Southwark Five Year Forward View

Stocktake for Southwark Health & Wellbeing Board - June 2019

Southwark Council
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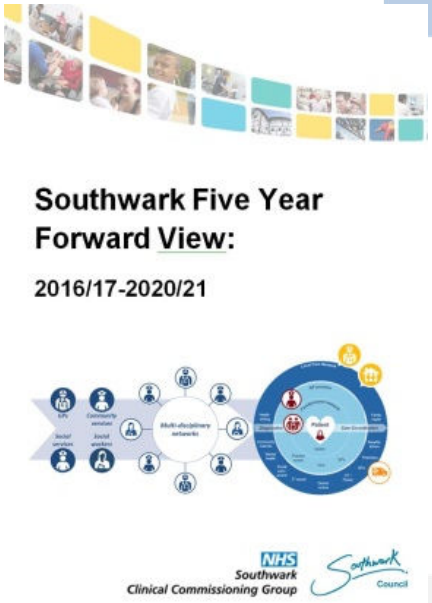
Southwark
Clinical Commissioning Group

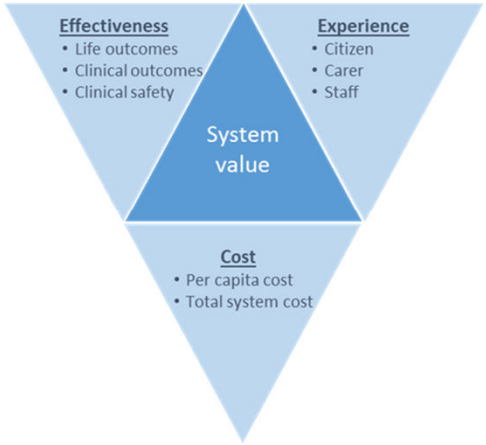
Local strategic vision: Southwark's Five Year Forward View

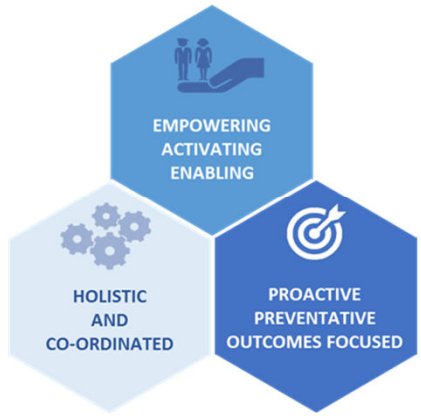
Southwark CCG and Southwark Council in 2015 developed a local vision for health and social care in Southwark: 2016/17 to 2020/21 to transform local NHS and care services in the borough. Both the CCG and Council together with local stakeholders agreed that we should be working toward establishing a health and care system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements.



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**

Local strategic vision: Southwark's Five Year Forward View

So far we have joined together some commissioning arrangements (as a **Partnership Commissioning Team**) and are working to set-up contracts that focus on improving outcomes for local populations rather than the quantity of activity delivered. **CCG system reforms**, particularly the greater integration of commissioning across Council and CCG in support of place based boards, enable us to accelerate this and to move towards a focus on a 'Southwark Pound'.

In parallel, health, care and VCS organisations have begun working together in the borough to deliver services more effectively, embed new ways of working, and ensure care and support is centred around the needs of individuals and local populations. We have made much progress and many of the building blocks we need for integrated population-based care are in place; **however, these are not always joined up or coordinated to deliver the best impact**.

Partnership Southwark, our **Local Care Partnership**, is bringing this work together, making sure it is aligned and effective, and moving the system forward at pace. Aligning with the ambitions of the **Southwark Five Year Forward View** and **NHS Long Term Plan**, Partnership Southwark seeks to drive more joined up population-based strategic commissioning and robust place-based delivery models.

Over the next 2 to 3 years, health and care services will transition to the delivery of integrated population-based care through Partnership Southwark. Services and support will be population focused; delivered within and across **neighbourhoods of 30 to 50k people**. This model will enable groups of practices within **Primary Care Networks** to work in partnership with community services, social care and other providers of health and care services around the needs of a geographically coherent population.

Neighbourhoods will **maximise utilisation of estate and other community assets**, embrace a **culture of continuous improvement and learning**, **harness and diversify the workforce** to better meet needs, embed a culture that welcomes **authentic community and patient/service user partnership**, and **make better use of data and technology**.

Purpose of today's discussions

The purpose of this presentation is to provide a brief reminder and stock take on our progress and our key next steps in delivering **Southwark's Five Year Forward View** and our ambition to integrate care for the residents of Southwark.

