APPENDIX 1

NHS Southwark Clinical Commissioning Group

Southwark Five Year Forward View: Into Action

Local Care Networks: What have we achieved and where do we need to go next?

June 2017

For people like Roy, health is not separate from other parts of his life. His experience shows we could do more to take a holistic view

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Strategic challenges

https://youtu.be/yu2ZykjcSYw

- **Multimorbidity is the norm**: "I had my first heart attack when I was 37…I'm also a type II diabetic…I have neuropathy in my feet…and vascular disease in my legs"
- **Managing care is burdensome and complex**: "Over a year [I have] 50-60 appointments…I take [about] 25 tablets a day". "After my second heart attack I had about eight or nine doctors around my bed, but the doctor I'd seen before them wasn't with them".
- **Our approach leaves people feeling disempowered:** "I very rarely ask questions…I wouldn't understand what they were saying anyway…and letters [may as well be in another language]."
- **All parts of a person's life are affected by chronic disease**: "I'm pretty much in pain all the time with my legs and feet." "The nurse said: 'You're clinically depressed'…[by the end of the conversation] I was in tears".
- **People's goals are about their lives, not their diseases:** "I want to get up and go fishing, go and see my grandson, see him grow up…but I'm not expecting anything special"

Our strategy is to maximize the value of health and care for Southwark people, ensuring our services are person-centred and empowering

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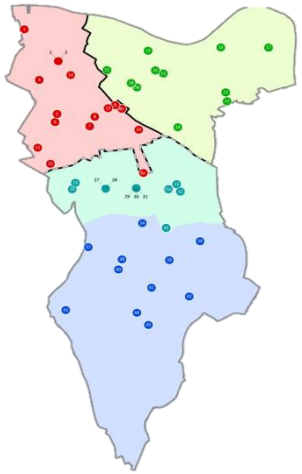
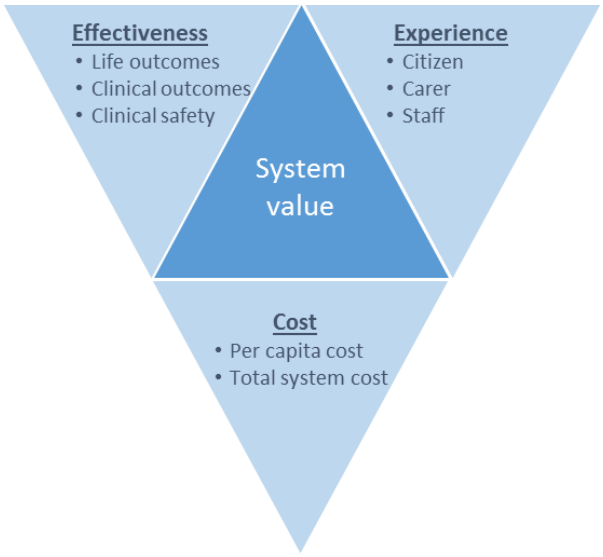
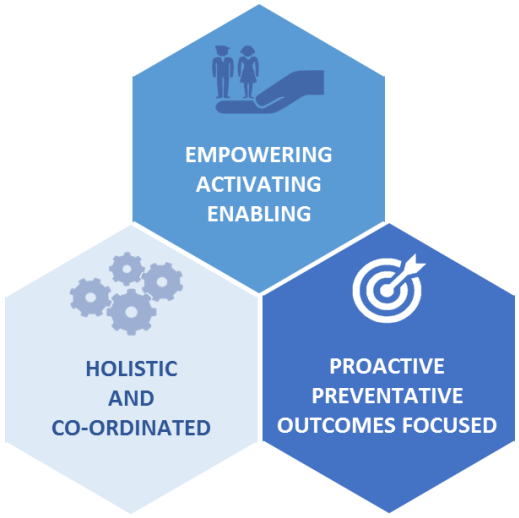
Strategic vision

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

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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

That fragmentation is reduced when professionals work together across boundaries to support people as 'whole people'

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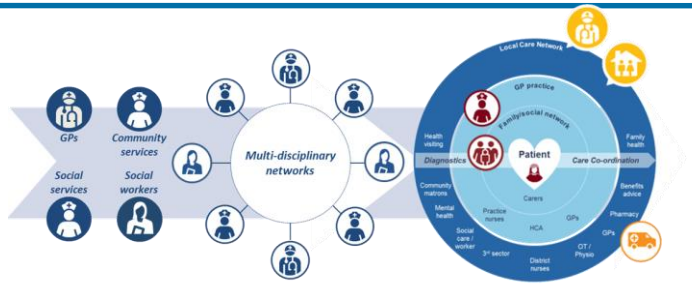
Strategic aim



In each Local Care Network a multi-specialty community team needs to:

- Include all individual general practice staff within the locality, operating as part of an effective and collaborative federation, which can – individually or jointly – deliver core and enhanced primary care services (drawing on existing and new roles such as clinical pharmacists and care navigators).
- Include social workers, operating on a geographical basis, whose clients live within the locality.
- Include the district nursing services, community mental health teams and the home care services that operate within the LCN, recognising that this will require those teams to have an alignment with the LCN geography and strong functional integration across those services.
- Include named specialists (for example consultant or specialist nurses in paediatrics, general and elderly medicine, chronic diseases such as diabetes/respiratory/HF, and mental health) who can provide accessible outreach and support and who can act as a point of contact when residents from a locality require inpatient care.
- Formally link to the urgent response and post-acute care services, such as Enhanced Rapid Response and @home, so that preventable admissions are reduced and transitions into and out of hospitals are timely, well planned and coordinated.
- Formally link to the wider network of institutions that support people in their daily lives, for example local schools, community pharmacists, care homes, nursing homes, and other local voluntary and community sector providers.

We have been talking about Community Based Care for a long time; over 18 months we've made some significant progress on delivery

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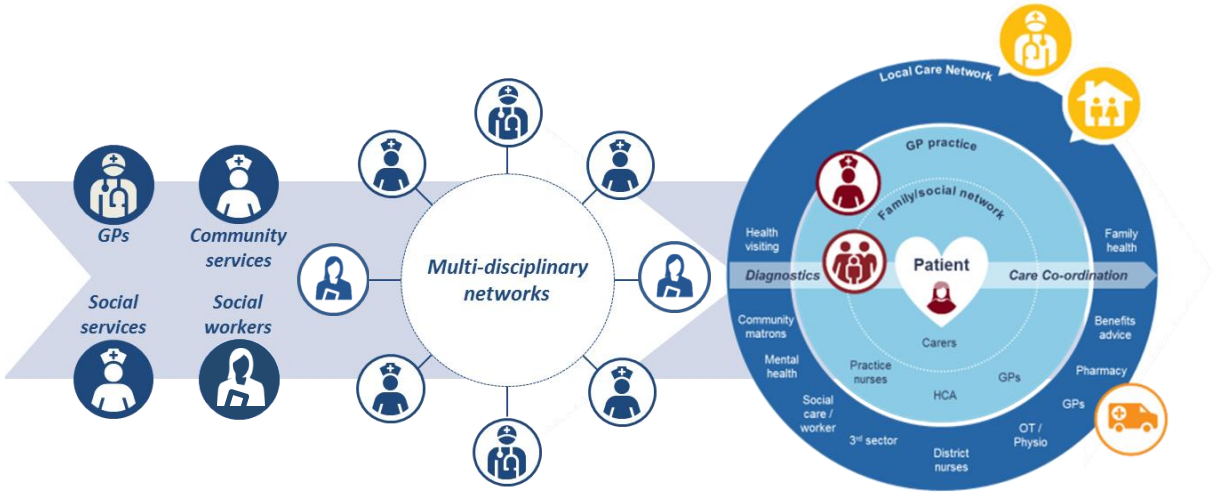

1. Start small and do something practical
2. Reflect, learn and celebrate success
3. Align and build

We have achieved a lot over the past 18 months – building stronger relationships and using collaborative models of working

