NHS
Southwark
Clinical Commissioning Group

SOUTHWARK

Five Year Forward View

HWBB
Strategic Partnership & LCNs update

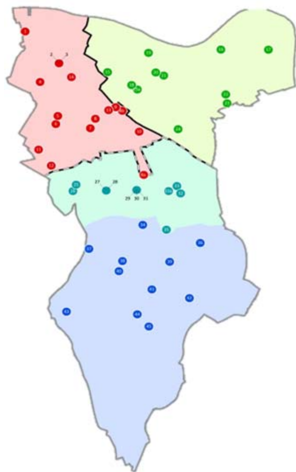
July 2016

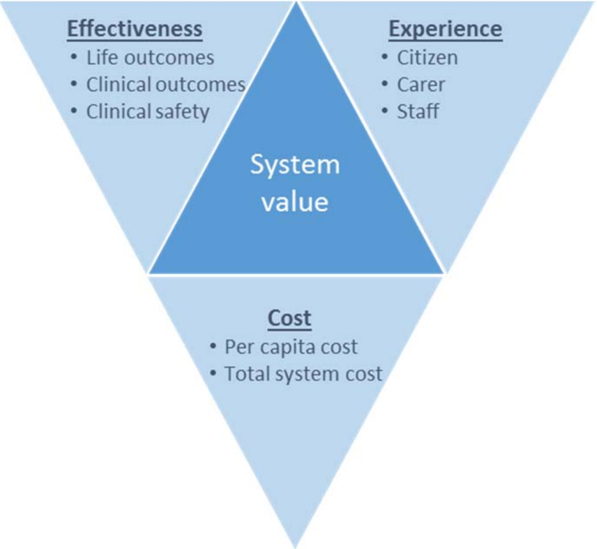
Southwark Council
southwark.gov.uk

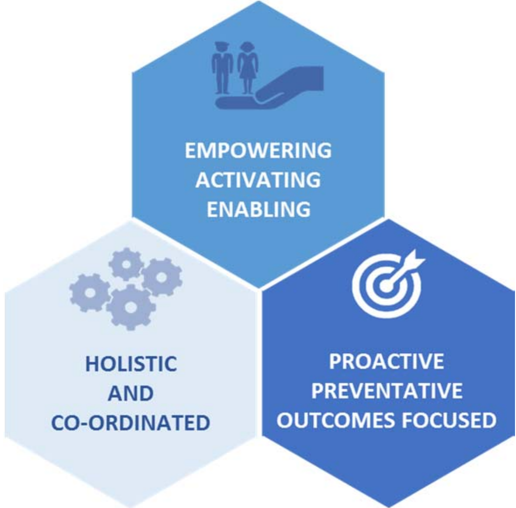
Our strategy is to maximize the value of health and care for Southwark people, ensuring our services exhibit positive attributes of care

We are changing the way we work and 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**

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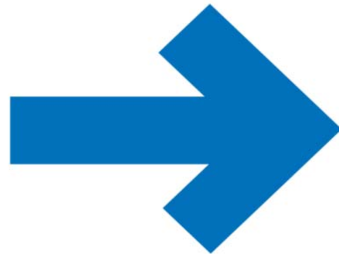
If we don’t change the way we work we won’t address the workforce and financial challenges that currently undermine the sustainability of general practice

Why?

NHS England

GENERAL PRACTICE FORWARD VIEW

APRIL 2016



Developed in partnership with:

RCGP Royal College of General Practitioners

NHS Health Education England

#GPforwardview

“*One of the great strengths of general practice in this country has been its diversity across geographies and its adaptability over time. So one size will not fit all when it comes to the future shape and work of primary care.*

But in the round [the GP Forward View] support package is likely to herald the ‘triple reinvention’ - of the ***clinical model****, the* ***career model****, and the* ***business model*** *at the heart of general practice.*”

Our practices tell us that something needs to change

- **Our members tell us that the model of general practice must change** if we are to meet the expectations of patients, and if general practice is to be sustainable from a workforce or funding perspective in the long term.
- **Our members have told us that they see a route to sustainability by working collectively**. All practices are doing this through membership of formal federations of practices, and some practices are seeking closer relationships through mergers of their practices.