We will use the next presentations to provide more detailed updates on two key elements that support the **realisation of our Forward View strategy** and the journey towards development of an **Integrated Care System**:

- **Partnership Southwark,** our Local Care Partnership in the borough
- How we are proposing to change CCGs in South East London through **CCG System Reforms.**

Providing better outcomes and reducing inequalities for our residents needs an integrated approach. *Two examples*

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Charlie is five years old and lives with his mother, father, two younger siblings (aged 19 months and three) and one older sibling (aged ten). They live in private rented housing which is overcrowded.

Charlie often spends time including extended overnight stays at his Grandmother's flat, who lives nearby and is shared with his Aunt and her two children aged 11 and 14.

Charlie is in reception at primary school and his attendance has been 68%. He and his siblings had previously been on child in need plans due to domestic violence and neglect, but no longer are.

Charlie first presented at the GP with respiratory symptoms when he was 2 years old and between 2014 and 2016 presented at A&E fourteen times (all via London Ambulance Services) with asthma. He was admitted six times and in two cases was in respiratory arrest. London Ambulance staff recorded a damp, cold and untidy home but with toys and food in the fridge and noted that Charlie had been very short of breath for the previous three hours.

During the third admission his parents were taught CPR prior to discharge and the asthma nurse was informed. A referral to a paediatric respiratory consultant was made. It was subsequently noted that Charlie's attendance at outpatient appointments was very poor.

School nursing was informed of all admissions and arranged a care plan for school, including catch up on pre-school boosters.

The asthma nurse visited the home but was refused access by the father and noted that it smelt strongly of cannabis. The asthma nurse rang mother and re-arranged their visit for the next week but again was refused access and thus made a children's social care referral. A social worker visited the house and improvements had been made to the decor and good interaction was noted between Charlie and his mother.

The family have now been allocated an Early Help worker.

Mrs Andrews is an 84-year-old woman. She lives with her 85-year-old husband who is still relatively fit and driving. They have a grown-up daughter, with a family of their own who lives in Leeds and provides support over the phone to her mum and dad. Their son lives overseas and has little contact with his parents.

Mr and Mrs Andrews have lived in the same two-storey council property in Southwark for over 40 years, and they rely on a state pension with few savings. Although fiercely independent, they have become increasingly isolated over recent years.

Mrs Andrews sees her GP infrequently and takes a few medications for hypertension and heart failure. Her memory isn't what it used to be, and she needs help to climb up the stairs. In recent weeks her legs have been getting swollen and she has been breathless at times.

Mr and Mrs Andrews live in an upstairs flat with no lift and she goes out less and less due to this. The local council have offered to rehouse – however they have found the system hard to navigate and they don't want to leave their home.

Mr Andrews is experiencing carer stress and does not know where to go for help. He has also hurt his back through lifting shopping. There is also extended family stress – their children are worrying about Mrs Andrews' memory and want to make future plans, but the couple won't discuss these and are not in agreement about what to do next.

Mrs Andrews had a fall in her bathroom, was taken to hospital by ambulance and admitted to hospital. Although her hip was not fractured she had a lengthy stay in hospital during which time she deteriorated and had a further fall, spraining her wrist. Twelve days after admission it was decided that she was not suitable for rehabilitation and should be discharged with a care package. Unfortunately she had further falls at home and was admitted on a temporary basis to a care home. As a result of further deterioration she was permanently admitted and never returned home.

A population-based, value-driven care system is an integrated care system

We must address four key issues that make our existing system a less than integrated care system