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1 Start small

Build a coalition and agree practical objectives

Create relationships and shared understanding

Developing LCNs and a shared programme

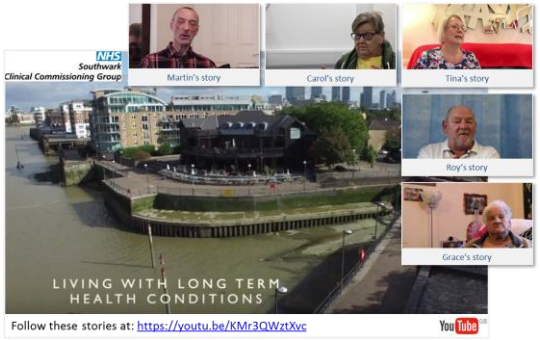
Phase 2

- Coalition of the willing
- Regular LCN meetings
- Programme boards in each organisation
- Long term chair arrangements
- Care Coordination Programme

Co-design new ways of working

Get more people involved

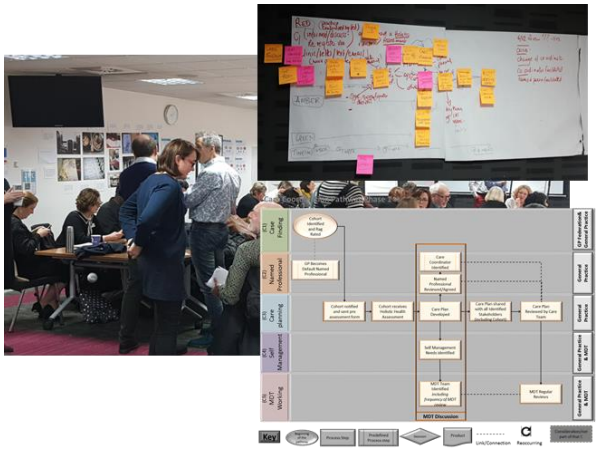
Collecting stories and learning together



Make this part of the 'day job'

Test learn and improve…

LCN teams planning for delivery



We created a local Strategic Partnership, and agreed to focus our efforts on a practical redesign task, underpinned by a CQUIN

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1 Start small

We have worked together to improve care pathways for people with multiple LTCs

One in five Londoners are living with one or more complex conditions. Other people go through periods of severe, complicated, health problems which may last months or years before they are resolved.

Changes to the GP contract focus on the over-75s, but in London it is often younger people who live with complex health problems which may be harder to manage because of drug or alcohol dependence, mental health problems or financial and social pressures.

Many Londoners, young and old, will be receiving care from several different services, which can become confusing and frustrating if the services don't work in close collaboration.

Firstly we need to identify the patients who would benefit from this approach. Many will be elderly and suffer from multiple chronic conditions while others may suffer from mental health issues or have a set of social circumstances and lifestyle issues which are best addressed though coordinated care.

Dr. Rebecca Rosen (Greenwich GP)

C1 Case Finding → C2 Named Profession → C3 Care Planning → C4 Self-Management → C5 MDT Working

1. Source: https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

We built new relationships that have deepened over time, and we recruited new leadership posts to add extra practical support

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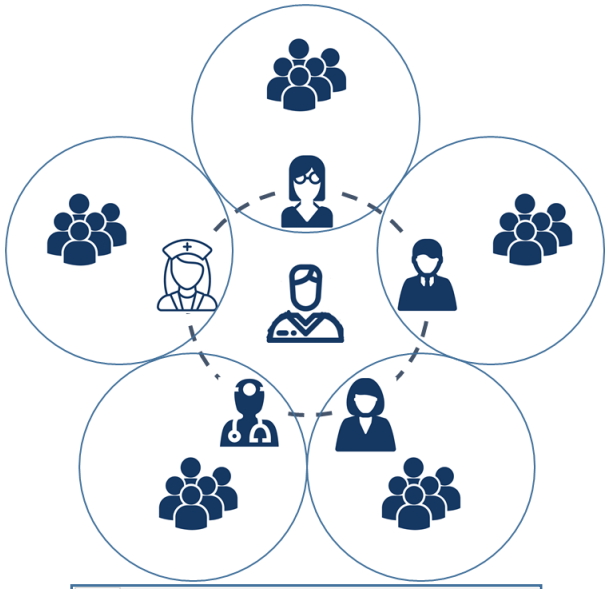
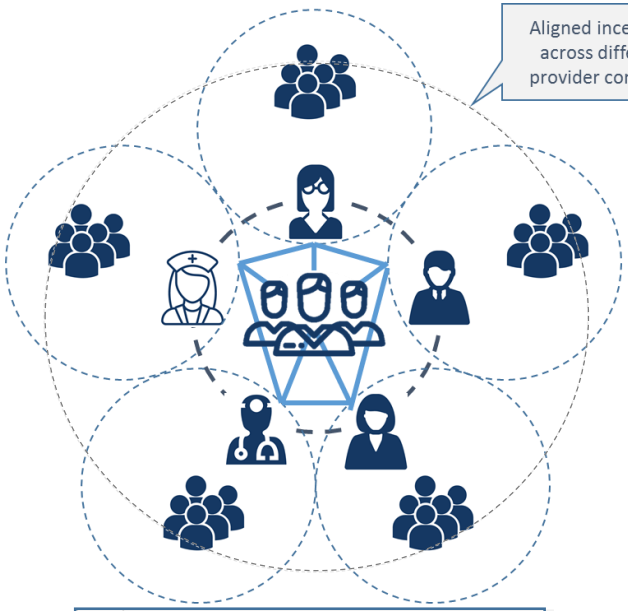
1 Start small

LCNs have matured from simple meetings of the willing, increasingly becoming more robust and resourced leadership teams





Phase 1
- Coalition of the willing
- Regular LCN meetings
- Interim chair arrangements
- Joint projects

Phase 2
- Coalition of the willing
- Regular LCN meetings
- Programme boards in each organisation
- Long term chair arrangements
- Care Coordination Programme

Phase 3
- Formal partnership (i.e. MOU and shared contract incentives)
- LCN meetings & internal programme boards
- Chair, COO (8d), Senior Change Manager (8b)
- Care Coordination Programme

We involved local clinicians in Expert Reference Groups and workshops to begin to build a description of a new pathway

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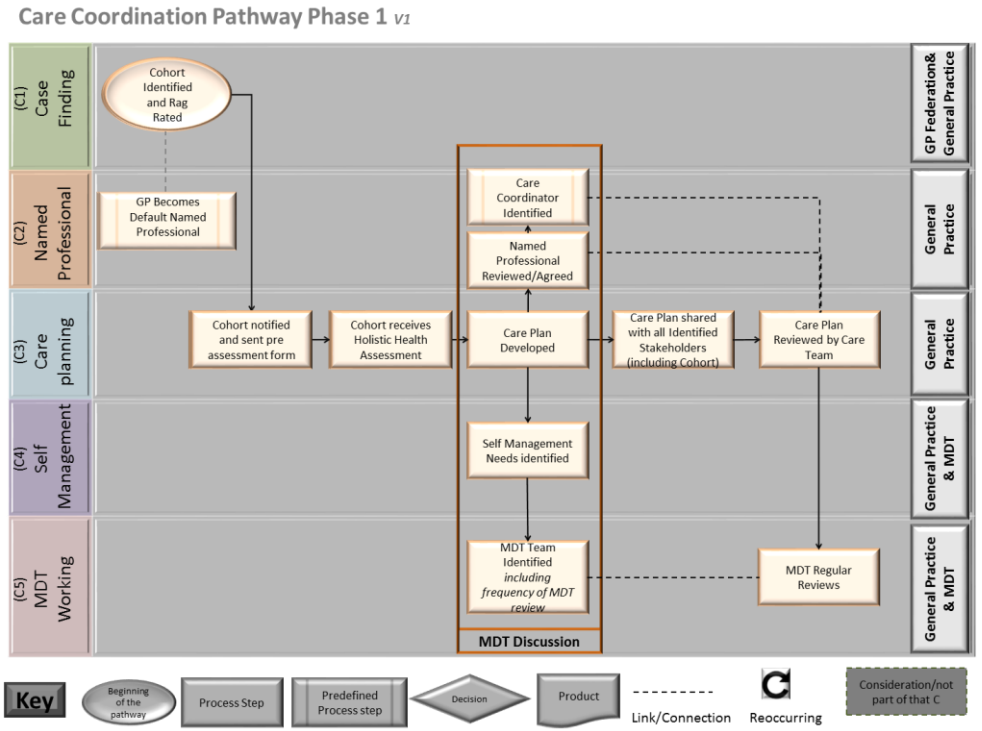
1 Start small

