDINATION OF THE RESPONSE

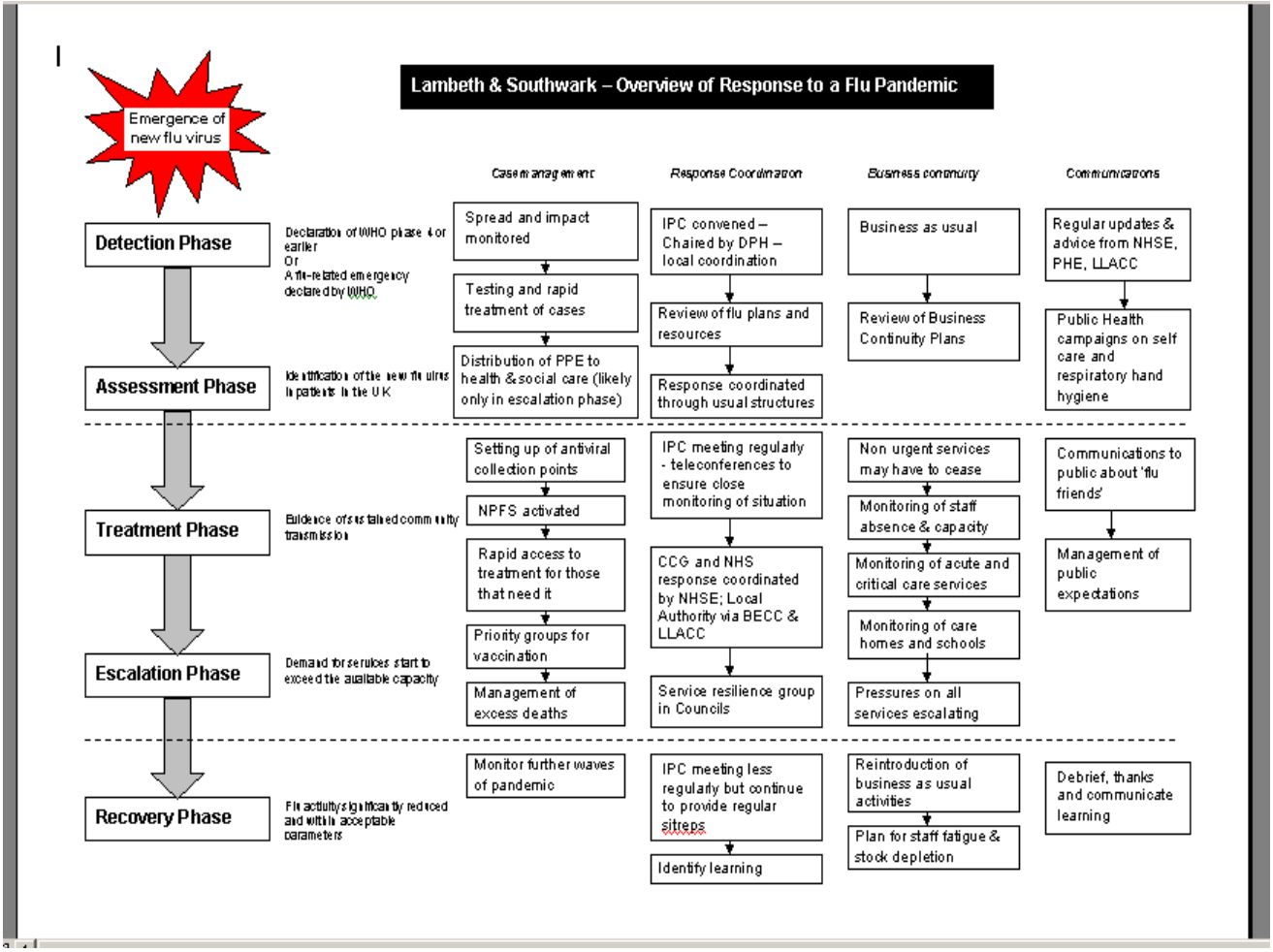
9. OVERVIEW OF RESPONSE

The diagram below provides an overview of the response to a pandemic at the different stages. Following the initial response of detection and assessment, the main period of response will occur during the treat and escalate stages. A national decision will be taken to move to the treat stage, however movement to the escalate stage will be determined locally based on pressures. For London this will be determined by the NHS England Pandemic Influenza Incident Response Team (see section 11 of this plan).

COBR will oversee the overarching response and the Department of Health is the lead government department.

Stage	Lead Organisation
Inter-pandemic multi agency planning	Public Health England
Detection	Public Health England
Assessment	Public Health England
Treatment	NHS England
Escalation	NHS England

NHS England, CCGs and provider organisations will regularly review pressures, to determine at an early stage whether escalation is required. Responsibility for escalation will ordinarily lie through the mechanisms used at other times of pressure surge, eg winter.



10. ROLES AND RESPONSIBILITIES OF KEY AGENCIES

10.1. Public Health England

Public Health England (PHE) will undertake the following at a regional level providing consistent response across London.

Stage	Lead	PHE Activity
Detection	PHE	• Intelligence gathering • Enhanced surveillance • Diagnostic development • Provision of communications to public and professionals
Identification of the novel influenza virus in patients in the UK.		
Assessment	PHE	• Collection of clinical and epidemiological data including FF100 cases • Estimates of impact and severity in the UK • Reducing risk of transmission by: o Actively identifying cases o Treatment o Antiviral prophylaxis for close/vulnerable contacts
Evidence of sustained community transmission.		
Treatment	NHS England	• Support response
Escalation	NHS	• Support response

	England	
Recovery	All	• Support recovery

Detection and assessment from the initial response and may be combined due to the speed with which the virus spreads or severity with which individuals and communities are affected.

As more information is gathered on the characteristics of the virus more detailed information will be distributed by PHE.

10.2. NHS England

NHS England (London) has a number of roles and responsibilities during a future influenza pandemic. These are summarised below and are available in more detail in the national NHS England Pandemic Influenza Operating Framework (October 2013)[2] and the NHS England (London) Pandemic Influenza Operating Arrangements (June 2014).

Stage	Lead	NHS England Activity
Detection	PHE	• establish pandemic influenza response arrangements at NHS England • review and finalise directly-commissioned response arrangements (eg Antiviral Collection Points (ACPs), pandemic specific vaccination arrangements, NHS delivery locations for the national stockpile)
Identification of the novel influenza virus in patients in the UK.		
Assessment	PHE	• as described above, plus • establish regular engagement regime with NHS commissioners and providers in London • establish a recovery working group • oversee and coordinate the NHS response in London
Evidence of sustained community transmission.		
Treatment	NHS England	• as described above, plus • provide regular situation reports on the status of the NHS in London to central government, sharing with regional partners as appropriate • ensure business as usual NHS services are maintained as far as appropriate • ensure treatment of cases through NHS services • enhance the health response to deal with increasing numbers of cases • activate directly-commissioned response arrangements (e.g. ACPs) • potentially prepare for pandemic influenza specific vaccination through directly-commissioned services • oversee the distribution of national stockpiles to frontline

[2] www.england.nhs.uk/wp-content/uploads/2013/12/framework-pandemic-flu.pdf

		NHS providers
Escalation	NHS England	• all points described in Treatment • escalate surge management arrangements in partnership with Clinical Commissioning Groups/ Commissioning Support Units (as per winter arrangements) • prioritise and triage service delivery to maintain essential services • enact business continuity arrangements to maintain own services as necessary
Recovery	All	• restore business as usual services • debrief the NHS and NHS England responses • maintain readiness for a subsequent wave or significant winter pressures • address staff exhaustion and recognise endeavours

10.3. Clinical Commissioning Groups

As Category two responders under the CCA (2004), Clinical Commissioning Groups (CCGs) have a role in supporting NHS England and providers of NHS funded care in planning for and responding to a flu pandemic[3].

The CCG Accountable Emergency Officer (Director of Governance & Development in Lambeth and Chief Financial Officer in Southwark) is responsible for '*ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event*' (Emergency Officers' for Emergency Preparedness, Resilience and Response (EPRR) 2012). CCGs must assure their Governing Body, NHS England and Local Health Resilience Partners that suitable arrangements are developed, tested and maintained.

Before a pandemic

- Each CCG has identified a Pandemic Influenza Executive Lead who will lead internal planning activities in light of national and international developments, advice and guidance. These are:
    - Lambeth CCG – Director of Governance and Development
    - Southwark CCG – Chief Financial Officer
- Both CCGs have business continuity plans in place that are suitable for use in a pandemic.
- Participate in relevant planning groups to discuss, plan, exercise and share best practice
- Ensure early engagement of communications professionals to devise, deliver and maintain internal, external and stakeholder/ cross-partnership communications before, during and after a pandemic
- Work with commissioned service providers, in planning for surge in relation to elective work and possible financial implications if there is disruption to normal service levels.

[3] NHS England Gateway: 00857. Guidance on the Roles and Responsibilities of CCGs in preparing for and responding to an influenza pandemic.