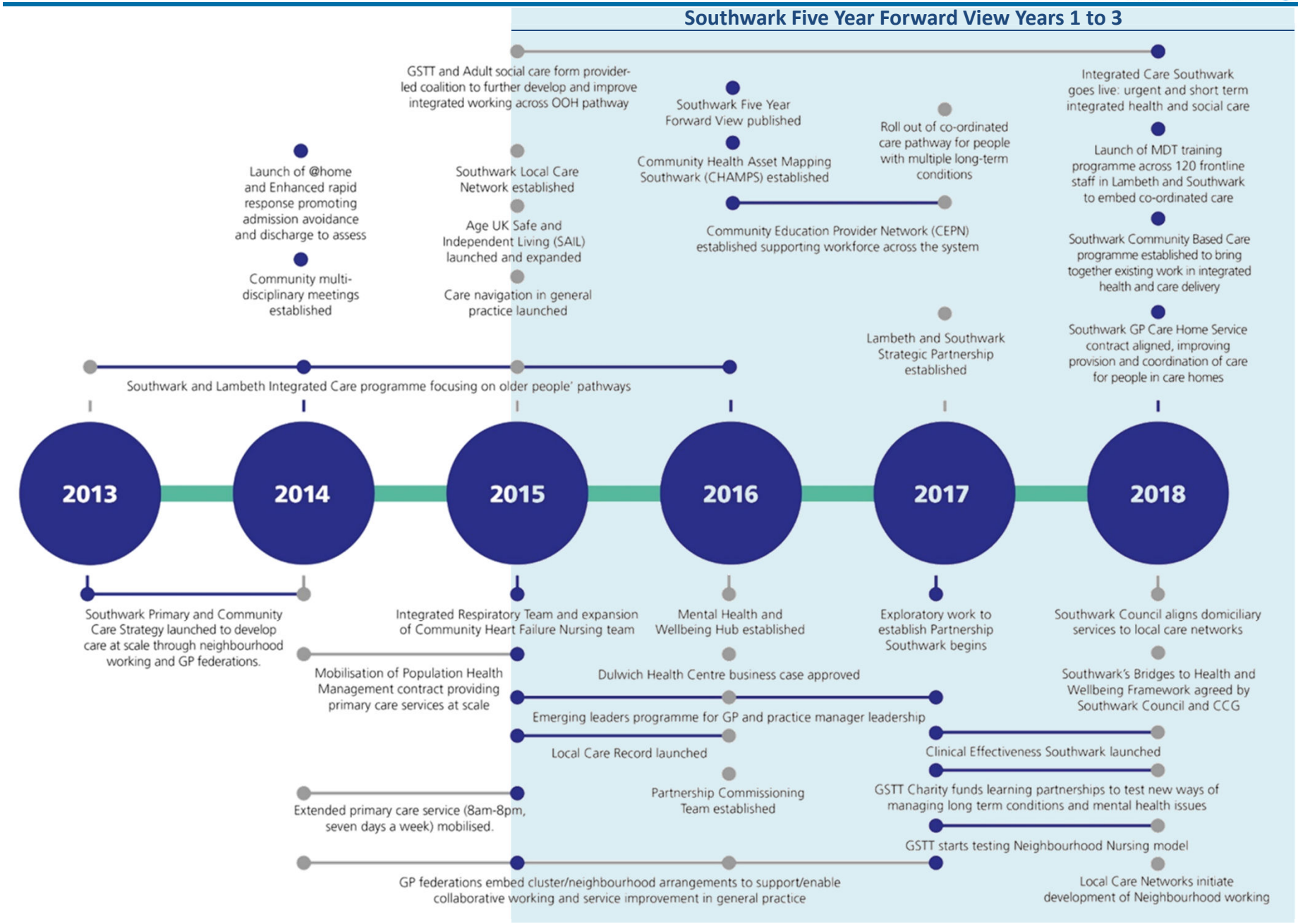
1. The **fragmented contracting arrangements** can make it difficult to move resources to where they are needed to deliver what really matters to people

2. The **fragmented arrangement of organisations and professions (including training)** 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 enabling/integrator partnership to support different agencies in the local system to share information, to align workforce strategies, or to coordinate purposeful developments within a shared transformation plan.

Some key elements of our journey to date



June 2019: Where are we now?

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 been addressing fragmented arrangements of commissioning & contracting, for example:

- Partnership Commissioning being developed as an integrated CCG and Council function to work on a population and outcomes basis, supporting place based boards from April 2020
- Further implementation of Joint Mental Health and Wellbeing Strategy across the CCG and Council with investment aligned to the Strategy
- Implementation of the findings of the Joint CAMHS Review across CCG, Council and SLaM, with investment aligned to the review outcomes
- Continuing to fully utilise BCF opportunities and seeking opportunities for shared system benefit
- Making the most of our commissioning opportunities to simplify GP contracting and support collaboration with the wider health and care system
- Establishing a common SEL planning process and commissioning intentions across health providers including community based care and prevention.