Illustrative examples of the type of cross-borough planning and design workshops we have led



We engaged in some focused patient insight work to help us to understand the nature of living with multiple long term conditions

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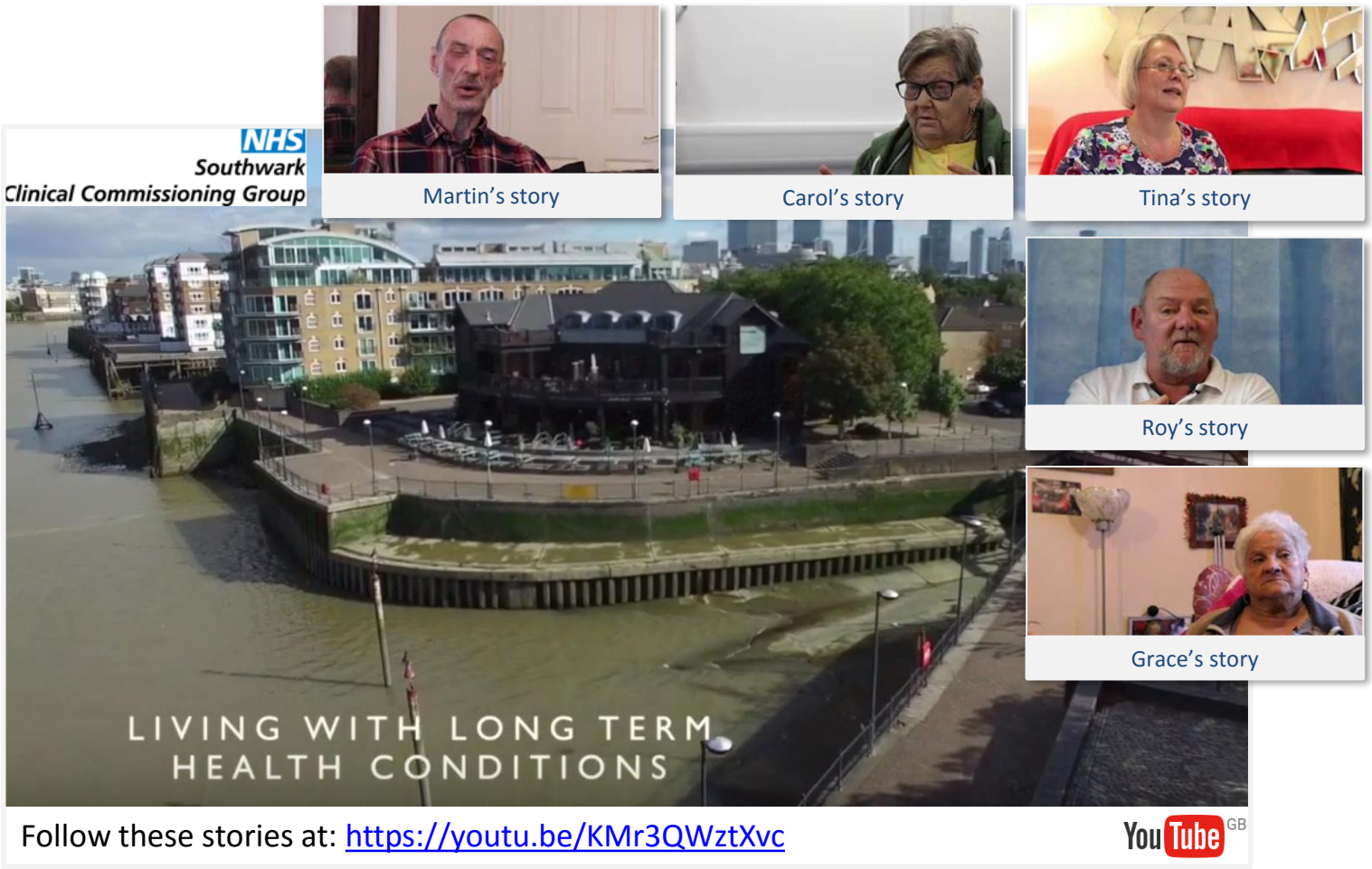
1 Start small



Follow these stories at: https://youtu.be/KMr3QWztXvc

We broadened our engagement to include all GP practices, alongside local people, interacting in a series of PLT learning events

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1 Start small

PLTs and patient engagement were jointly led between the CCG and the LCNs; and participants included CCG leads, local GPs, district nurses, SAIL reps, and acute consultants

Thinking about the issues and challenges	Exploring new guidance and ways of working	Exploring new guidance and ways of working
• Used videos of patient stories as the basis for discussion • Explored practical challenges and aspirations for managing patients with multiple LTCs • Worked in groups to explore what practice data shows about processes and gaps (collected and presented by federations)	• Heard from LCN leads about the plans for 3+LTC pathway • Heard from national NICE lead GP about the new multi-morbidity guidance • Explored practical changes that could be made to improve care and make the most of general practice input	• Ran a morning patient session, with people who have lived experience of 3+ LTCs • Showcased patient stories through artwork • Ran a co-design discussion session between clinical staff and patients to talk about care planning • Staff received training on collaborative care planning

We have worked within the limits of existing contracts, but we have made real progress to align incentives for collaborative working

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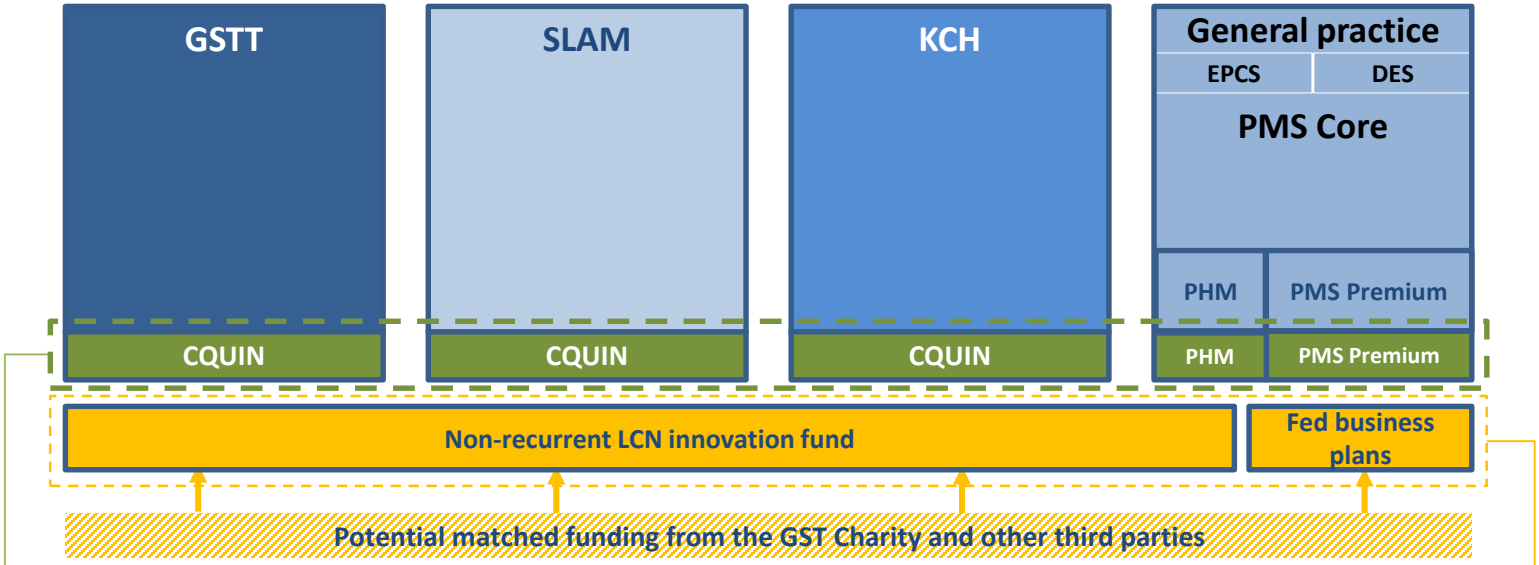
1 Start small