- Participate in assurance processes regarding their arrangements and be assured that their commissioned services have adequate provisions in place for managing a pandemic
- Work with NHS England Regional and Area Teams to identify appropriate local providers to support the delivery of a pandemic influenza response, particularly regarding the provision of antiviral collection points through community pharmacies

During a pandemic

- Support the national pandemic response arrangements as laid out in Department of Health and NHS England guidance issued prior to or during a pandemic occurring
- In line with other guidance, ensure 24/7 on-call arrangements remain robust and maintained, particularly with respect to surge and responding to major incidents
- Lead the management of pressure surge arrangements with their commissioned services as a result of increased activity as part of the overall response
- Support NHS England Regional and Area Teams in the local coordination of the response, e.g. through tried and tested surge capacity arrangements, appropriate mutual aid of staff and facilities, and provision of support to the management of clinical queries
- As necessary share communications with locally commissioned healthcare providers through established routes
- Participate in the multi-agency response
- Maintain close liaison with local NHS England colleagues, particularly when considering changes to delivery levels of NHS commissioned services
- Enact business continuity arrangements as appropriate to the developing situation to ensure critical activities can be maintained
- Maintain local data collection processes to support the overall response to the pandemic, including completion and submission of relevant situation reports and participation in coordination teleconferences
- Undertake and contribute to appropriate, timely and proportionate debriefs

10.4. Local Authorities

As Category 1 responders under the Civil Contingencies Act 2004 are responsible for:

- Developing and publishing a plan for the council to ensure essential services continue to be delivered
- Supporting the NHS as appropriate particularly with regard to the care of the vulnerable in the community
- Set up local communications for public, councillors and staff and align to NHS communications
- Distribute PPE to front line staff.
- Management of SocCon (situation reporting)
- Implement any agreed local escalation arrangements to assist faster hospital discharge or admission avoidance
- Encourage frontline staff to access vaccination programme when available.
- Support ‘flu friend’ arrangements
- Liaison with voluntary organisations to support the health and social care response
- Review mutual aid arrangements and requests
- Management of excess deaths

In addition, the local authority now has public health responsibilities. The Director of Public Health will lead and coordinate the local response to a pandemic – including convening the Pandemic Coordination Group.

10.5. Acute Trusts

It is the responsibility of NHS Trusts and Foundation Hospitals to support local planning and develop contingency arrangements for the provision of health care. Plans should pay particular attention to the projected requirement for significant acute sector surge capacity, increased demand for specialist beds, patient transport, supporting the maintenance of patients in community settings, redeploying staff at short notice, providing staff protection and strict infection control. In the event of a pandemic flu outbreak, acute trusts will:

- Review and if necessary suspend non-emergency activity when required to free capacity and staff.
- Implement agreed business continuity arrangements and aim to create capacity.
- Monitor and review staffing levels and re-deploy to priority areas as necessary.
- Assess and provide for ongoing training needs.
- Monitor staff health and provide occupational health services (vaccination/anti-viral drugs) according to national policies.
- Work closely with the critical care network including ECMO services and paediatric critical care services.

10.6. Community Health Services

- To maintain essential functions and service delivery – business continuity/ capacity plan
- Support the Acute sector through increased discharge of patients to free beds (normal business/major incident response)
- Support, with social care, vulnerable patients in the community, including the potentially increased numbers of terminally ill.

10.7. Primary care

GPs and community pharmacies will continue to be a key part of the health response. In a pandemic of moderate service impact suspension of non-urgent clinical care and non clinical activities, with other measures such as telephone consultations may free up additional capacity. Close working between primary care, social care, the voluntary sector and secondary services will support the majority of patients requiring home care. However, pressure in individual practices or teams may be heavy and smaller practices may experience disproportionate difficulties caused by increasing demand and reduced staffing levels. Pre- planned buddying arrangements between practices may assist in maintaining continuity.

Within Lambeth there are three GP localities, with a locality care network lead allocated to each who can provide CCG support where necessary. In Southwark CCG there are two neighbourhood development managers who can provide CCG support as required.

During a pandemic general practice will be expected to continue business as usual. The aim of planning is to respond in a practical and proportionate way and to use usual processes as far as possible. If a symptomatic patient comes into a practice then they should separate that patient *if it is possible to do so.* Usual cleaning and infection control procedures should apply.

Primary care is commissioned by NHS England and therefore they will take the lead in the coordination of the primary care response. All practices should have business continuity plans in place and a local decision would have to be taken about practices sharing space or personnel ('buddying'). NHS England would not coordinate or direct this.

NHS England has stated that the National Flu Line will go live early to ensure that most patients use this process rather than visit their GP.

Communications to practices would go through the usual routes – CAS alerts plus primary care commissioning. All practices should ensure they are signed up to receive CAS alerts if they haven't done so already.

11. NATIONAL AND LONDON COORDINATION

The Department of Health is the lead government department for pandemic preparedness and response. All other departments are directly or indirectly involved in preparing and play an active role in informing and supporting contingency planning in their areas of responsibility. During a pandemic it is likely that the Cabinet Office Briefing Room (COBR) will activate a Scientific Advisory Group for Emergencies (SAGE) to coordinate strategic scientific and technical advice to support UK cross government decision making.

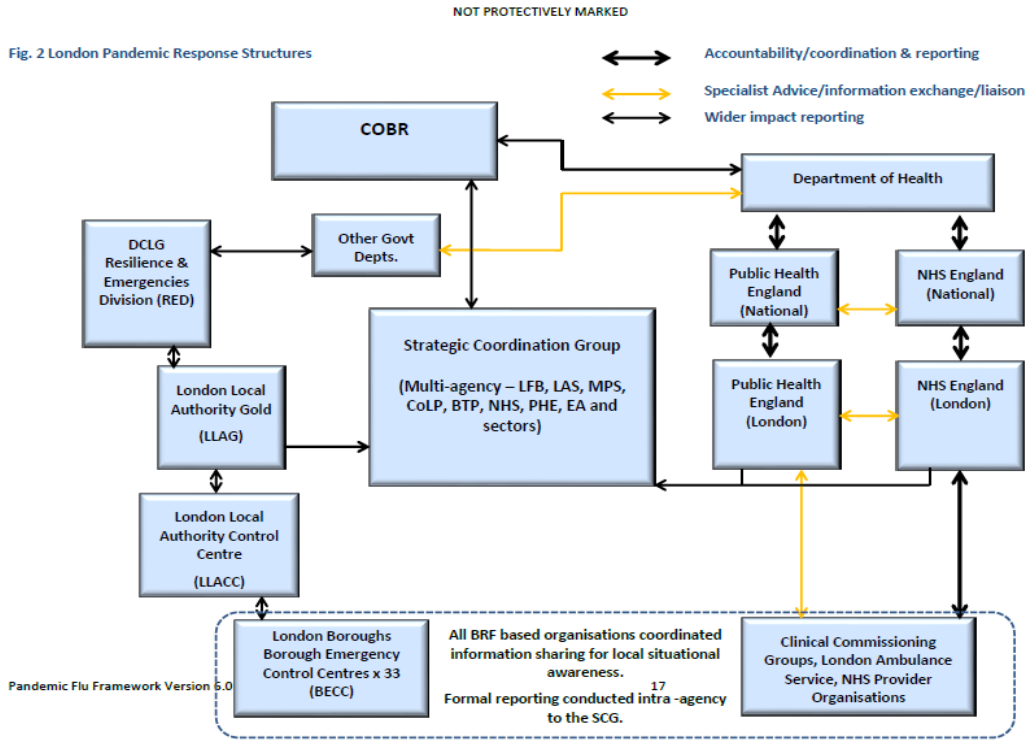
NHS England will monitor, manage and support the NHS community during a pandemic. Where possible and appropriate, existing arrangements and procedures will be used, underpinned by major incident coordination processes. NHS England will not coordinate non-NHS organisations.

NHSE (London) will establish a dedicated Pandemic Influenza Incident Response Team (PI-IRT) that will operate out of a dedicated Pandemic Influenza Incident Coordination Centre. In line with the national strategy, these will be flexed to meet demands, and some may not be relevant to all DATER stages. These include (but are not limited to) to:

- Oversee and coordinate the response of the NHS in London appropriate to the current and predicted impact;
- Ensure the NHS and partners are kept appraised of the evolving situation;
- Oversee the most effective deployment of available resources through adapting the response according to capacity;
- Ensure that NHS England (London) Directorates and Teams enact their business continuity plans and mobilise resources appropriately as necessary;
- Ensure prompt and timely establishment of a Pandemic Influenza Recovery Working Group (PI-RWG) to run in parallel with the response;
- Set the strategy for the PI-RWG;

- Provide progress updates and assurance regarding the NHS response in London to the NHS England (London) Delivery Group;
- Liaise with NHS England National, and neighbouring Regional and Area Teams to support the local response, securing mutual aid if required;
- Act as a central point of contact for stakeholders and partners (eg London NHS provider and commissioning organisations, NHS England (National), the Department of Health, Public Health England (PHE), and the wider multi-agency partnership through the London Resilience Team (LRT);
- Ensure appropriate escalation and two way communication of relevant issues and decisions
- Oversee delivery of pandemic-specific aspects of response; this includes, but is not limited to, antiviral distribution, pandemic specific vaccination campaign, and PPE distribution;
- Manage the NHS response to pandemic-related surge; ensuring the commissioning of additional NHS capacity where required (e.g. intensive care capacity (through Clinical Commissioning Groups (CCGs) and extra corporeal membrane oxygenation (ECMO) capacity (through NHS England Specialised Commissioning);
- Oversee the management of London-wide critical care resources and surge capacity demands through appropriate discussion, escalation and resource allocation;
- With communications colleagues, coordinate London-wide NHS messages to ensure consistent, clear and timely dissemination of information and guidance to the NHS, partners, the public and the media;
- Collate and analyse information for submission to NHS England (National) and other bodies as appropriate related to pressures and capacity within the NHS in London.