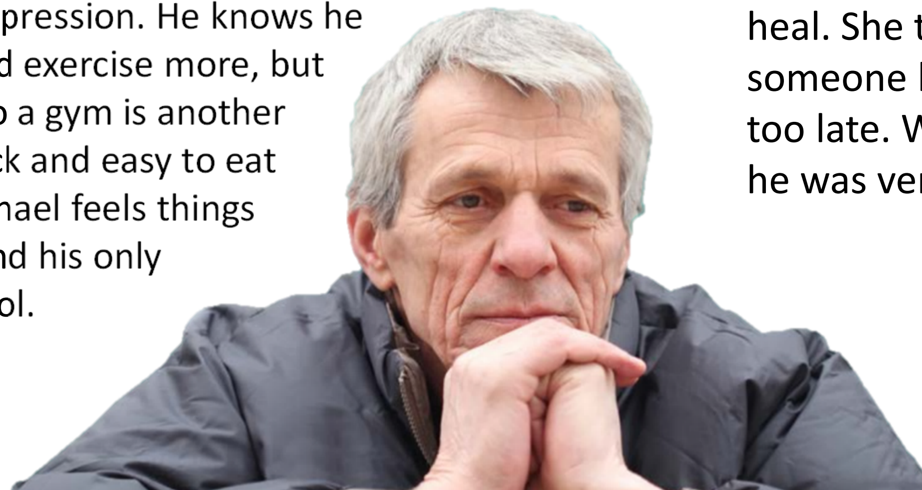
Fragmentation means that services often don't take a holistic view of a person's needs and this can lead to poor care, poor outcomes and avoidable medical interventions

Why?

Michael's story is an illustrative account, showing how a holistic, whole person approach which considers health, social and economic needs could make a real difference.

Michael is 62. He moved to Southwark ten years ago for work, but has recently been made redundant. He lives alone in rented accommodation. Since losing his job Michael sees fewer people. He worries about his rent, and growing debt.

Michael has insulin-dependent diabetes, hypertension and depression. He knows he should eat better and exercise more, but it feels hard; going to a gym is another expense and it's quick and easy to eat take-away food. Michael feels things are out of control, and his only real comfort is alcohol.



The police have taken Michael to A&E four times in the past six months, after he collapsed in the street following particularly heavy drinking. His diabetes is a problem; he has called an ambulance twice in the past month and been admitted into hospital with hypoglycaemia because he hadn't eaten enough.

In hospital Michael met other people with diabetes. One person had had a heart attack related to diabetes. She had also had an amputation last year as her leg ulcers refused to heal. She told Michael that she wished someone had helped her before it was too late. When Michael was discharged he was very worried; he didn't want to have a heart attack or end up needing an amputation but he didn't know what to do.

We want to develop local care so that it is more integrated, coordinated and so that it is financially sustainable now and for the future