Shared incentive

- Separate contracts with each existing contract holder
- Acute contracts include an identical CQUIN component
- Primary care contracts to include an equivalent component, to fund delivery of core parts of the new pathway
    - PHM Contract (focused on higher complexity)
    - PMS Contract (focused on lower complexity)

Aligned transformation funding

- We are asking GP federations to continue to focus on developing neighbourhood based models of working
    - Embedded team to mobilise PHM
    - Investment in cluster working
- We have funded two VCS organisations (Pembroke House and Time & Talents) to explore how they can support people with multimorbidity as part of an LCN
- We are supporting community pharmacy to be involved
- We have given additional discretionary funding to the LCN boards to test new ways of working

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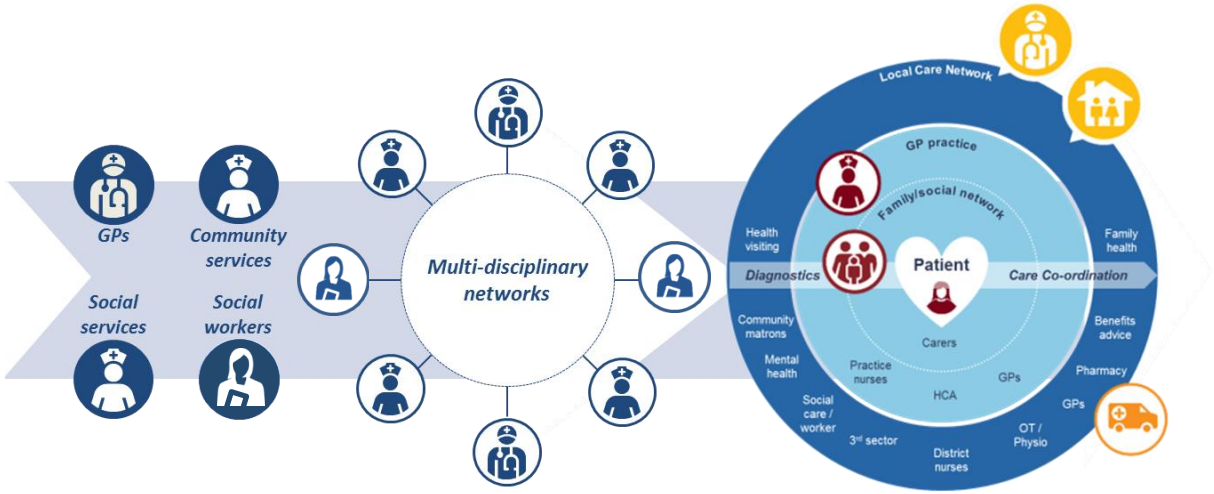

This has been hard, but we have demonstrated new ways of working and we have landed some significant agreements

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2 Celebrate success

- It takes time to build a common understanding of what we are trying to do
- Building strong relationships and supporting culture change is hard, and it requires investment of time and effort
- It is important to make sure that people are aware of what is happening and that they are able to join in
- Genuine patient engagement is not easy, but it is hugely valuable and brings fresh perspectives
- It requires patience, commitment and skill to turn collaborative design work into agreed contracts
- The design phase is the easy bit, we now need to implement this, taking a 'test and learn' approach
- As we have worked together on this practical pathway it has become easier to talk about what else LCNs can do together

- Months of discussions led to agreeing the 2016/17 CQUIN
- Regular LCN Boards in north and south
- Co-located N/S LCN working groups
- GP Incentive for audits of 3+ LTC patients
- Three PLTs with MDT representation
- Five deep dive professional videos
- Contact with all patients with 3+ LTCs
- PMS negotiations initially stalled – now PHM and PMS look very positive
- Southwark and Lambeth LCNs are developing an implementation plan
- …other service redesign / alignment

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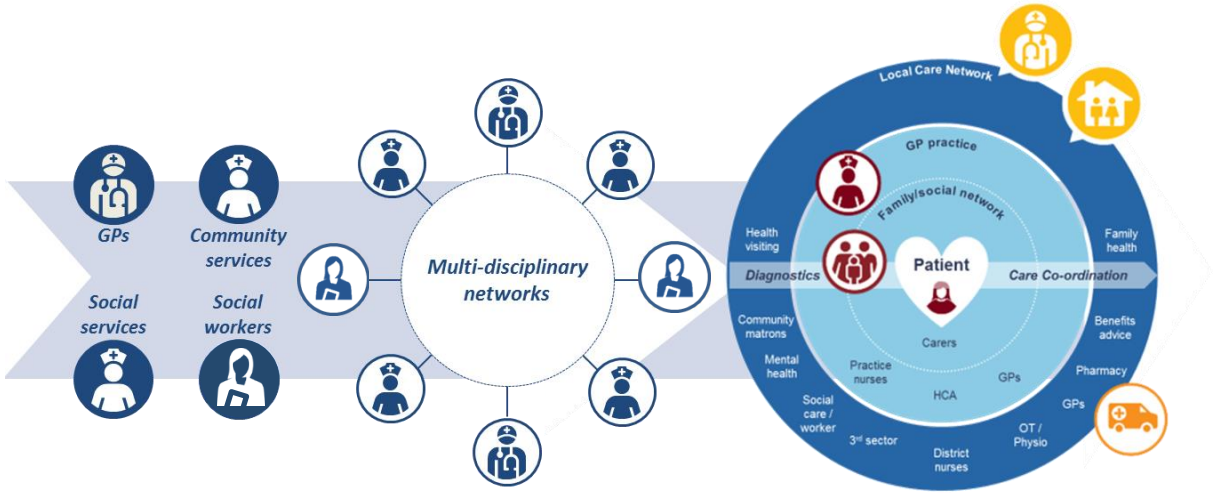