The London pandemic response structures[4] are shown in the diagram below:



[4] London Resilience Partnership (Feb 2014). Pandemic Influenza Framework. V6.0. p17

12. LOCAL COORDINATION

12.1. Lambeth & Southwark Pandemic Coordination Group

An effective local response will require the cooperation of a wide range or organisations and the active support of the public. Local leadership challenges may include high levels of uncertainty during the initial response phase, requiring flexibility and rapid adaptability of plans, and increased pressures and demand on services which may be exacerbated by staff absence. Key issues include:

- Visible director level leadership, direction and ownership of plans;
- Engagement, motivation and support for staff;
- Pre-established and tested command and control arrangements;
- Good coordination;
- Appropriate channelling of communications to maintain public confidence.

In the event of a pandemic affecting the local community, a Lambeth & Southwark Pandemic Coordination Group will be convened by the Director of Public Health to coordinate and lead the local response and will have the following core membership*:

Director of Public Health (Chair)	Local Authority Emergency Planning Leads
CCG Pandemic Leads	Chief Pharmacists
Local Authority Directors of Adult's Services	Acute Trust Leads
Local Authority Directors of Children's Services	Mental Health Leads
Local Authority Communications lead	Community Health Services Leads
PHE – SEL Health Protection Unit	CCG Communications Lead
NHS England (London)	

**Other multi agency Local Resilience Forum members will be called upon if necessary.*

The Pandemic Coordination Group will be chaired by the Lambeth and Southwark Director of Public Health based at Southwark Council. It will report to the Lambeth and Southwark Health & Wellbeing Board, the local Borough Resilience Fora, the London Strategic Coordination Group and/or the London Local Health Resilience Partnership if required to do so. It will provide a leadership, rather than a command role, and will consider information and request assurance around systems, processes and issues arising during the response, including:

Cases of flu

- Numbers of cases, severity, deaths
- Populations affected
- London and national picture and projections

Local organisational pressures

- Current demand for services (health and social care)
- Continuity of other services
- Staff absence
- Impacts on essential services and supply issues (eg medicines, fuel, water, waste etc)

Local support to the health service

- Antiviral points, agency support, voluntary and community inputs and mutual aid

Antiviral and vaccination situation

- Local antiviral collections points – location and how to access
- Demand for and supply of antivirals
- Vaccination updates

Management of deaths

- Local situation and capacity (certification, storage, registration, crematoriums, cemeteries)

Communications

- National and local communications – staff, patients and public
- Location of services, ACPs, infection control messages etc.
- Media coverage

12.2. CCG Pandemic Response Team

Both CCGs will identify a team to lead their response to the pandemic. This team will have responsibility for ensuring all actions relating to the pandemic are carried out: reporting; briefing senior CCG staff and attending the local Influenza Coordination Group and participating in teleconferences as necessary. Membership will include:

- Pandemic Flu Lead
- Chief Pharmacist
- Performance Lead (CSU)
- Urgent Care Lead
- Communications lead
- Admin support

The CCG Pandemic Response Team will ensure they keep detailed records of all decisions made and actions taken. These records will need to be stored securely following the pandemic. The CCG will also set up regular teleconferences with their commissioned services to assess pressures and incidents. This function may be coordinated by NHS England during a pandemic. Should there be a need to convene a SEL-wide teleconference, it should be done using the following information:

Details deleted for public version of document

12.3. Acute Trusts

A Pandemic Response Group will likely be convened at both of the local acute trusts. Depending on the severity of the pandemic the emergency control rooms might also be open to coordinate the response. Refer to each Trusts Pandemic Plan for further information.

13. ON CALL & CONTACT DETAILS FOR KEY ORGANISATIONS

All Category 1 organisations maintain an on call system and have capabilities to open an emergency control room if necessary. A summary of key local organisations is outlined in the table below and additional contact details can be found in appendix A.

Names and contact details have been deleted for this public version of document

Organisation	On call and contact details
NHS England (London)	NHSE (London) maintain a 24/7 on call rota for NHS organisations, to manage health service emergencies: NHSE Pandemic Influenza Response Team and Coordination Centre – will be set up and establish dedicated phone numbers and email for a pandemic response. The South Patch Team can be contacted during office hours:
PHE SEL Health Protection Team	The local South East London Health Protection Team can be contacted in the following way: During office hours: Out of hours: Email:
NHS Lambeth CCG and NHS Southwark CCG	There are shared on call arrangements in place for all of the six SE London CCGs. At any time, there are two Directors on call. They both hold a pager which is part of the PageOne network: Accountable Officers: Southwark – Lambeth – The PageOne accounts and on call process and rotas are maintained by the Surge and Resilience Manager for South East London, who is based at NHS Southwark CCG. Current contact details are:
Southwark Council	Each department that delivers critical risk services maintains their own out of hours service. In addition Southwark has trained personnel to fulfil its duties under the Civil Contingencies Act. The emergency scheme consists of Local Authority Liaison Officers (LALOs), Emergency Support Staff and Rest Centre Managers. There are also a number of staff trained to operate within the Borough emergency Control Centres.
Lambeth Council	Emergency Planning Lead:
Lambeth & Southwark Public Health	The Director of Public Health will coordinate the local response but does not have a formal on call process. In the event of a pandemic affecting the local community, she will ensure staff are available to respond at least during office hours
Guys & St Thomas' NHS Foundation Trust	In the first instance contact the Site Nurse Practitioner via the switchboard:

Kings College Hospital NHS Foundation Trust	Pandemic Flu Lead: Emergency Planning manager:

SECTION C: PANDEMIC SPECIFIC RESPONSE

14. NATIONAL PANDEMIC FLU SERVICE (NPFS)

The NPFS is designed to supplement the response provided by primary care if the pressures during a pandemic mean that it is no longer practical for all those with symptoms to be individually assessed by a doctor or other prescriber in order to access antiviral medicines. The NPFS aims to:

- Reduce pressure on primary care services;
- Allow people with flu like symptoms to remain at home;
- Enable rapid self service assessment, care advice, GP referral and antiviral authorisation, and
- Provide an additional source of data relating to trends in activity and profile of people assessed as suffering from pandemic symptoms.

The NPFS comprises an online and telephony self assessment service where individuals are assessed by a non-clinician following an algorithm, to determine whether the person who is ill is eligible for an antiviral medicine. Individuals may also be directed to other health interventions such as home care advice or ambulance response. The process is:

- A symptomatic individual, or their Flu Friend[5], will contact the NPFS and an assessment using a clinical algorithm will be undertaken.
- If required, the individual will be authorised to receive an antiviral medicine. They (or their Flu Friend) will then need to note down an authorisation number.

[5] Flu friends can be relatives, neighbours, representatives of the voluntary sector and friends who can collect antiviral medicines, food and other supplies on behalf of symptomatic individuals.

- The Flu Friend will then attend the antiviral collection point, provide the authorisation number and collect the antiviral medicine.

A national network of Antiviral Collection Points (ACPs) will be set up (likely to be community pharmacies) so that friends or relatives can collect the antiviral medicine on behalf of the person with flu, enabling them to remain at home and minimise further spread of infection.

The decision whether and when to activate the NPFS will be taken nationally in the light of pressures and impact of the pandemic at the time, eg close monitoring of the level of consultations with GPs. It will take about three weeks for the necessary arrangements to be put in place for the NPFS to go live. This will be coordinated by NHS England.

15. ANTIVIRALS AND VACCINATION

15.1. Antivirals

Antiviral medicines can reduce the length of symptoms and usually their severity. There are three main aspects of the antiviral strategy during a pandemic:

- Providing rapid assessment and authorisation of antiviral medicines (including using the NPFS to enable people to stay at home and to reduce pressures on primary care)
- Ensuring there is a robust system in place to distribute antiviral medicines (ie antiviral collection points – ACPs)
- Ensuring there is a robust system in place to manage, store and deliver antiviral stock.

The Government maintains a stockpile of antiviral medicines to treat up to half of the population in a new pandemic. In line with current advice, both oseltamivir and zanamivir have been stockpiled to ensure the response can be as flexible and resilient as possible, particularly against the risk of a pandemic virus strain developing resistance to oseltamivir.

In light of scientific and clinical advice at the time, antiviral treatment may be limited, for part or all of the pandemic, to those in at-risk groups if the pandemic proves to be very mild in nature or if antiviral medicine supplies are being depleted too rapidly.

For maximum benefit, antiviral medicines need to be taken as soon as possible and best within 48 hours. Depending on the severity of the pandemic, a National Pandemic Flu Service (NPFS) may be set up to provide symptomatic members of the public with rapid access to assessment, advice, triage and if appropriate, authorisation of antiviral medicine treatment. Operational plans should be built on the basis of treating all symptomatic patients within 7 days of symptoms onset and ideally within 48 hours. As well as antiviral medicine being available through the NPFS, GPs and other healthcare professionals will be able to authorise supply of antivirals medicines without a prescription using special authorisation vouchers (or the right hand side of the FP10SS for patients aged 13 and over), for the duration of the pandemic only. Developing sufficient capacity in primary care to assess patients promptly is therefore critical to the effective provision of antiviral medicines.