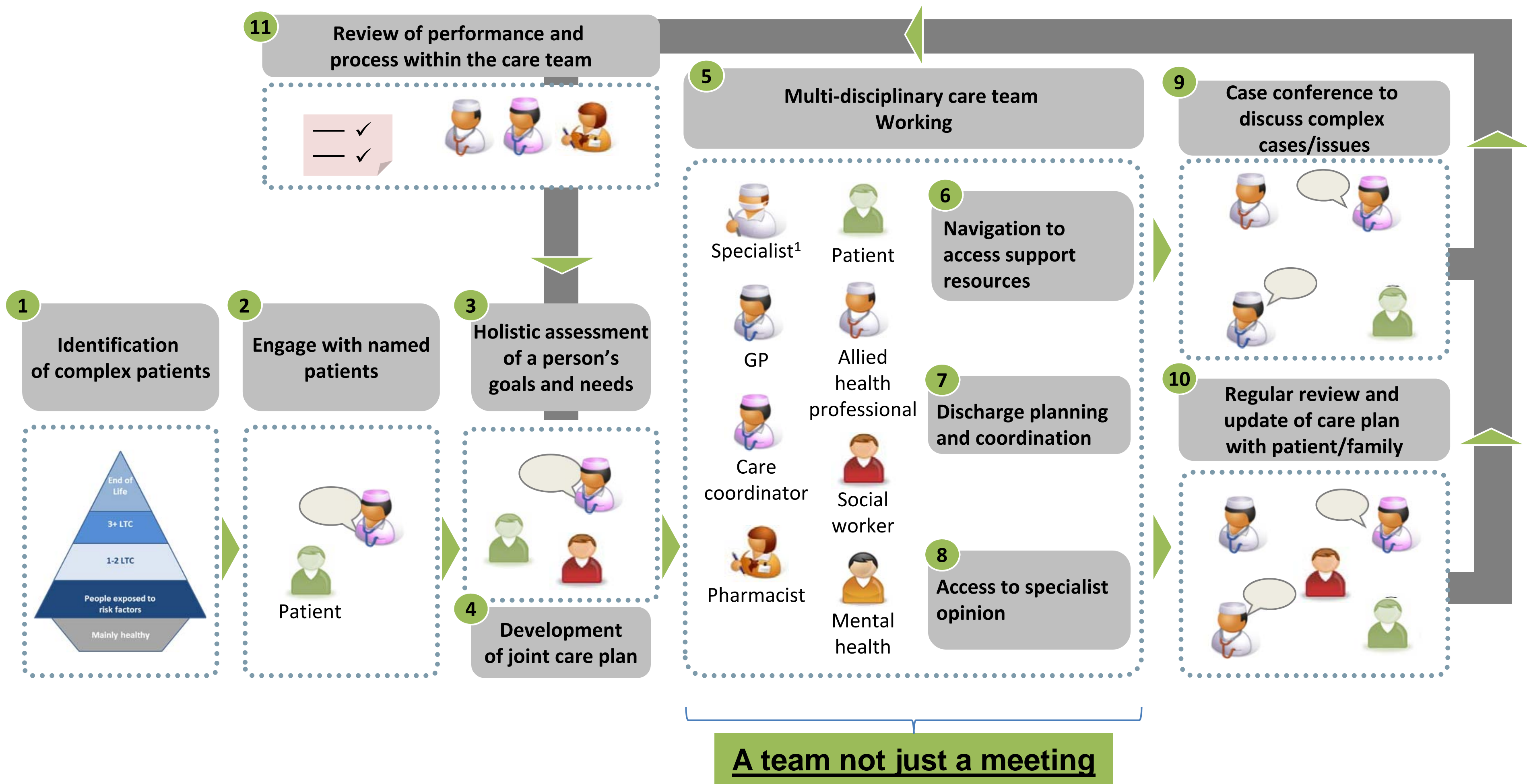
What?

- GPs, nurses, social workers and hospital consultants will collect and use information to identify people like Michael early and arrange the best support for them. Integrated teams will understand all of his needs and capabilities.
- The team will have the time to understand Michael, what is important to him and his goals. Michael's mental and emotional needs will be considered equal to his physical health needs, and his care team will include psychologists and psychiatrists.
- The team will use techniques like proactive care planning to help Michael start to take control of his life. Michael will feel like he is working with an expert care team, rather than just being treated by them or being told what to do
- Michael will be able to meet other people who are experiencing similar things in peer-support groups. He will be able to access education and self-management support to feel more confident and live well with his conditions. Michael will feel reassured that he can contact a care team member quickly, if he needs to.
- Michael will find it easier to access social activities and groups, and feel more connected and able to make friends. He will get practical advice on issues like housing, debt-management, benefits, and employment.
- Living a healthier life will be simpler. Michael will know where the local parks are, and that they're safe. He will be able to access free gyms and swims, and cycling and walking will be easier because the roads will be safe and well lit.

Operating models for coordinated care put multidisciplinary working at the heart of the system. Members of the Strategic Partnership can help develop and implement this new care model.

What?