1. Start small and do something practical
2. Reflect, learn and celebrate success
3. Align and build

NHSE are trying to support the development of LCN-type approaches

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3 Align & build

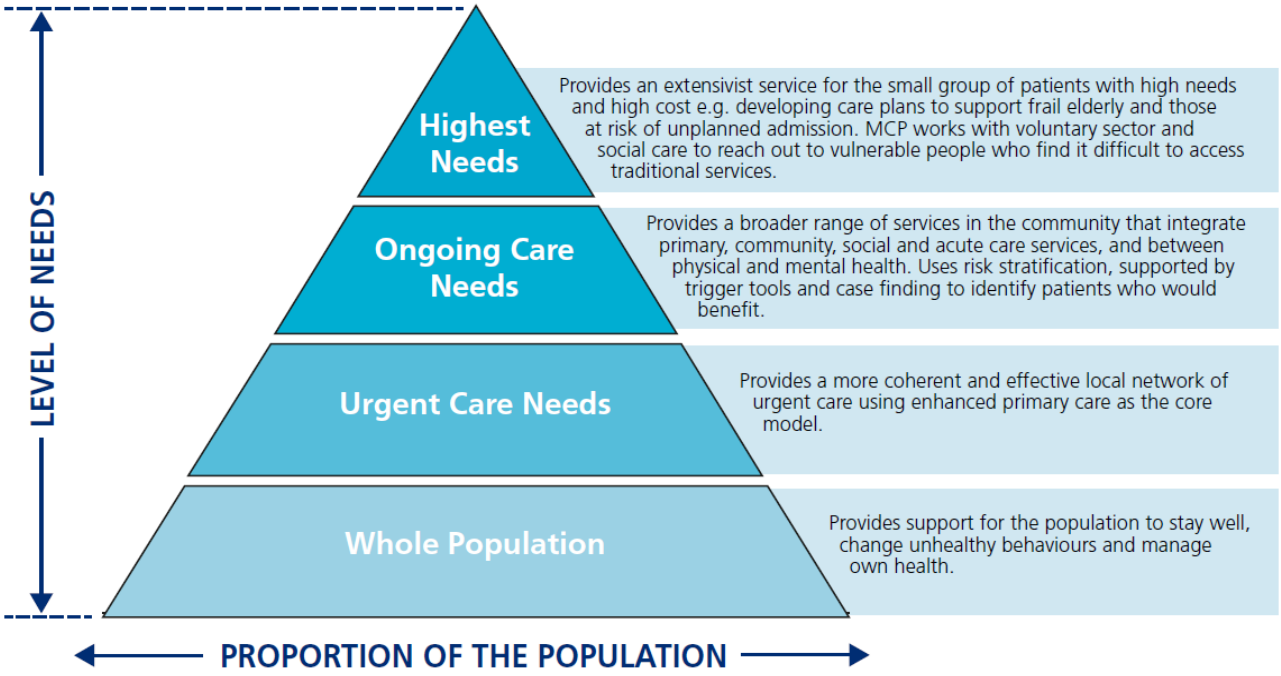
- Last year NHS England launched a framework in relation to the Multispecialty Community Provider (MCP) new model of care. The fundamental rationale for introducing the MCP is to address the reality that – as a patient, clinician, or commissioner – we would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services.

- The **MCP model attempts to dissolve those divides** and to create integrated and accountable care, it is **a new type of provider, with greater freedoms and accountability**. MCPs are firmly **grounded in the registered list** and therefore they will only get off the ground and be viable with the inclusion and active support of general practice, working with local partners. An MCP supports practices to work at scale and also to benefit from working with larger community based teams. **It offers practices, federations and super-practices the potential to combine with community services and create a broader, more holistic and resilient form of general practice**.

- MCPs are providers not a new type of commissioner, and in that sense it is very different from GP multi-funds or practice-based commissioning. However, the creation of accountable care providers will necessarily change what CCGs do in future – **potentially many of the existing functions of a CCG will be performed by the MCP**.

MCPs are accountable for providing care and proactive management to the whole population – its what our LCNs could become

Figure 1: The four levels of the MCP care model



MCPs offer a practical route to rearrange service delivery in order to deliver **place-based services to a whole population**.

Importantly, **MCPs can cover primary care services as well as community services, community mental health services, social services and potentially aspects of acute care**. And they play an important role in organising urgent and emergency care, as well as supporting integration of care for people with chronic needs.

Note: Some MCP Vanguards have integrated health and social care budgets, whereas others such as Dudley have seconded adult social care workers into the MCP with a view to fully integrating at a later date.

Many of the things described in MCP Vanguard areas are already done here! The challenge is to align them around our populations

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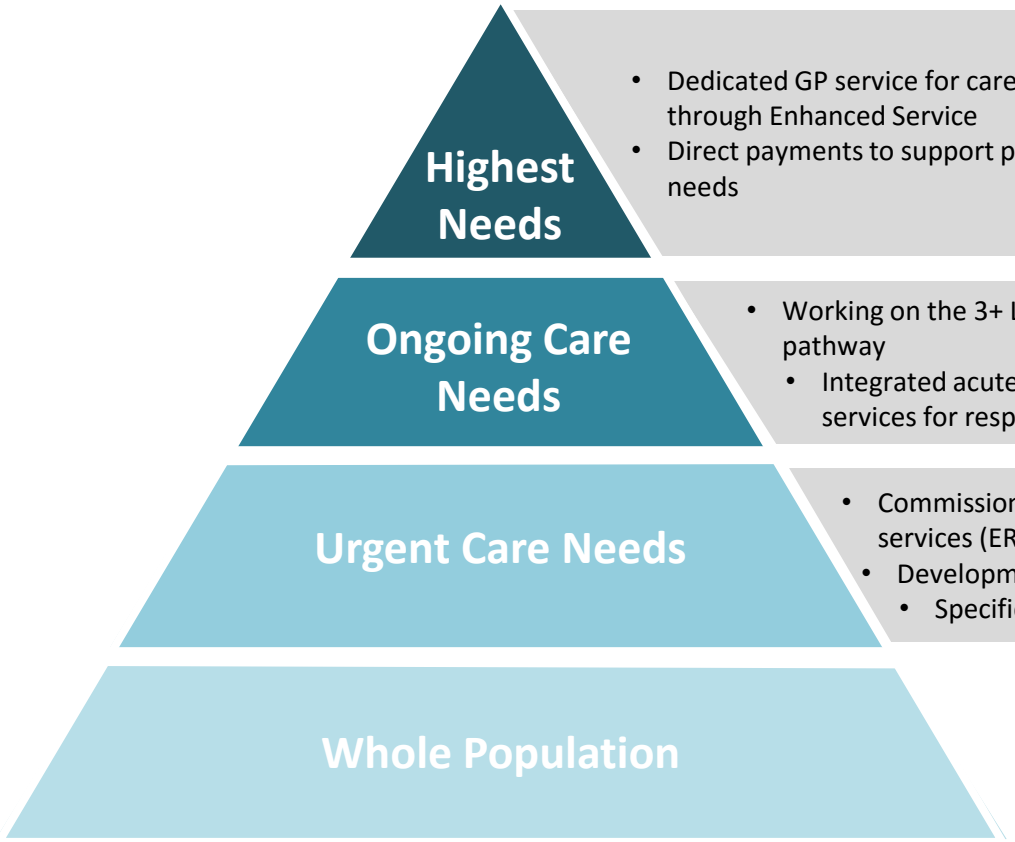
3 Align & build



	Changes we are have already made	Additional things need to explore
Highest Needs	• Dedicated GP service for care home, delivered through Enhanced Service • Direct payments to support people with CHC needs	• The MCP approach could allows for local areas to align services more explicitly around local populations / neighbourhoods
Ongoing Care Needs	• Working on the 3+ LTC care coordination pathway • Integrated acute, nursing and GPwSI services for respiratory and diabetes	
Urgent Care Needs	• Commissioning new nursing services (ERR/@home) • Development of EPCS hubs • Specification for new 111	

Local examples: our Care Homes Service has a single registered list, pharmacist and social care input, and dedicated consultant support