NHS England (London) will coordinate the distribution and delivery of antivirals. This will most likely be via community pharmacies, which will dispense antiviral medicines to those requiring it, and NHS England will arrange delivery of the medicines directly to the pharmacies.

Further information will be required from NHS England in advance about exactly what the arrangements would be in Lambeth and Southwark for the distribution and delivery of antivirals, including who would supply any institutions e.g. schools, nursing homes. In addition what the arrangements will be for on call pharmaceutical support for pharmacies issuing antivirals.

15.2. Antibiotics

Secondary bacterial infections are likely to be a major cause of death during a flu pandemic. The main role of antibiotics is to reduce the severe illness and deaths which would arise from secondary complications.

The government maintains a stockpile of antibiotics most likely to be useful for complications arising form pandemic flu. These will be made available if there was clear evidence of shortages in the supply chain in primary or secondary care during a pandemic. NHS England (London) will coordinate distribution.

15.3. Vaccination

There are two distinct types of pandemic vaccine:

Pre-pandemic vaccines that are produced in advance of a pandemic and are designed to protect against a strain of flu that experts judge to be a potential cause of a future pandemic. The Government currently holds a limited supply of H5N1 vaccine. This could possibly offer some protection in the event of an increased threat of a new pandemic arising from this virus (avian flu), but would offer no protection from another virus. If used, these vaccines will be prioritised for the protection of frontline healthcare workers and those in clinically at risk groups.

Pandemic-specific vaccines that are developed specifically to protect against the pandemic viral strain, once it has been isolated. Once available, a pandemic specific vaccine should protect from clinical illness and may also reduce illness severity, hospitalisation and death and therefore the national impact of subsequent waves of the virus. The production process is highly complex and is likely to take at least four to six months after the start of the pandemic before becoming available. It is therefore more likely to be of use during subsequent waves. It will be prioritised to clinical risk groups and frontline health and social care workers.

NHS England (London) will coordinate the local delivery of vaccine stock to local delivery points – onward distribution may be needed to GP surgeries and other locations.

16. INFECTION CONTROL AND PERSONAL PROTECTIVE EQUIPMENT

Influenza viruses can spread from person to person via the respiratory route when an infected person coughs and sneezes and through hand-to-face (mouth, nose or eye) contact after a person or surface that is contaminated with infectious respiratory droplets has been touched.

The virus can survive on commonly touched surfaces for periods ranging from a few hours to several days, depending on environment condition.

To protect others and reduce the spread of infection, anyone ill with pandemic flu should:

- Stay at home and practice good effective hand washing (leaflets available from GP surgeries)
- Minimise close contacts
- Adopt thorough respiratory and hand hygiene practices, ie covering the nose and mouth with a tissue when coughing and sneezing, disposing immediate of that tissue and washing hands frequently with soap and warm water, or alcohol gel if water is not readily available.

The incubation period can range from one to fours days. People are most infectious soon after they develop symptoms, though they can continue to shed the virus, for example in cough or sneezes, for up to five days (longer in children). Generally, people become less infectious as their symptoms subside. Once the symptoms are gone they can be considered as no longer infectious to others. People who have become infected with a particular strain of the virus will become immune to that strain.

The meticulous use of infection control procedures such as segregation, isolation and cohort nursing are fundamental in limiting the transmission of the virus. Local risk assessment for required levels of infection control should be regularly performed in hospitals, communal living environments such as residential homes, social care environments and supervised mental health residences or prisons. Stringent attention to hand and respiratory hygiene should also be observed.
Surgical face masks and respirators have a role in protecting healthcare workers as long as they are used correctly and in conjunction with other infection control practises. The Government has a stockpile of masks and respirators for health and social care workers and NHS England (London) will coordinate the distribution of these to NHS organisations during the treatment and escalation phases of a pandemic. They will also coordinate any training necessary for NHS organisations. The NHS is not responsible for the distribution of face masks to social care – and a resolution about how they might be distributed is currently being worked on by the Department of Health and DCLG colleagues.

Advice on infection control in the workplace, in hospitals and healthcare facilities and laboratories is available on the Health and Safety Executive website at:
http://www.hse.gov.uk/biosafety/diseases/pandemic.htm

17. VULNERABLE PEOPLE

Vulnerable people are those that are less able to help themselves in the circumstances of an emergency. In the event of a pandemic, these may include: children (the situation may be exacerbated by school closures), older people, mobility impaired, mental/cognitive function impaired, sensory impaired, individuals supported within the community, immuno-compromised children and adults, those with underlying health conditions, individuals cared for by relatives, homeless, pregnant women, and those in need of bereavement support. The Cabinet Office guidance: Identifying People Who Are Vulnerable in a Crisis (February 2008)[6] provides some guidance for emergency planners and responders.

[6] https://www.gov.uk/government/publications/identifying-people-who-are-vulnerable-in-a-crisis-guidance-for-emergency-planners-and-responders

It is not possible to create and maintain a central database of vulnerable people so a more pragmatic approach is suggested. Most vulnerable people will at some point come into contact with at least one agency so each team within each agency can identify vulnerable people on their lists. The table below provides guidance about how to identify potentially vulnerable groups in Lambeth & Southwark:

Vulnerable Group	Possible organisations to target
Children	• Schools through local authorities • Non-LEA schools though their governing body • Crèches/playgroups/nurseries • Children's social care • GP surgeries
Older people	• Residential care homes and Nursing Homes • Help the Aged • Age UK • Adult social care • Community pharmacies – those who have medicines delivered • GP surgeries
Mobility impaired	• Local authorities – social care • Private care services • Wheelchair services • Community health services • Residential care homes
Mental/cognitive function impaired	• Residential care homes • Mental health services • Community mental health teams
Sensory impaired	• Local charities • Disability lists (eg blue badge, GP lists)
Temporarily or permanently ill	• GP surgeries • Community nursing teams
Individuals cared for by relatives	• Carers groups • GP surgeries
Homeless	• Shelters, soup kitchens etc • Council outreach teams
Pregnant women	• GP surgeries • Maternity units in acute trusts
Minority language speakers	• Community groups • Churches
Tourists	• Transport and travel companies • Hoteliers
Travelling community	• Local authority traveller services • Police Liaison Officer

During a pandemic it is important to ensure plans are in place to sustain patients in the community, including community care such as:

- Delivery of medicines
- Meals on wheels
- Community nursing

18. MANAGEMENT OF EXCESS DEATHS

The Home Office is no longer the national policy lead for excess deaths. The Cabinet Office is therefore the effective lead currently, given that government departments play important roles in responding to an excess deaths event.

In London, the regional lead agency is the Greater London Authority (GLA), and will draw upon advice from the London Resilience Team and will work with the Strategic Coordination Group if established. The London Excess deaths Framework[7] will be initiated if the arrangements at local level are unable to cope with the increased demand.

Local capacity

Contingency arrangements may be required at all stages of the deaths process – certification, registration, mortuary services, transportation, funeral, arrangements. Many of these teams are small, and the impact of a pandemic in small teams may be high.
Southwark and Lambeth have limited capabilities to deal with excess deaths. At present cremation services in Southwark estimate that around 40 services could be completed during a week if the facilities were used to full capacity. Across three cemeteries the estimate is up to 12 per week at each giving a total estimate of 76 per week (40 cremations and 36 burials possible).

What must also be considered is the capacity of the local undertaking services, which may not be able to process the increased numbers, particularly at time when staffing levels may be low. Excess deaths will also impact on both the Registrar's and the Coroner.

Guys and St Thomas' NHS Foundation Trust provide mortuary services for Southwark. Lambeth and Southwark both fall within the Coroner's District of Greenwich, and the designated mortuary for excess deaths in the district is:
Greenwich Public Mortuary
3 Devonshire Drive,
Greenwich, SE10 8LP

19. PUBLIC GATHERINGS AND TRAVEL

There is limited evidence to suggest that restrictions on mass gatherings or travel will have any significant effect on flu virus transmission. For this reason the working presumption is that the Government will not impose any such restrictions. The emphasis will instead be on encouraging all those who have symptoms to follow the advice to stay at home and avoid spreading their illness.

[7] http://www.london.gov.uk/sites/default/files/London%20Excess%20Deaths%20Framework%20v1.pdf

However, local organisers may decide to cancel or postpone events during a pandemic and the public themselves may decide not to mix in crowds or use public transport.

20. SCHOOLS GUIDANCE

School closures can be 'reactive', where the intervention is used once pupils have fallen ill or 'proactive when there is anticipation of an outbreak amongst children. There is some evidence to suggest that school closures can influence transmission but that their impact is highly dependent upon their timing[8].

Given the potential high impact of school closures, there would be a national steer on whether this method of mitigation should be implemented, depending on the characteristics of the virus. Once there was a national steer, then PHE perhaps in discussion with the DPH would advise on closure of specific schools.