2 We have been addressing the fragmented arrangement of organisations and professions, for example:

- Neighbourhood model established and underpins PCNs as building block for integrated working with health, care & VCS
- Common set of transformation priorities for all Partnership Southwark partners:
  - Helping people with frailty / long term conditions to be supported in their home
  - Focused support for residents of care homes and nursing homes
  - Improving support for people with mental health issues in a primary and community care setting
  - Developing a shared approach and model for children and young people
- Model and approach being tested in four neighbourhood learning partnerships: Dulwich, Peckham, Rotherhithe and Walworth Triangle
- Intermediate Care Southwark providing urgent and integrated health and social care for the borough
- Implementing the GP Forward View, including ensuring that Extended Access Hubs support Integrated Urgent Care (111)
- Shared care record in place and being integrated with social care record.

3 We have been addressing the need to empowering residents and service users, for example:

- Holding public meetings to inform our approach to local contracting (including creating a local outcomes framework)
- Involving local residents in the development of new models of care (through ethnographic research, user stories and experience-based co-design)
- Supporting residents to have greater control over their own health and wellbeing, enabling community connectedness and reducing social isolation e.g. by connecting people to local community assets through social prescribing and community hubs
- Exploring approaches to develop flourishing communities – for example the development of Walworth Living Room
- Joined up Council and CCG planning to maximise value from development of community estates.

4 We have established Partnership Southwark by MoU, bringing together the CCG, Southwark Council, GSTT, SLaM, our GP Federations QHS and IHL linking to our Primary Care Networks. Shared priorities, shared governance and shared transformation resource across partners.

2019/21: Where are we going next?

Partnership Southwark and the opportunities created by CCG system reforms and the move towards becoming and Integrated Care System, will enable us to accelerate the pace of transformation during the final two years of our Strategy

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

- Bringing together local authority and NHS commissioners in a Southwark Place based Board
- Integrating CCG and Council commissioning and bringing this into Partnership Southwark to support an integrated system approach to commissioning and service development, initially focused on three areas, expanding over time:
  - Children and young people
  - Mental health
  - Older people with frailty / Long Term Conditions
- Adopting Southwark Bridges to Health and Wellbeing as the common approach and language across commissioners and providers for commissioning based on outcomes for our local population
- Developing delivery partnerships and alliances – deeper and more aligned contractual forms that better align objectives and share risk and incentives
- Linking new PCN contract specifications to Partnership Southwark priorities e.g. care coordination, care homes.

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

- Scaling our Neighbourhood Model from current four pilots to full system wide adoption across all eight neighbourhoods in Southwark
- Quality improvement 'test and learn' approach embedded as the way to design, test and scale change within and across Neighbourhoods
- Supporting the development of a joined up PCN workforce including GPs, practice nurses, PCN clinical directors, clinical pharmacists, social prescribers, first contact physio, primary care paramedics, and physician associates. Linking this with the broader neighbourhood team including community nurses, community mental health professionals, voluntary sector hubs and social care
- Work with partners across the STP to support development of a regional approach to health and care data sharing to support population analytics and direct care through the London LHCRE programme.

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

- Exploring new models of engaging residents in support of a Southwark 'Place Based Board'
- Continuing to involve local residents in the development of new models of care through a range on co design and co production approaches
- Supporting residents to have greater control over their own health and wellbeing, enabling community connectedness and reducing social isolation e.g. by connecting people to local community assets through social prescribing and community hubs
- Continuing to explore approaches to develop flourishing communities – learning from pilot approaches and working with local partners and the GST Charity
- Maturing community estates programme across the borough applying a joint Council and NHS approach to planning new hub developments such as Elephant and Castle.

4 **We will develop Partnership Southwark** through a a multi-year strategic alliance agreement across the Council, CCG and all provider partners and a Strategic Partnership Board bringing together all system partners including Kings College Hospital, the community and voluntary sector, and the GST Charity

System transformation actions and next steps during Quarter 2

Partnership Southwark

- Mobilising Strategic Partnership Board (system focused board for Southwark, all partners)
- Planning the milestones and deliverables associated with shared system priorities
- Moving to a formal alliance agreement across partners and defining how local contractual alliances will be developed around care coordination, primary and community mental health and children and young people
- Launching Primary Care Networks and linking them into broader system priorities.

CCG System Reform

- Engaging with staff, CCG membership and system partners in order to further develop the emerging proposals
- Defining how a Place based Board would work for Southwark
- Defining what integrated commissioning arrangements would be in place from 01 April 2020
- Using engagement input gathered to shape merger application for Governing Body decision in September 2019 and NHS England decision after that.

- Defining how integrated commissioning and transformation teams will operate from 01 April 2020
- Defining and agreeing how system governance will work – including Place based Board, Strategic Partnership Board, and also interaction with this Health and Wellbeing Board.

The next presentations explore these two areas in more detail.