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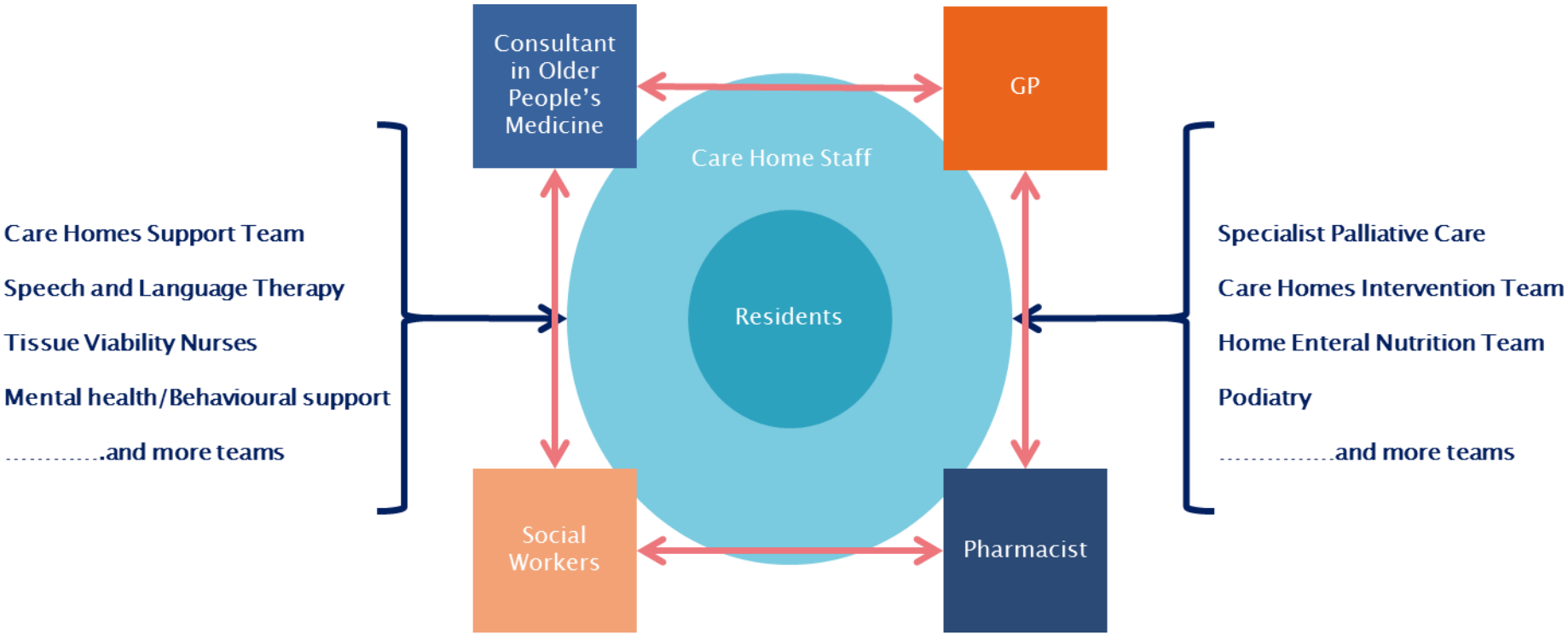
3 Align & build



Monthly MDT

Local examples: Our Integrated Respiratory Service builds increasing specialist support around general practice

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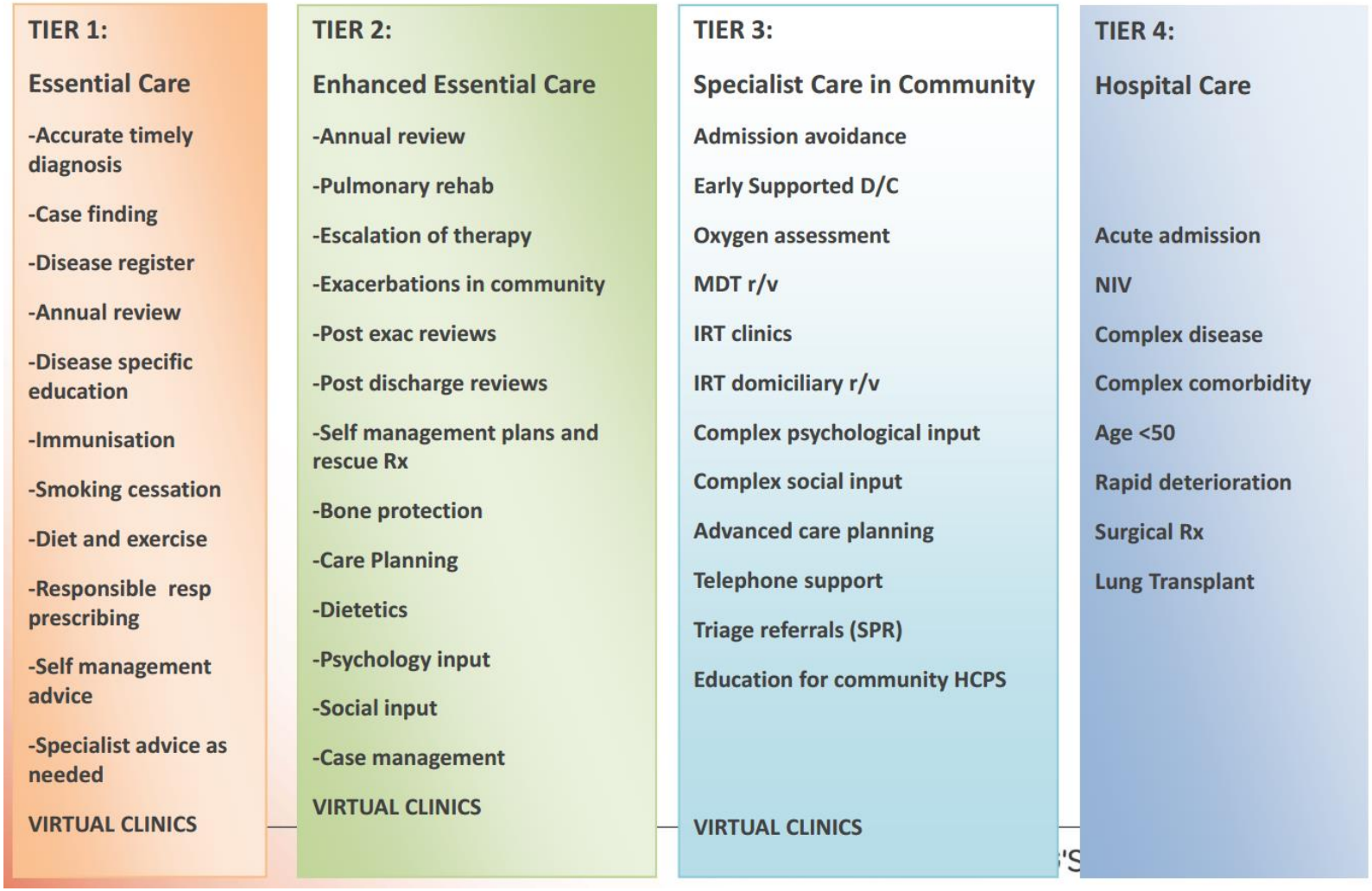
3 Align & build



1. *Source: http://www.kingsfund.org.uk/sites/files/kf/media/noel-baxter-irem-patel-integrated-care-respiratory-may14.pdf*
2. *See the vimeo slideshow at: https://vimeo.com/95417541*

Some adult social care services are being shaped around LCN populations in the north and the south of the borough

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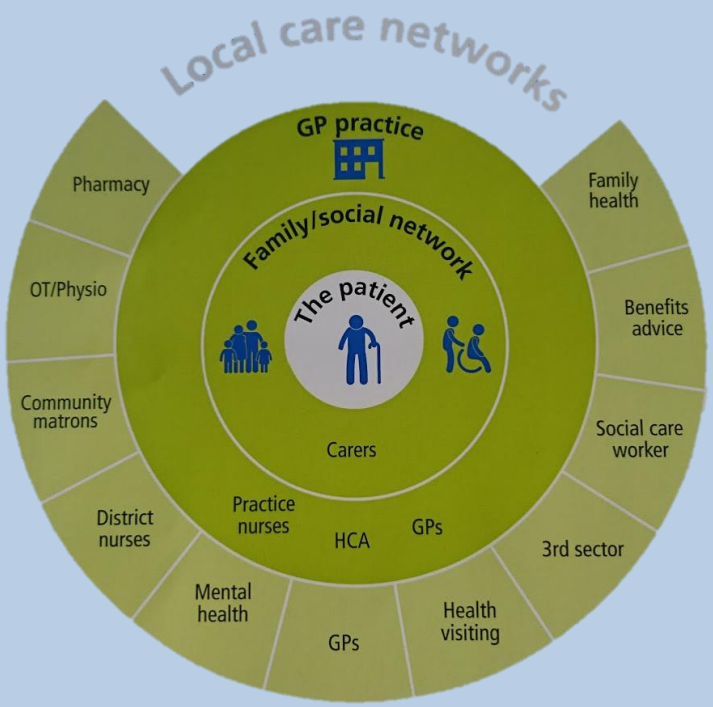
3 Align & build

Our vision for adult social care

"To enable people with care and support needs to live healthy, independent and fulfilling lives. We will achieve this by putting their well-being and safety at the centre of our work and doing what we can to prevent, reduce and delay the need for care and support through well-coordinated, personalised health and social care services"



Some services – such as the Contact Adult Social Care (CASC), and Urgent Rehabilitation & Reablement – are provided at a pan-borough level; whereas other services, such as the PD & OP Intake (assessment) and Case Management functions are aligned to LCN populations and geographies.