For illustration only

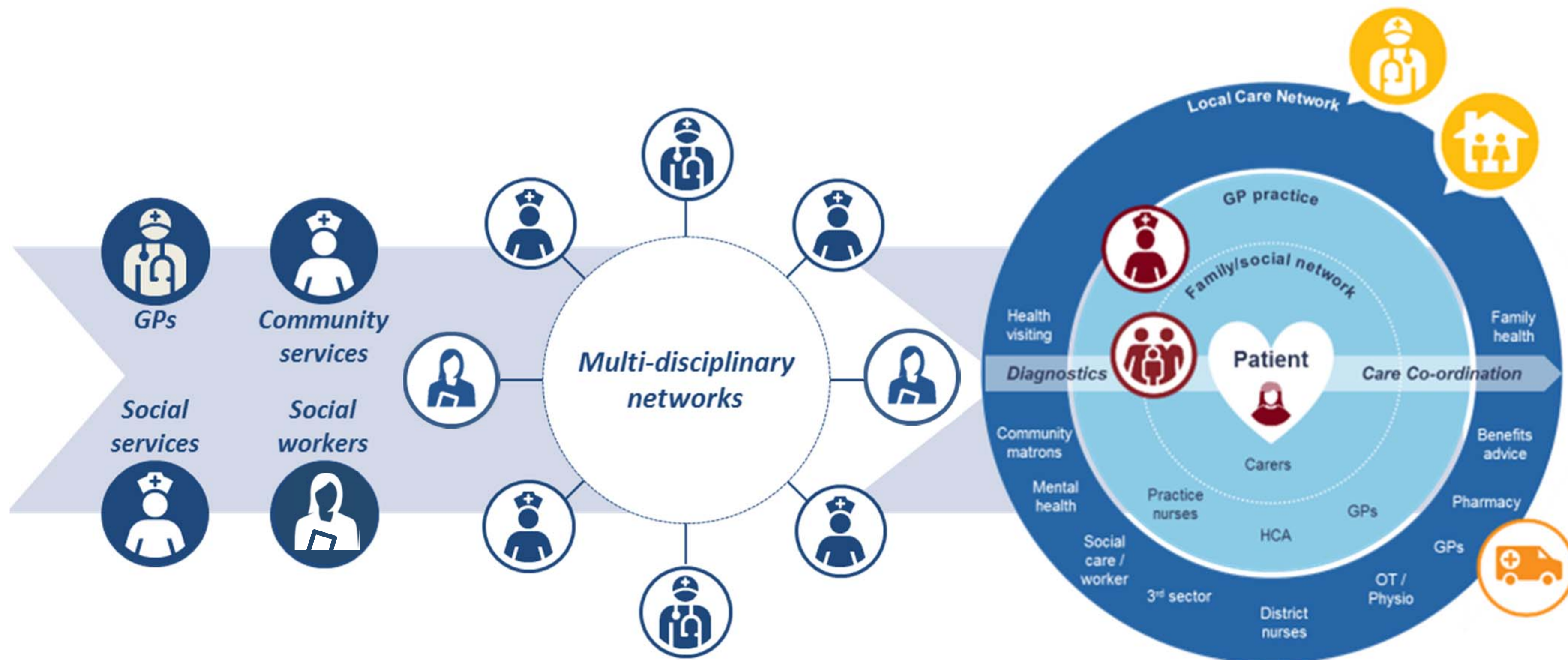


A team not just a meeting

Source: Adapted from Carter, Chalouhi, Richardson – What it takes to make integrated care work (McKinsey Health International, 2011)

This type of team working between practices and with the rest of the system is what we mean when we describe a Local Care Network

What?



We need new relationships and working practices to emerge if LCNs are going to feel 'real' and deliver better services for local people

How?

Delivering our Southwark Five Year Forward View

Bring people together regularly to develop relationships	&	Focus that leadership group (and their teams) on a practical task

Federations and LCN Boards

- Help develop robust federations that can promote at-scale working in primary care
- Support practices to access development opportunities and resilience support
- Support the emergence of new working practices that are possible at-scale (e.g. shared staffing)
- Help embed general practices and federations within a wider LCN governance