Under some circumstances (eg for operational reasons if there were insufficient staff to run the school safely) the school may take the decision to close their establishments temporarily. Such closures should be guided by the following principles:

- Taking into account the national steer and depending on the public health risk assessment, PHE and DPH may advise localised closures. The purpose would be to reduce the initial spread of infection locally while gathering more information about the spread of the virus.
- Once the virus is more established, the general policy is likely to be that schools should not close – unless there are specific local business continuity reasons (staff shortages or particularly vulnerable children). This policy will be reviewed in light of information about how the pandemic is unfolding at the time.

21. COMMUNICATIONS

21.1. National

A robust communication strategy is an important part of the response to a pandemic. Nationally this is outlined in the UK Pandemic Influenza Communications Strategy 2012[9]. The aim of the national strategy will be to instil and maintain trust and confidence by ensuring that the public and professionals know:

- What is going on, both nationally and in their local area;
- Where they can find reliable answers to questions they may have;
- How to access relevant information on self care and medical support if required.

The Department of Health will be the primary source of central government's health related public messages and will work closely with the Cabinet Office, other government departments and Public Health England to deliver a nationally coordinated communications strategy.

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215666/dh_125333.pdf

[9] Department of Health (2012). UK Pandemic Influenza Communications Strategy 2012

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21.2. Public Health England

Movement through the UK stages will be cascaded to partner agencies using the normal communication routes. PHE will continue to undertake surveillance throughout each of the UK stages, this information will be circulated within the London partnership and up to central government. Borough specific information will be provided using the agreed local mechanism.

PHE will provide public communications utilising the 'London Gold Communication Strategy' to deliver a consistent London message. Locally tailored messaging is the responsibility of local organisations.

21.3. NHS England (London)

NHS England's communications at all levels with the NHS, partners, stakeholders and the public during a pandemic will build on existing mechanisms and good practice. NHS England staff will be trained and briefed to provide messages to audiences in a timely and appropriate manner. Additionally communications cascades will be used to ensure information reaches audiences. Where appropriate, messages will be developed and delivered in partnership with other organisations, including Public Health England and the Local Health Resilience Partnership and Local Resilience Forum partners.

21.4. Local communications

Good liaison between local and national communications teams is essential so that both are aware of the content and changes in their respective outputs. Local public communication plans should be drawn up to include:

- Methods of communicating with the public and are appropriate for individuals with hearing, visual and other disabilities or limited English speaking.
- Local arrangements to support central Government in communicating advice to the local population
- Identification of individuals within organisations with responsibility for coordinating the information
- Roles and responsibilities during a pandemic;
- Arrangements for communications with the public about necessary prioritisation of services;
- Location of, and how to access ACPs;
- Tailored communications messages for different audiences, for example staff and stakeholders;
- Lists of health care entities, including points of contact, within the Local Resilience Forum locality (eg hospitals, long term care, residential facilities, clinics, GPs) with which it might be necessary to maintain communication
- Strategies to challenge incorrect information to mitigate the risk of misinformation (such messages need to be communicated clearly and promptly to the local population as their behaviour will contribute to the effectiveness of the response);
- Public messages that encourage good hygiene behaviours such as respiratory and hand hygiene (those used for seasonal flu and lessons from H1N1 (2009) flu pandemic should be reviewed when preparing these messages);

- Transparent and open communication of the risks and benefits, for example of vaccination.

Use of social media and other modern communication channels should be considered to meet these goals.

Lambeth and Southwark Councils each have a communications teams and they would lead the local communications response under the direction of the Director of Public Health.

For local Clinical Commissioning Groups, the Commissioning Support Unit communications team operate a reactive, out-of-hours press office service on behalf of CCGs from 5pm through to 9am five days a week and throughout weekends if required. In addition to supporting Directors on-Call in managing pressure surge incidents or major incidents (liaison with NHS England as lead organisation) the communications team may be contacted by the media with an urgent query about the CCG that does not relate to either of these operational processes.

Further guidance for the CCGs is contained within the SEL CCGs Director on Call handbook. Should alerts need to be cascaded throughout the Local Authorities and CCGs then the cascades and contact lists (deleted in this version of the document) attached in **appendix A** will be used. These have been adapted from the severe weather cascades.

It may be necessary to provide a local telephone helpline for the public. A similar service has been established by the Lambeth and Southwark Public Health team for the Ebola epidemic, using existing Southwark Council customer experience operators. Training can be provided and the service can also be extended to cover Lambeth residents.

Guys and St Thomas' NHS Foundation Trust and Kings College Hospital NHS Foundation Trust will run usual telephone line messages, front facing website messages via their communications teams. Service changes will be notified to patient via usual routes and will target vulnerable individuals.

22. SITUATION REPORTING

Information is crucial to the understanding and response to any major incident. During a pandemic, each organisation will be required to supply situation reports to their host Government Department which will be fed to COBR. Additionally, each organisation will provide reports to the London Resilience Team to produce an overall London picture. The London Common Recognised Information Picture (CRIP) will provide key information and data on the present situation in London.

The London Resilience Partnership guidance[10] suggests that Borough Resilience Fora should put in place a mechanism to share local situational awareness among partners to ensure an understanding of the impacts of the pandemic are understood. In Lambeth and Southwark this will be done by the DPH-led Pandemic Coordination Group (see section 12 above).

[10] London Resilience Partnership. Pandemic Influenza Framework. v6.0 February 2014

The London Local Authority Coordination Centre (LLACC) provides the conduit for the flow of information between London Local Authority Gold and the 33 London Boroughs. They will request situation reports to inform the Regional Common Recognised Information Picture (CRIP) and inform boroughs of the priorities and strategy set by Gold.

Frequencies of reporting (battle rhythm) will be determined at the time and will be dependent on the severity of the pandemic, the scale of the challenges arising and available resources.

Certain reporting templates or tools may be put in place, such as:

- FluCon – used by the NHS to report pandemic impact on local organisations
- CritCon – relates to pressures in intensive care units, currently used across the NHS as a capacity management tool.
- SocCon – designed to give children's & adult's social services local staffing pressures and allow national government assessment of the impact of flu on social care services.

Examples of reportable intelligence are[11]:

Agency	Examples of possible reporting lines
PHE	• Enhanced surveillance and epidemiology • Transmission and spread, eg circulating strain and severity
NHS	• Surge, including primary care • Impacts on elective work • Critical care capacity • Mortality and morbidity data
Local Authorities	• Impacts on local critical services • Social care provision • Impacts on cremation and burial services • Community concerns • Business issues • Local support to the health service/voluntary and community inputs and mutual aid issues and solutions • Public communication activity and media coverage • Requests for assistance
Other agencies	• Impacts on service delivery • Staff absenteeism • Public communication and media coverage • Requests for assistance

Each organisation should maintain their usual incident reporting mechanisms for non-flu related incidents to ensure these continue to be managed during a pandemic.

There must be robust processes in place to document and record decisions made and actions taken during the pandemic by each organisation, as well as any flu related incidents that occur.

[11] ibid

A decision log will be used to record all communications and activities, including time the decision was made, who made it and the rationale behind the action or decision.

23. MUTUAL AID

Mutual aid may be varied in nature including but not exclusively confined to personnel and material. Many Trusts have pre-agreed processes in place as part of their major incident plans, however where this is not the case, or where these options have been exhausted, NHSE (London) will act as a broker both within London and with other NHSE Regions. For critical care, the aim would be to prevent Trusts moving to 'triage for resource' for critical care (as opposed to triage for outcome) when accessible elective capacity or capability remains available elsewhere.

The CCGs and local authorities will support the health economy where possible seeking and supporting mutual aid requests as required. In addition, the South East London Surge Manager will support and facilitate health mutual aid where possible.

24. ETHICS

Ethical considerations are important in determining how to make the fairest use of resources and capacity. Decisions should be in proportion to the demands of the pandemic and other existing pressures and should be aimed at minimising the overall harm caused by the pandemic. Many people will also face personal dilemmas such as tensions between their personal and professional obligations. Decisions are more likely to be understood and the need accepted if these have been made in an open, transparent and inclusive way and based on widely held ethical values.

The Committee on Ethical Aspects of Pandemic Influenza developed an ethical framework that was first published in 2007[12]. This document remains appropriate and fit for purpose in planning for a future pandemic. The routine use of these principles can act as a checklist to ensure that all ethical concerns have been considered. This will support professional groups of staff in resolving ethical issues that may arise from the demands of their work.

12 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080729.pdf

SECTION D: RECOVERY

25. RECOVERY

The Recovery Phase will start once demands on services reduce to a level that there may be a gradual return to 'normalisation' of services or a re-grouping prior to a further wave of the pandemic.

Recovery is the process of rebuilding, restoring and rehabilitating the community following an emergency and may be coordinated across a local area via a multi-agency Recovery Coordination Group. The focus of this stage would be to return services to normal, or perhaps a new definition of what constitutes normal service. This would include:

- Restoration of business as usual services, including an element of catching up with activity that may have been scaled down as part of the pandemic response.
- Post incident review of response.
- Sharing information on what went well, what could be improved and lessons learnt.
- Taking steps to address staff exhaustion.
- Planning and preparing for a resurgence of flu, including activities carried out in the detection stage.
- Continuing to consider targeted vaccination, when available, and preparing for post pandemic seasonal flu.

The Department of Health will issue information to inform plans following a review of the first wave and then availability of countermeasures.