The development of LCNs requires us to think differently about how we align resources to population groups

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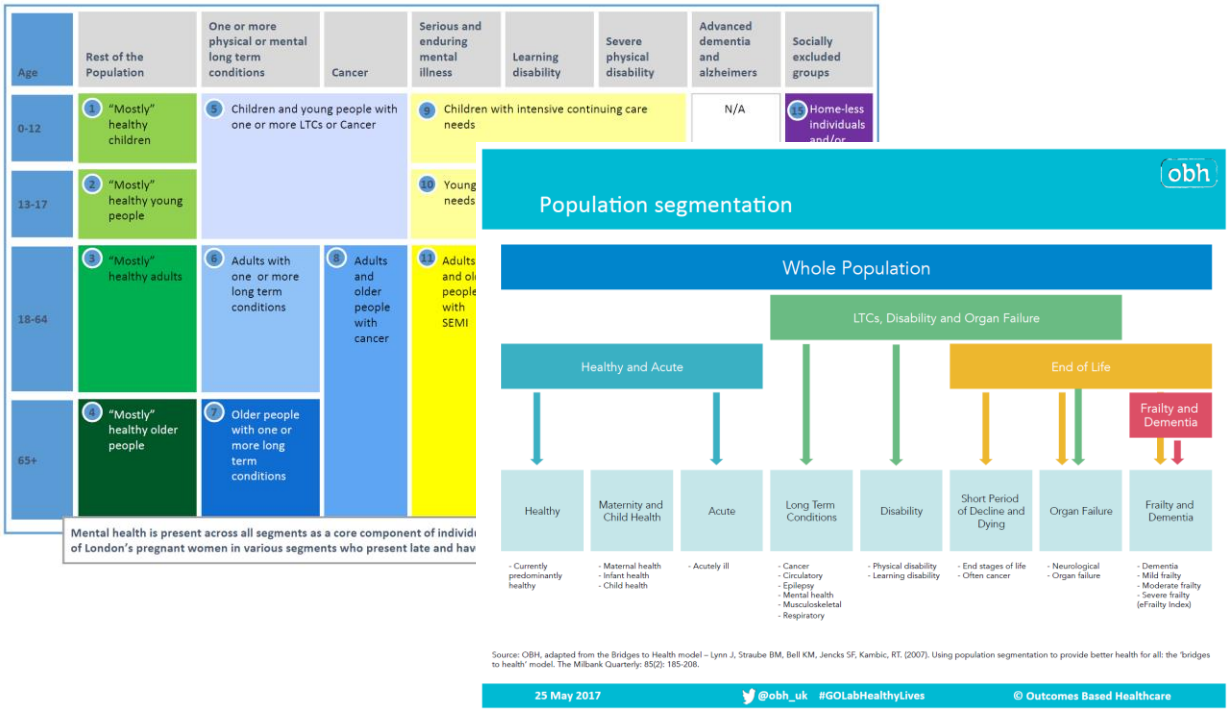
3 Align & build

- Through the Integrated Planning and Delivery Group (IPDG) the CCG and the Council are exploring how whole population segmentation can help us to move towards a more person-centred and place-based approach to commissioning and contracting.
- These types of approaches underpin the development of many accountable care systems
- There is no perfect way to approach segmentation; but we are seeing that several approaches have been developed for health and social care, and they share many important features



A

Appendix – background information

In places such as Dudley, they are building towards an MCP via a series of consolidating steps

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A Vanguard examples

Stage 1: Teams without walls

The first stage, already substantially in place, of delivering this mutual-networked care is to establish across Dudley **a joined up network of GP-led, community-based multi-disciplinary teams** which enable health, social care and the voluntary sector to work together in **"teams without walls"** for shared benefits and outcomes, coordinating the care planning for individual patients. These teams transcend organisational boundaries and interests, and focus collectively on delivering integrated patient centred care aimed particularly at that cohort of patients identified as being most at risk of emergency hospital admission. **This concept begins at practice level with Multi-Disciplinary Teams (MDTs) including the GP, District Nurse, Assertive Case Manager, Mental Health Worker, Social Worker and Voluntary Sector Link Worker.**

Stage 2: Align specialist services

This involves **expanding the mutual network of care to fully incorporate all specialist community services and some aspects of urgent care,** better aligning health and social care services into a single approach – such as single access to CAMHs services and the integration of telecare and telehealth. This includes the **establishment of a community rapid response service, designed to intervene in a crisis in the patient's home** – both avoiding the need to go to ED and connecting the person back into their local network of care. This also includes using our **primary-care led urgent care centre as a point of triage for all patients attending hospital**.

Stage 3: Community-led retrieval

This **extends the model to include current consultant-led services which operate to support population health and wellbeing**. This will include specialties which support the management of long-term conditions such as diabetes medicine and respiratory medicine. Consultants will work in partnership with GPs to the same outcome objectives for improving population health and wellbeing. This will include collaborating to deliver improved services to the frail elderly. Our ambition is to remove all delayed transfers of care from the system. We will achieve this by **shifting the locus of control from hospital to community. The integrated MDT, with support from consultant physicians, will become responsible for the whole pathway of care for the frail elderly**: from community, into hospital and back into the community – so that there are no longer any transfers of care. **Patients will be retrieved back into the community rather than transferred from one team, or one organisation, to another**.

http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/04/Operational-Plan-2016-17-V2.pdf *(see pages 39-46)*

In places such as Fylde Coast, integrated 'Extensivist' services are being developed to support people with complex needs

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A Vanguard examples

Cohort Identification:

- >60yrs
- 2+ LTCs (incl: CAD, AF, CHF, COPD, Diabetes, Dementia; excl: CKD, epilepsy, cancer)
- Risk score >=20

Local population size: 151,436
Estimated cohort size: **500 people**

Training and development

The service will seek to develop a specific Extensivist training programme for all roles in the team. Basic components include:

- CBT and behavioural support
- How to support patients with dementia
- End of life planning and emotional support
- Patient activation and motivation
- General training on the LTCs of the group
- Leadership training for all staff
- Team working and continuous improvement
- Use of IT systems, including EMIS and home monitoring

A dedicated team operating at a supra-practice level (covering 500 patients)

The team is made up of:

Identified patients are de-listed from their practice and enlisted with the Extensivist service

Clinic leaders

- 2 x Extensivist / senior medical leader (one GP plus one consultant) leading care planning
- Advanced practitioner, making differential diagnoses, coordinating patient care

Care Coordinators

- Nurse, OT, Physiotherapist, Social worker, pharmacist, dietician

Delivering specialist care in-line with individual training

Sub-specialists will also cover the most complex patients with the disease they specialise in

Wellbeing support worker

Build a strong supportive relationship with the patient

Act as the point of contact for the patient and their family

Responsible for self-management support (patient activation)

Bridge the gap between clinician and the patient

Assist in navigating the system

Administration

- Service manager / Analyst – regular analysis of performance
- Administrators – support day-to-day clinic operations

Service Times

Full service: Monday-Friday, 8am-7pm | Out of Hours: Sat / Sun / BH 9am-1pm | No service: all other hours