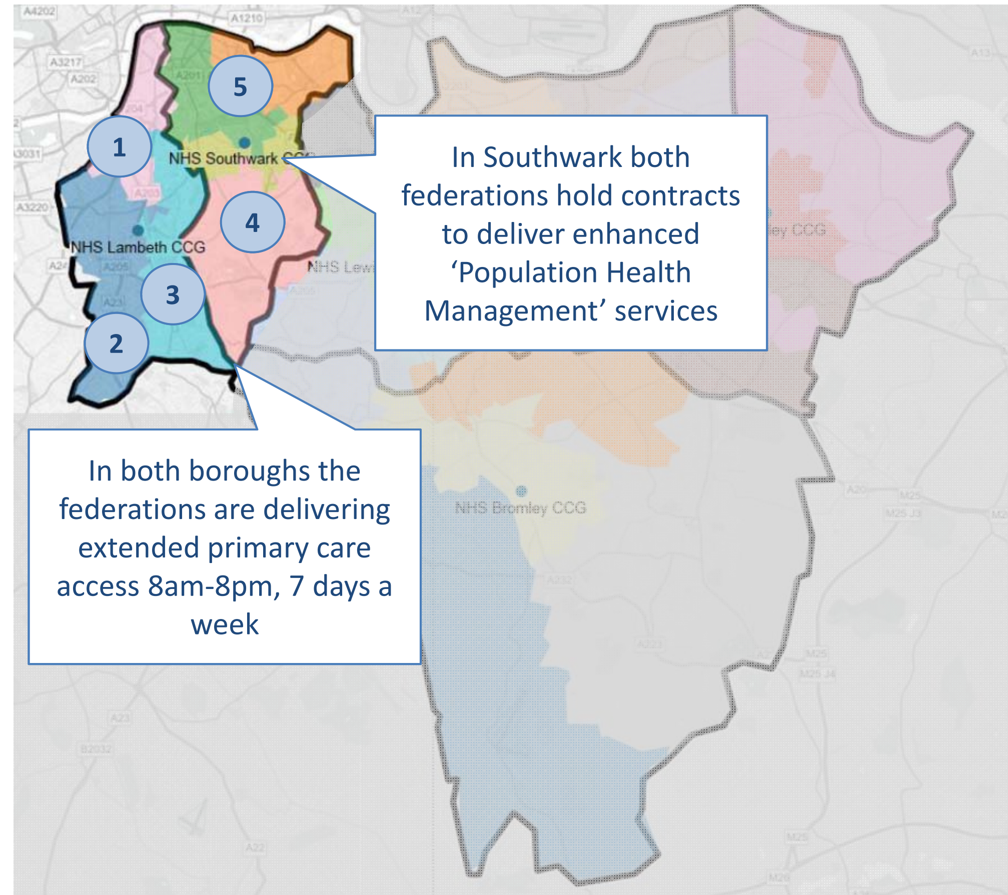
Coordinating care for people with complex needs

- Identify people with complex needs and assess a person's needs holistically
- Ensure a named professional is responsible for care
- Co-develop a care plan (accessible across a care team)
- Support self-management and activation
- Enable multi-disciplinary team working

Enablers		Federations and LCN Boards	Coordinating care for people with complex needs
	Workforce	Ensuring CEPNs are integral to LCNs, and helping federations to develop career models and training	Focusing CEPN funding to promote multi-disciplinary working and improvement in managing LTCs
	Informatics	Supporting infrastructure improvements across general practice (e.g. telephony system)	Ensuring that infrastructure investments address clinical needs (e.g. Coordinate My Care, linked data)
	Estates	Shaping strategic investments in the general practice estate to facilitate at-scale working	Ensuring that infrastructure investments address clinical needs (e.g. service delivery from hubs)
	Funding	Help develop an understanding of new contractual forms and a transition towards LCN-level contracts	Ensuring that specific contract negotiations support the development of coordinated care (PMS, CQUIN)

New general practice organisational forms are established and delivering services in Southwark and Lambeth

- Five LCNs involving >87 GP practices and covering 0.6m residents
- Five GP federations established
  - Incorporated as legal entities
  - Boards, governance and management teams in place
  - CQC registered
  - Delivering services under CCG contracts



We have made significant progress in supporting general practices to work at scale and deliver new population-based services…but we are now looking to take the next step towards whole system working

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In addition a new **Southwark and Lambeth Strategic Partnership** provides leadership, programme support and accountability at an LCN and cross-borough level