Health and social care services may experience persistent secondary effects for some time, with increased demand for continuing care from:

- Patients whose existing illnesses have been exacerbated by flu
- Those who may continue to suffer potential medium of long term health complications
- A backlog of work resulting from the postponement of treatment for less urgent conditions.

The pace of recovery will depend on the residual impact of the pandemic, on-going demands, backlogs, staff and organisational fatigue and continuing supply difficulties in most organisations.

Summary of roles during recovery

CCGs	• Identify lessons • Prepare for a second wave • Continue to communicate with all partners and public. • Contribute to local, regional and national health post-pandemic debriefs and consider the implementation of recommendations from any subsequent reports • Acknowledge staff contributions • Assess the impact of the pandemic on the provision of commissioned services and ensure that the ongoing service level is sufficient to meet the demands of the system • Ensure the recovery of services to business-as-usual as soon as appropriate • Review response update plans, contracts and other arrangements to reflect lessons identified, particularly where these have been commissioned locally • Collect financial and contractual impact information from commissioned providers
NHS Providers (acute, community, mental health, GPs, community pharmacy)	• Continue wider vaccination campaign • Identify lessons • Prepare for second wave • Ensure the recovery of services to business-as-usual as soon as appropriate • Continue to communicate with all partners and public. • Contribute to local, regional and national health post-pandemic debriefs and consider the implementation of recommendations from any subsequent reports • Acknowledge staff contributions and consider physical rest/emotional support for staff. • Maintain seasonal flu vaccination campaign
Local Authority	• Identify lessons • Prepare for second wave • Encourage social care staff to access seasonal flu vaccine • Continued communications to public/councillors/staff • Agree prioritised return to business as usual • Acknowledge staff contributions and consider physical rest/emotional support for staff. • Contribute to local, regional and national health post-pandemic debriefs and consider the implementation of recommendations from any subsequent reports

Winter planning

The pandemic virus is likely to persist for a number of years as one of the circulating seasonal flu viruses. Surveillance systems will be tracking its impact in other countries as they enter their winter flu season. It should be noted that the characteristics of the seasonal flu viruses that emerge in other countries may differ from that experiences in the UK or Europe. Therefore planning for seasonal flu, including good vaccine uptake, as part of routine winter planning is prudent.

26. DEBRIEFS

All organisations will be expected to contribute to internal and external debriefs. A pan London debrief will be established to report back to the public, the LRF and Central Government.

The Pandemic Coordination Group will also hold a debrief to feedback positive and negative learning from the pandemic. If required, learning from this will be provided to the Health and Wellbeing Board, the BRFs, as well as both CCGs and Local Authorities, and the wider NHS if requested.

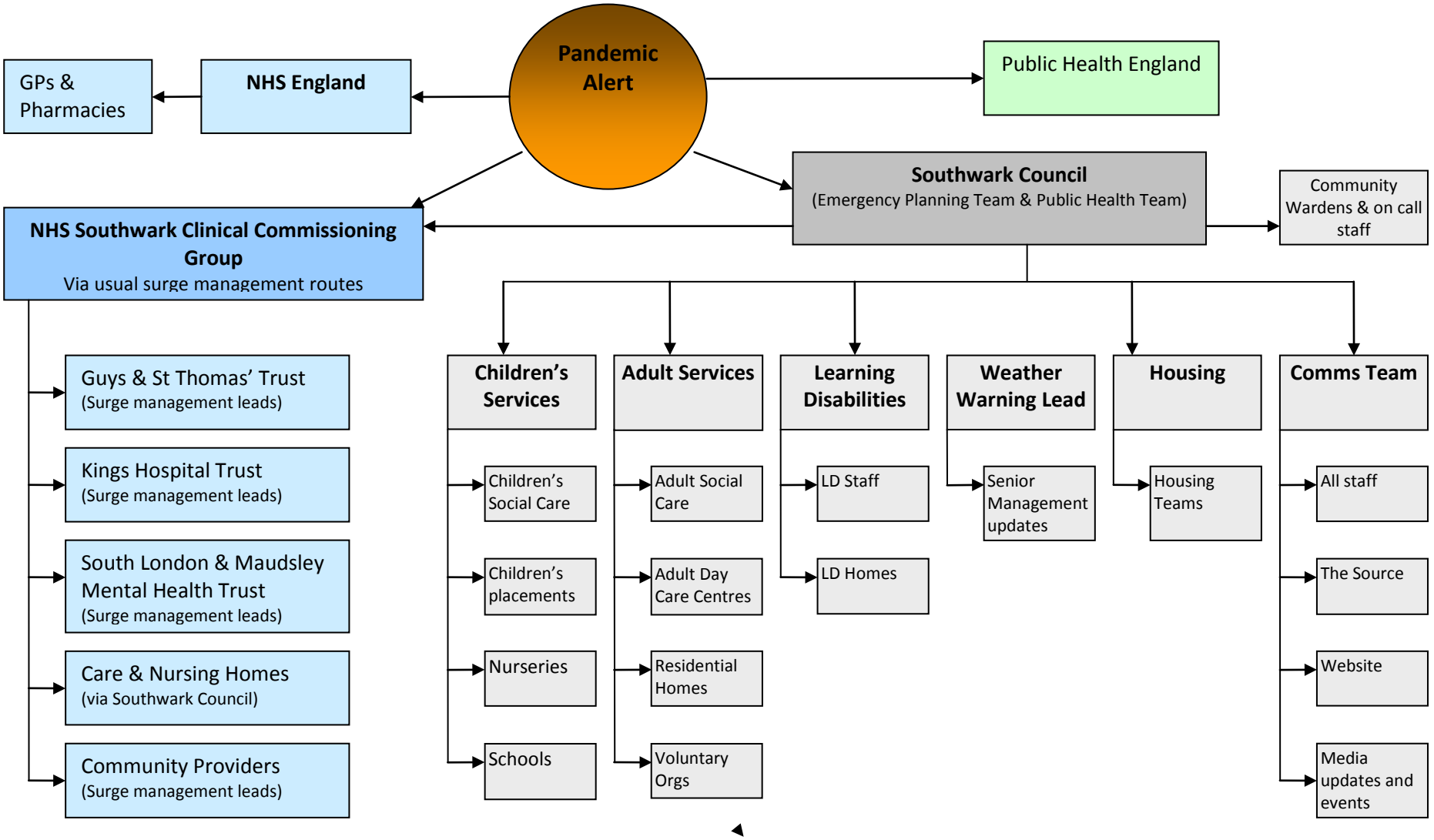
27. STAFF SUPPORT

The following issues might need to be addressed following the pandemic:

- Occupational health and welfare of all staff and their families
- Bereavement support
- Funerals, memorials and anniversaries
- Rewarding and acknowledging the efforts of staff.