1. For more detailed team role descriptions and the high level process map see the following link
http://democracy.blackpool.gov.uk/documents/s3471/Appendix%207a%20Fylde%20Coast%20Extensivist%20Service%20Summary%20Report%20of%20Progress%20171114.pdf

We built new relationships that have deepened over time, and we recruited new leadership posts to add extra practical support

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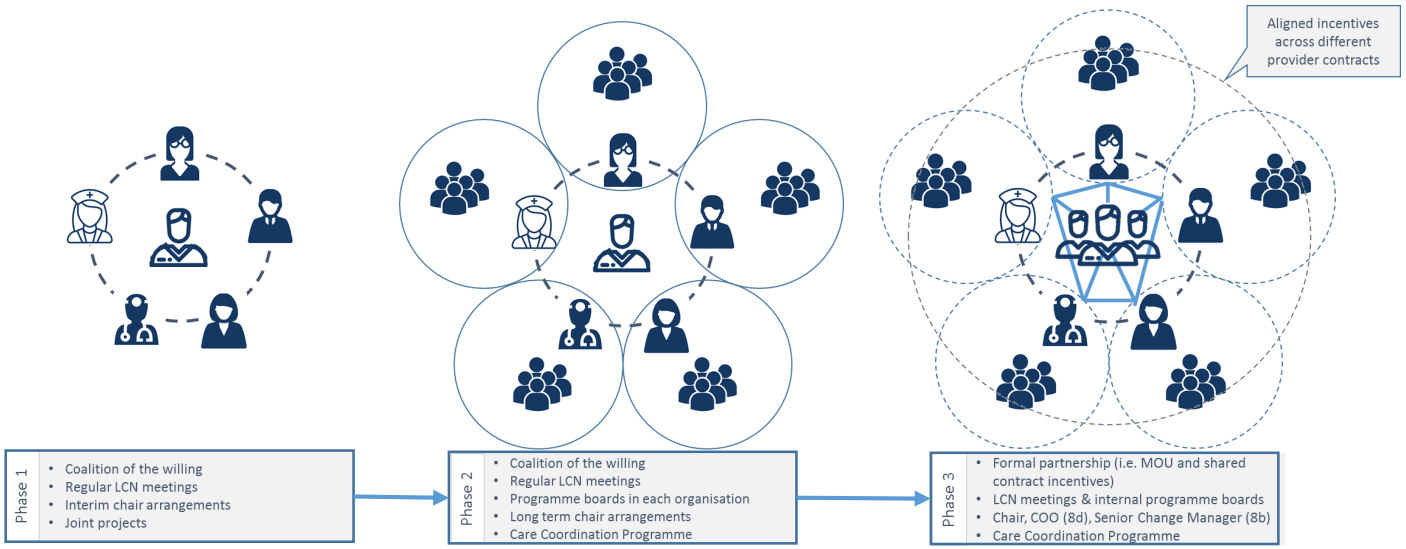
A LCN members



North LCN Board	
Louisa Dove (Chair)	QHS (GP Federation)
Aarti Gandeshi	Healthwatch
Sue Bowler	Guy's and St Thomas' (GSTT) - ALS
Rederi Grobler	Guy's and St Thomas' (GSTT) - ALS
Mick Wright-Turner	South London and Maudsley
Graham Collins	Community Southwark
Rebecca Dallmeyer	QHS (GP Federation)
Louise Flynn	QHS (GP Federation)
Simon Rayner	Southwark Council
Atul Patel/Zahir Harunani	Community Pharmacy

South LCN Board	
Dr Emily Finch (Chair)	South London and Maudsley
Cathy Ingram	Guy's and St Thomas'
Aarti Gandeshi	Healthwatch
Dr Dan Wilson	King's College Hospital
Dr Lauren Parry	Improving Health (GP Federation)
Gordon McCulloch	Community Southwark
Harprit Lally	Improving Health (GP Federation)
Jill Solly	King's College Hospital
Nicola Jones	Guy's and St Thomas'
Nigel Smith	Improving Health (GP Federation)
Pauline O'Hare	Southwark Council
Zinat Abedin	Local Pharmaceutical Committee
Popoola Fatai/Ade Olayide	Community Pharmacy

In 2016/17 we have made progress in all addressing fragmentation in our system

NHS Southwark Clinical Commissioning Group

A Plan on a page

We are trying to maximize the total value of health and care for Southwark people, ensuring that commissioned services exhibit positive attributes of care (services respond to a person's mental and physical health needs; they are proactive, preventative, and empowering; and they are well coordinated)

1 **We have begun** to address the fragmented arrangements of commissioning & contracting, by:

a) Establishing joint population-based commissioning development groups (CDGs) and a Joint Committee

b) Creating fully assured BCF plans

c) Recruiting a Associate Director to oversee the implementation of a joint Partnership Commissioning Team for the CCG and the Council

d) Establishing a shared system incentive (with alternative arrangements for general practice)

e) Starting formal options appraisal and engagement to determine if we will submit an application for delegation

2 **We have begun** to address the fragmented arrangement of organisations and professions, by:

f) Establishing two Local Care Network Boards in Southwark, with consistent multi-agency representation, and funded LCN chairs – additional resources are being agreed to support further development

g) Putting into practice two 'at scale' Extended Access Hubs, developing GP federations, and orienting adult social care around neighbourhood and LCN geographies

h) Agreeing our local Sustainability and Transformation Plan (STP) and launching a consultation on an elective orthopaedic centre model

3 **We have begun** to address the need to empower residents and service users, by

i) Holding public meetings about our GP contracts, involving local residents in the development of a new pathway of care for people with complex needs, and the incorporation of Healthwatch reports into our CDGs

j) Creating a tripartite VCS Strategy informed by a series of discussion events

k) Successfully bidding to be a pilot site to embed Patient Activation Measures in our local services

l) Requiring providers to include collaborative care planning and self-management in the pathways for people with chronic conditions

4 **We have worked with others to establish** a local Strategic Partnership of commissioners, statutory providers and residents to ensure alignment of organisational strategies and to coordinate and enable the delivery of our shared transformation programme

For 2017/18 we have identified further specific objectives that will support the delivery of our shared five year forward view

NHS Southwark Clinical Commissioning Group

A Plan on a page

We are trying to maximize the total value of health and care for Southwark people, ensuring that commissioned services exhibit positive attributes of care (services respond to a person's mental and physical health needs; they are proactive, preventative, and empowering; and they are well coordinated)

1 **We will continue** to address the fragmented arrangements of commissioning & contracting, by:

a) Using our CDGs to develop plans that support population-based and outcomes-focused contracting for CYP, adults and SMI groups

b) Fully utilising BCF opportunities, moving towards a thematic approach to H&SC funding within the scheme

c) Deepening our joint working with the Council by establishing a Partnerships Commissioning Team

d) Making the most of our commissioning opportunities to simplify GP contracting and support collaboration with the wider health and care system

2 **We continue** to address the fragmented arrangement of organisations and professions, by:

f) Building greater capacity and purpose within our Local Care Networks – investing in an 'engine room' to drive a wider programme of activity (covering aspects of coordinated care, planned care, and urgent care)

g) Implementing the GPFV, and increasing the scope of our Extended Access Hubs to meet the London Access Specification (including offering routine pre-bookable appointments)

h) Beginning to deliver projects within our local STP, including sharing corporate functions and the further development of the Local Care Record and analytics

3 **We continue** to address the need to empowering residents and service users, by

i) Holding public meetings to inform our approach to local contracting (including creating a local outcomes framework)

j) Undertaking more focused community development work as part of a wider ambition around social regeneration

k) Building on the PAM pilots so that self-management is more effectively supported in Southwark; and that service users and staff to make the most of collaborative care planning

l) Involving local residents in the development of a new pathway of care (through ethnographic research, patient stories and experience-based co-design)

4 **We will continue to work within our** local Strategic Partnership of commissioners, statutory providers and residents to ensure alignment of organisational strategies and to coordinate and enable the delivery of our shared transformation programme