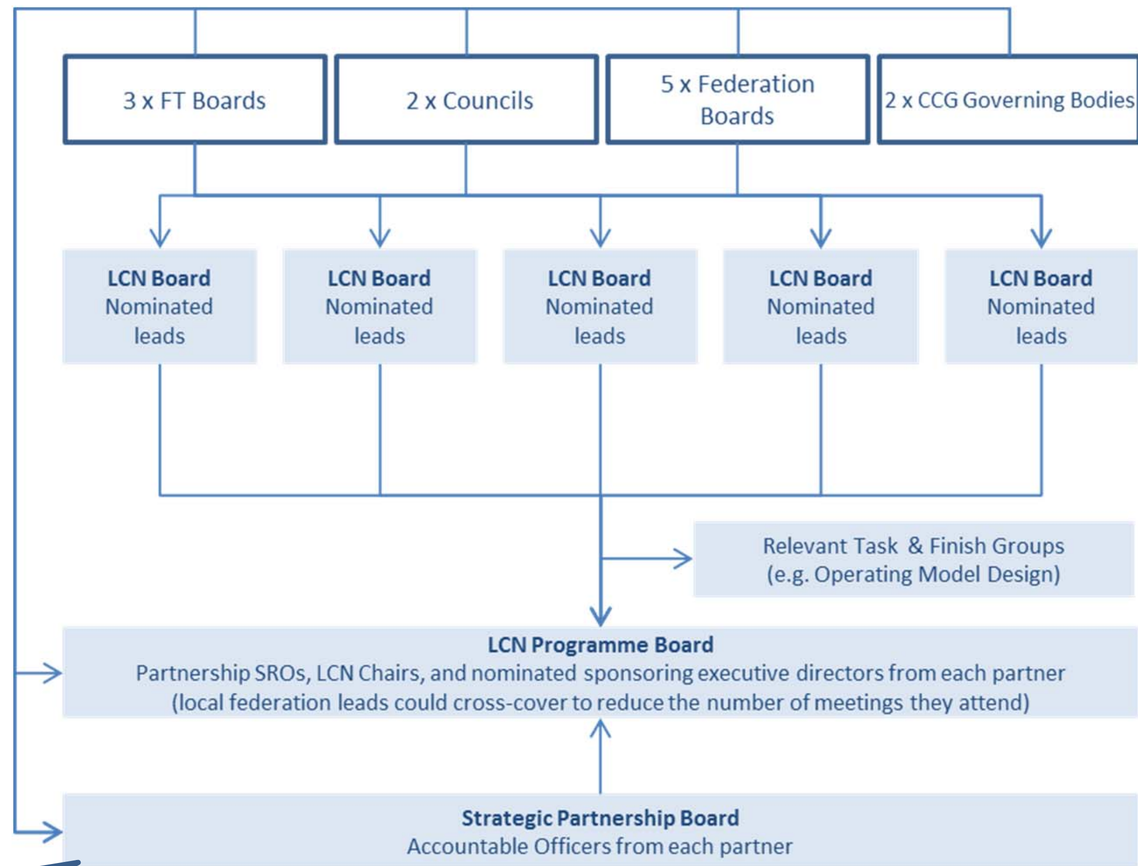
New relationships and new leaders are being developed at all tiers of the local system: a process of culture change

- LCN Boards members are drawn from the main provider organisations (GPs, community services, social care, mental health, acute). There are nominated chairs of each group. They meet regularly and act as the main point of local co-ordination, planning and implementation.

- A cross-borough LCN Programme Board is chaired by a CEO-level SRO. LCN Chairs and sponsoring exec directors from each organisation attend that board to coordinate LCN activity and provide a means of escalation to resolve difficult issues.

- Accountable officers from all partners (including GP federations) meet regularly to provide oversight, organisational commitment and strategic leadership, convened by an independent chair (to be recruited).