APPENDIX A

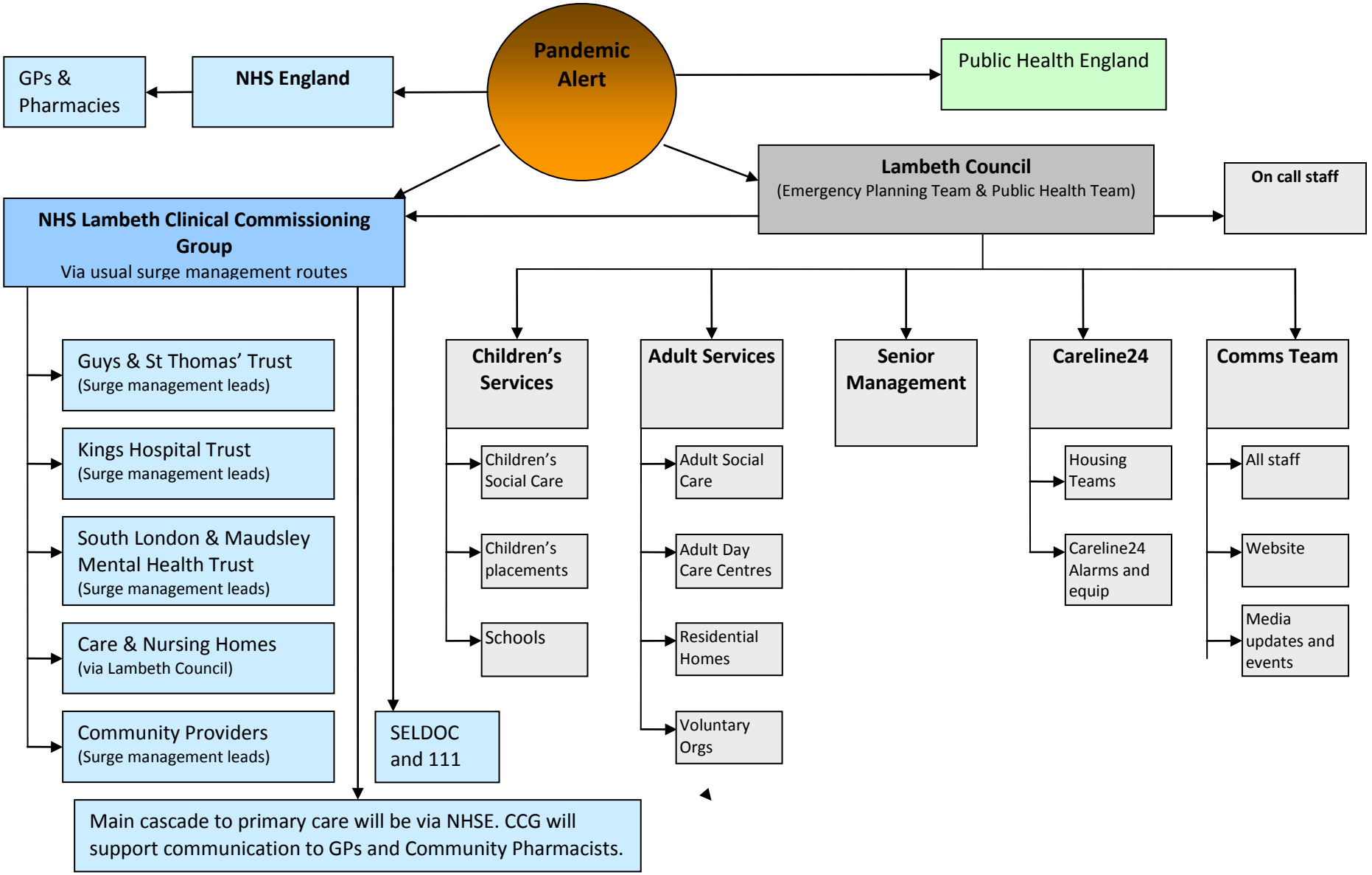
Southwark



Contact List – Southwark

Deleted in public version of document

Lambeth


Pandemic Alert
GPs & Pharmacies
NHS England
Public Health England
Lambeth Council
(Emergency Planning Team & Public Health Team)
On call staff
NHS Lambeth Clinical Commissioning Group
Via usual surge management routes
Guys & St Thomas' Trust
(Surge management leads)
Kings Hospital Trust
(Surge management leads)
South London & Maudsley Mental Health Trust
(Surge management leads)
Care & Nursing Homes
(via Lambeth Council)
Community Providers
(Surge management leads)
SELDOC and 111
Children's Services
Children's Social Care
Children's placements
Schools
Adult Services
Adult Social Care
Adult Day Care Centres
Residential Homes
Voluntary Orgs
Senior Management
Careline24
Housing Teams
Careline24 Alarms and equip
Comms Team
All staff
Website
Media updates and events
Main cascade to primary care will be via NHSE. CCG will support communication to GPs and Community Pharmacists.

Contact List – Lambeth

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Agenda Item 9

Item No. 9.	Classification: Open	Date: 31 March 2016	Meeting Name: Health & Wellbeing Board
Report title:		Council Owned Large Format Advertising Hoardings – Influence on type of Advertisements	
Ward(s) or groups affected:		All	
From:		Eleanor Kelly, Chief Executive	

RECOMMENDATIONS

1. That the Health & Wellbeing Board:

   1) Note the council's limited ownership of large format advertising sites, acknowledging that the impact of direct intervention through this medium will be correspondingly low, but nevertheless would contribute along with other council initiatives to signal council priorities and policies;

   2) Note that the leases the council grants to large format advertising site operators already prohibit content to which the council might reasonably object;

   3) Note that a mechanism (IDM approved report "Promoting a Vibrant, Sustainable Retail Estate Aligned to Local Need") exists for identifying undesirable uses in the letting of commercial premises, which could be extended to specific large format advertising hoardings content;

   4) Direct on any specific prohibitions in new leases, or at lease renewals as they fall due, noting the potential commercial impact of these restrictions;

   5) Instruct officers to monitor and review the commercial impact of any additional controls adopted, and to review practice and experiences in other local authorities.

BACKGROUND INFORMATION

2. According to the Valuation Office Agency website, looking at business rates paid in the borough, there are in the region of 300 commercial advertising rights in Southwark. These range from simple advertisements on bus shelters to major digital installations.

3. Amongst these the council owns a small number of large format sites (five in total), which are held as part of the investment portfolio managed by Property and let out to third party operators commercially at a rent:

Unit Address	Post Code	Tenant Name	Use
Advertising Right Land adjacent 280 Borough High Street (Redman House)	SE1	Outdoor Plus Ltd	Large format advertising only
Seven Islands Leisure Centre Lower Road	SE16	Clear Channel UK Ltd	Large format advertising
Site at 563-571 Old Kent Road	SE1	Primesight Limited	Large format advertising (digital media)
Advert Hoarding 1-5 West Lane	SE16	Primesight Limited	Large format advertising (digital)
Advert Hoarding Tower Bridge Road	SE1	Daylite LED	Large format advertising (digital)

4. The council owned sites currently in use advertise (as at the second week of March) the following:

- Arla semi-skimmed milk;
- Virgin Media Football;
- Movies, holiday operator, missing persons;
- TV & music.

5. It should be noted that the council also licences advertising through a number of other media outside the direct scope of this report, including publications and promotional materials, small format highways based advertising and any bus shelter advertising not controlled by Transport for London.

KEY ISSUES FOR CONSIDERATION

Statutory controls on Advertising

6. In Planning terms the advertisement control system is set out in the Town and Country Planning (Control of Advertisements) Regulations 2007. Primarily this deals with the format in which outdoor advertising is presented.

7. Other consumer orientated regulations are geared at protecting the public from unfair advertising, dealing primarily with what might or might not, legitimately be said in advertisements. The Advertising Standards Authority has established a code of practice to which leases granted by the council for large format advertising require the operating companies to adhere.

Landlord's Restrictive use of Lease Terms

8. The above regulations control advertising in general terms. Where it owns a large format advertising site the Council (and partner agencies) can exercise an additional level of influence, through the drafting of the user clause contained in the lease or licence granted to the operator. This opportunity arises when new

leases are agreed either at inception or when lease are renewed (all the leases referred to above will come to an end within the next few years).

9. The council's standard lease for large format advertising requires that the tenant is *"in any event not to post any advertisement which is directly or indirectly of a political racial or religious nature nor any advertisement which the Landlord may reasonably object"*.

10. The clause has been in place for some years and has been relied on in the past to seek the immediate removal of inappropriate advertising, with the operator's full and responsible cooperation. This follows from a well established landlord and tenant relationship through which the tenant has been made fully aware of the council's expectations.

11. Therefore operating companies are normally happy to accept a small number of additional restrictions to protect against ethnic, religious and political sensitivities. Any such additional restrictions need to be easily definable (so that process can easily be put in place to exclude them and the requirement policed) but not to restrict the market for advertising space in any significant way. Nevertheless the council has a free hand to revise or extend this clause in new leases. It may decide to make the requirement more stringent; having regard, however, to potential impacts on rents received and the possibility of creating further large format advertising opportunities in the future (see Financial Considerations, below).

12. Our initial enquiries suggest that the only products specifically prohibited to date by other local authority landlords are payday loan shops, gambling and e-cigarettes. It would be prudent to try and list the specific products and Health and Wellbeing Board may wish to direct on the specific exclusions it would wish to see.

Policy implications

13. The council has previously agreed user clause restrictions which prohibit particular activities in its shops and business units. These are identified in the June 2014 IDM report "Promoting a Vibrant, sustainable Retail Estate Aligned to Local Need". The policy provides a mechanism for including additional uses to be prohibited and can be extended simply to cover the content of advertising hoardings when new leases are granted.

Community impact statement

14. It is envisaged that the proposals set out in this report will have a positive impact on a wide range of groups and the wider community, regardless of age, disability, faith, gender, ethnicity or sexual orientation.

15. There are no specific equality implications arising directly from this report. Indirectly the decision to eliminate the uses referred to from the council's portfolio will signal that the Council does not support products that contribute to unhealthy lifestyles and the potential impact they may have on vulnerable parts of the community.

Financial Implications

16. The combined rental income from the five large format advertising sites mentioned above currently stands at approximately £150,000 per annum (a capital value in the region of £2.25 million). The figures exclude revenues from small format highways based advertising which are believed to be of a similar value and from other sources. The income received is directed to fund council services and priorities.

17. Although the current income from this source is relatively small, it becomes more significant when it is considered that it relates to only five assets, include analogue advertising displays. Analogue is now seen to be a dated format – the future being digital displays. The tenants at two sites are in the process of upgrading their displays to digital formats which is likely to enhance the council's rental receipt considerably on a profit share basis. Furthermore there is additional opportunity to increase the total income from this source by bringing other sites into advertising use where it is feasible to do so.

18. Excessively limiting advert content, or being ambiguous about what can be advertised will adversely impact these incomes. Whilst the restriction advised by the Director of Public Health below provides some clarity about content that would be unacceptable to the council, commercial advertising consultants have advised that the proposals may render the entire media estate commercially unviable, with a strong risk that no operating company would be interested in taking on contracts with unilateral local restrictions of the nature now proposed.

19. In practical terms this would mean that each of the council's current sites would be terminated on expiry of contract over the next 5 years, as there would be no interest in renewal or retender. The operating companies would be likely to replace the advertising opportunities lost through the establishment of additional sites with private landlord.