This is essential to provide local leadership to the delivery of the STP (especially CBC)



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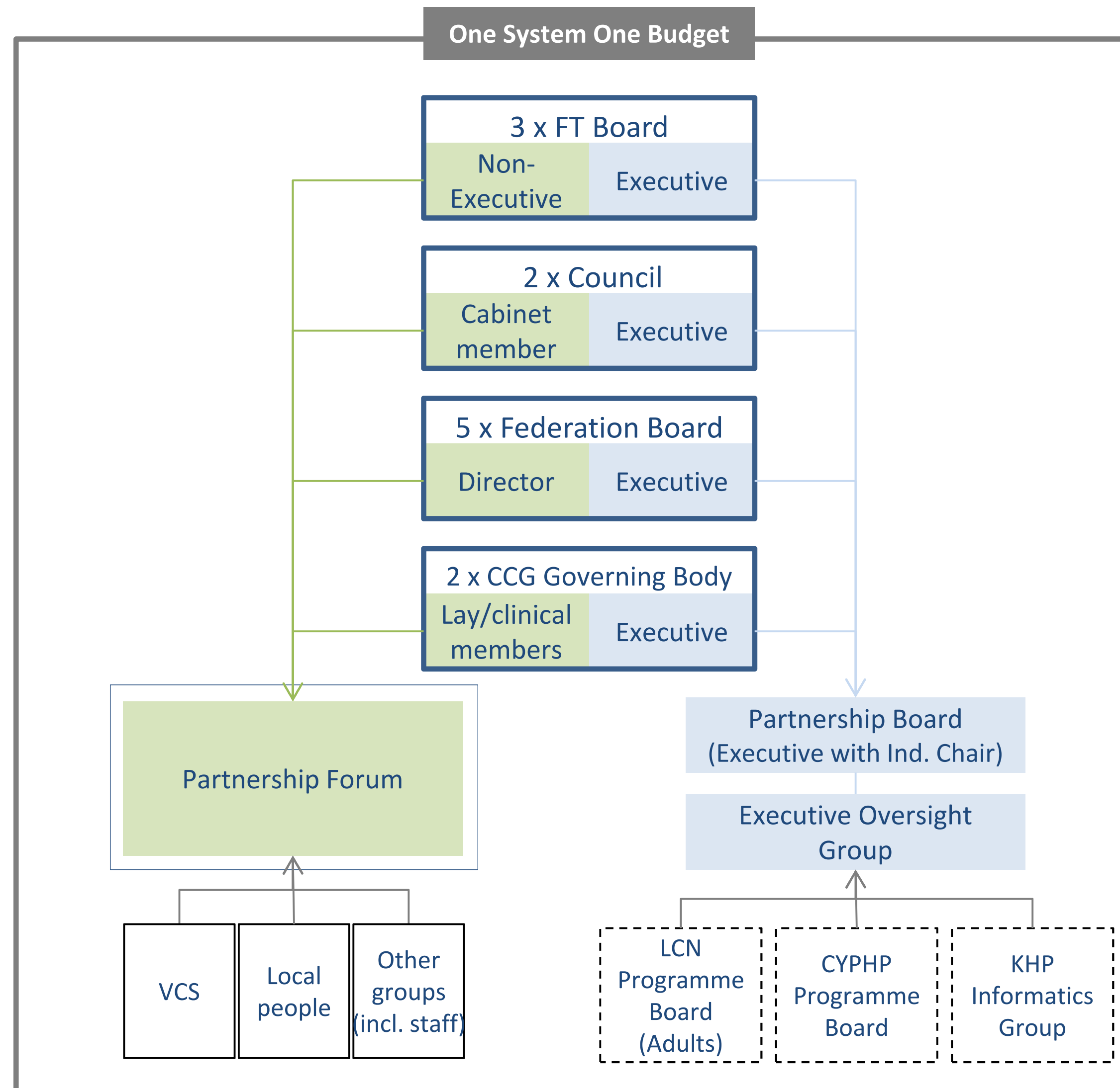
This LCN programme sits within a strategic partnership to ensure it is prioritised and support, but the accountability remains exercised through sovereign boards

- 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
- A Partnership Board (Acc Officer) and an Executive Oversight Group will ensure coherence across the partnership and link work plans to the business planning and contracting cycle
- Programme Boards will be established for specified priority areas. Each will have a nominated SRO. The SRO and PB are responsible for establishing the programme and describing resource needs.



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