20. In view of these commercial considerations and since the changes will be introduced over time, lease-by-lease, as new leases are granted, it will be possible to monitor the commercial impact of any new restrictions and agree any revisions as appropriate.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Director of Public Health

21. The Director of Public Health recommends that in relation to Council owned advertising hoardings, the following is adopted:

Southwark Council will not accept advertising that conflict with our residents living healthy lifestyles and is not complementary to the Council's aims and objectives. Examples of goods and services the council will not accept include:

- *Tobacco / tobacco products*
- *Alcohol*
- *Fast food*
- *Unhealthy foods**
- *Weaponry*

- *High interest lending*
- *Gambling*
- *Messages of a sexual nature*

**the Council actively promotes healthier living and will not support the advertising of foods that are not complementary such as fast foods, sugary foods and drinks and foods high in calories and saturated fats. For more information on healthy eating:*

http://www.nhs.uk/LiveWell/Goodfood/Pages/goodfoodhome.aspx

22. The Director of Public Health will continue to work with Events and Communications to ensure other advertising and sponsorship relating to publications, promotional materials and sponsorship of council events are appropriate and in line with council policies to promote and protect health and wellbeing.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Case file IDM report "Promoting a Vibrant, Sustainable Retail Estate Aligned to Local Need" (June 2014)	Property Davison, 160 Tooley Street	Matthew Jackson 020 7525 1332

APPENDICES

No.	Title
None	

AUDIT TRAIL

Lead Officer	Eleanor Kelly, Chief Executive		
Report Author	Matthew Jackson, Head of Property		
Version	Final		
Dated	18 March 2016		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Law and Democracy		No	No
Strategic Director of Finance and Governance		No	No
Cabinet Member		No	No
Date final report sent to Constitutional Team			18 March 2016

Agenda Item 10

Item No. 10.	Classification: Open	Date: 31 March 2016	Meeting Name: Health and Wellbeing Board
Report title:		Free swim and gym update	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The Health and Wellbeing Board is requested to note:

   a. The Free Swim and Gym (FSG) pilot scheme for 18s and under and over 60s

   b. The FSG health offer:

   - Free access at all centres, all of the time, for people with disabilities from July 2016;
   - Free swim and gym for health referral schemes from late April 2016.

   c. The FSG offer for all residents from July 2016:

   - Free access to gym and swimming for all residents – all day Friday; afternoons on Saturday and Sunday until close

   d. The FSG offer for all Southwark Council staff from July 2016:

   - Free access to gym and swimming for Southwark Council staff - all day Friday; afternoons on Saturday and Sunday until close.

BACKGROUND INFORMATION

2. The council recognises the importance of improving access to physical activity opportunities as part of the Fairer Future promises (promise number 2).

   'We will make it easier to be healthier with free swimming and gyms for all residents and doubling the number of NHS health checks.'

3. The purpose of this report is to update the Health and Wellbeing Board on progress with the 18s and under and over 60s offers, the health offers and general offer for all residents.

KEY ISSUES FOR CONSIDERATION

18s and under and over 60s – early pilot launch

4. A decision was taken to have an earlier phased launch for defined population groups ahead of an offer for all residents in order to learn from the registration and usage patterns to inform the wider all residents offer.
   - The FSG registration for 18 and under and over 60 launched in March

2015.

- From May 2015, FSG was available for these registered groups:

    - *18s and under free swim - all day Friday; afternoons from 2pm and 6pm on Saturday and Sunday*
    - *16 to 18 years free gym* - all day Friday; afternoons from 2pm until 6pm on Saturday and Sunday
    - *14 to 16 years free youth gym sessions* – at selected times on Friday evenings Saturday and Sunday afternoons
    - *Free 'Silver Sessions'* – access to over 60s sessions all week (Silver sessions include swimming, gym use and specific classes such as aerobics and circuits)

5. The 18 and under and over 60 scheme registration launch was accompanied by a strong communications strategy involving local press, printed material and web based media.

   A breakdown of registrations showed that:

   18 and under

   - Approximately 12% (over 7,000) of 18 and under in Southwark registered
   - Of the total registrations marginally more M than F registered (M/F 51%/49%)
   - In this age group 9.2% of the F population registered compared with 8.3% of M.
   - Higher BME registrations compared to BME in the wider population (73%/64%)

   Over 60s

   - Approximately 5% (over 1,700) over 60s in Southwark registered
   - Of the total registrations more F than M registered (F/M 60%/40%)
   - In this age group 5.5% of the F population registered compared with 4.2% of M.
   - Higher BME registrations compared to BME in the wider population (41%/27%)

   A breakdown of attendances showed that:

   18 and under

   - Of the total attendances more M than F attended (65%/35%).
   - Higher BME attendance compared to BME in the wider population (75%/64%)

   Over 60s

   - More F than M attended (74%/26%)
   - Higher BME attendance compared to BME in the wider population (67%/27%)

6. On registration, users were asked about barriers to physical activity. The top 3

identified were:

- Cost
- Not knowing what is available
- Feeling self conscious / body conscious

7. In addition to registration and attendance data, there was a 6 month follow up survey:

   - From 264 responses, 91% had maintained / or increased their physical activity levels
   - Approximately 40% of parents said that the scheme is helping their child be more active
   - The most common feedback was for the times to be extended.

8. The lessons from the early implementation for 18s and under and over 60s will inform:

   - Further marketing and training to address 'body conscious' culture
   - Maintaining the targeted marketing for F 18 and under as national research highlights this group as being less likely to be active compared to M 18 and under.
   - Work with the new leisure providers to enhance specific offers to better target different groups
   - Targeted marketing for men over 60
   - Extending the offer times from July

FSG offer for people with disabilities

9. The FSG scheme for people with disabilities will launch with the opening of the new leisure centre at the Elephant and Castle:

   - All day Friday and on afternoons from 2pm until close on Saturday and Sunday.
   - From July onwards, all day every day at all leisure centres across the borough.

10. FSG offer is open to all residents with disabilities who can provide formal evidence of proof of a disability from the following list:

    - Disability Living Allowance or a Personal Independence Payment, and Attendance Allowance
    - Hearing Impairment
    - Visual impairment
    - Blue Badge parking permit
    - Freedom pass (only if under state pension age and not qualifying under the Older Adult (60+) scheme.

11. The people with disabilities FSG offer has been developed with advice from local groups and users including Southwark Adult Social Care and Interactive London the lead strategic development agency for sport and physical activity for disabled people in London. There will be appropriate information materials and training and support for staff.

Health offer from April 2016

12. There is good evidence demonstrating that people who are least likely to be active will require additional motivation and support. People who are less active are also more likely to be of unhealthy weight or have poorer health or long term health conditions. Evaluations of brief interventions by health professionals have shown that this approach can increase physical activity levels. The FSG offer is enhanced for key health schemes:

- Physical activity on referral including Kickstart, Active boost (exercise on referral) and Cardiactive (cardiac rehabilitation phase 4)
- NHS Health Checks Programme
- Healthy Weight Programme.

13. The enhanced FSG offer for these health programmes will start from late April 2016 leading up to the introduction of the general offer in July 2016, allowing them to dovetail seamlessly into the roll-out of the general offer.

14. The health offer involves:

- Free Exercise on Referral and Cardiac Rehabilitation: the current charge of £1.60 per session will therefore cease from April 2016 for Southwark residents
- Clients using the Kickstart scheme will have a free 3 month FSG passport for anytime use (currently charged £20 per month at a reduced tariff)
- Clients referred through the NHS Health Checks / Health Improvement Motivational Hub for leisure centre based activity will have a free 3 month FSG passport for anytime use (currently charged £20 per month at a reduced tariff)
- Participants in the Healthy Weight Programme will receive two free public swimming sessions per week for one child and one adult whilst registered on the programme. This is to be used between Monday-Thursday at any Southwark leisure centre with a swimming pool. In additional all young people taking part will be eligible for the current pilot offer and in July 2016 will be incorporated into the general scheme.

Next steps

15. The FSG programme is an important part of the Southwark Physical Activity and Sport Strategy to increase levels of physical activity in the borough and to support people who are less active to be more active. There will be on-going learning to inform further action:

- To support our children and young people to be more active by refining the offer with the new leisure providers with targeted communications
- To continue to work with disabilities groups to ensure our leisure centres are well equipped to support people with disabilities and leisure staff is well trained
- To provide good leisure opportunities for older people to be active and stay healthy
- To continue to work with health colleagues to ensure that the 10% target to increase physical activity on referral is met.

16. The physical activity on referral materials are currently being revised for the launch of the health offer together with a publicity and communications campaign. Targeted sessions will be arranged with the range of health professionals involved in referring to physical activity to improve referrals. These sessions will include for example briefings to protected learning time events and various staff and professional group meetings.

BACKGROUND PAPERS

Background papers	Held at	Contact
Gateway 2 – Contract Award Approval - Management of the Council's Leisure Centres (Cabinet report – Item 17)	Constitutional Team 020 7525 7225	Paula Thornton 020 7525 4395
Link: http://moderngov.southwark.gov.uk/ieListDocuments.aspx?CId=302&MId=5144&Ver=4		
Free Swim and Gym Update – Cabinet Report February 2016 (Cabinet report – Item 18)	Constitutional Team 020 7525 7225	Paula Thornton 020 7525 4395
Link: http://moderngov.southwark.gov.uk/ieListDocuments.aspx?CId=302&MId=5144&Ver=4		

AUDIT TRAIL

Lead Officer	Ruth Wallis, Director of Public Health
Report Author	Paul Stokes, Southwark Public Health Team
Version	Final
Dated	17 March 2016
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		17 March 2016

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