

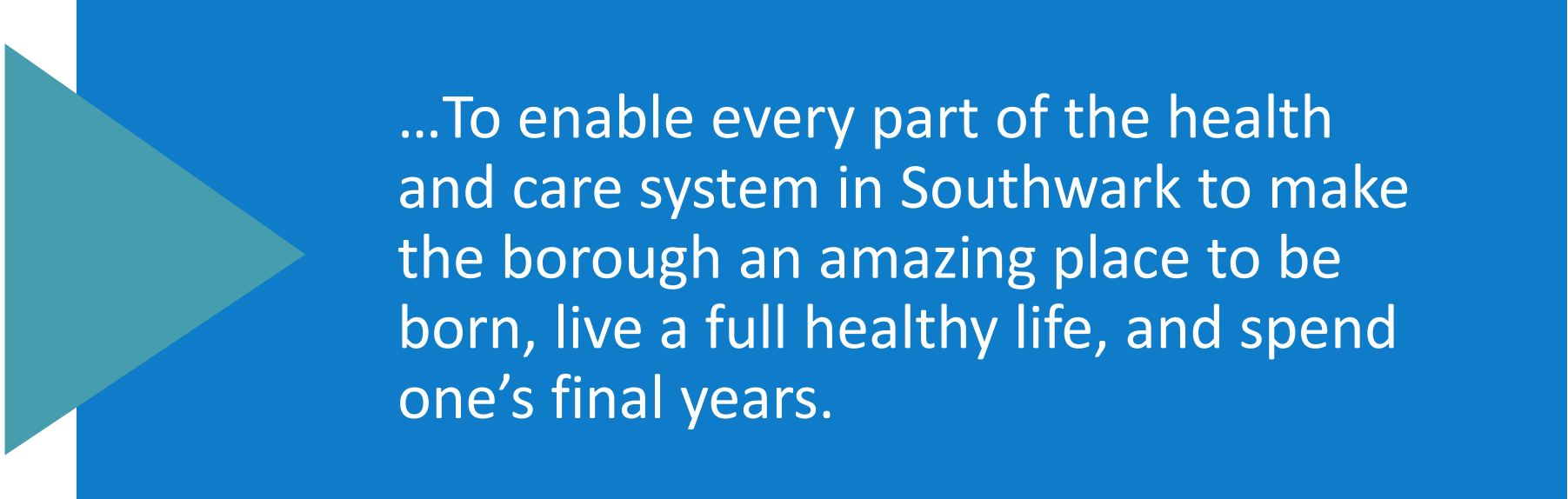
# Partnership Southwark



Working together to improve health and  
wellbeing for the people of Southwark

20 June 20

# Partnership Southwark: Our vision



...To enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years.





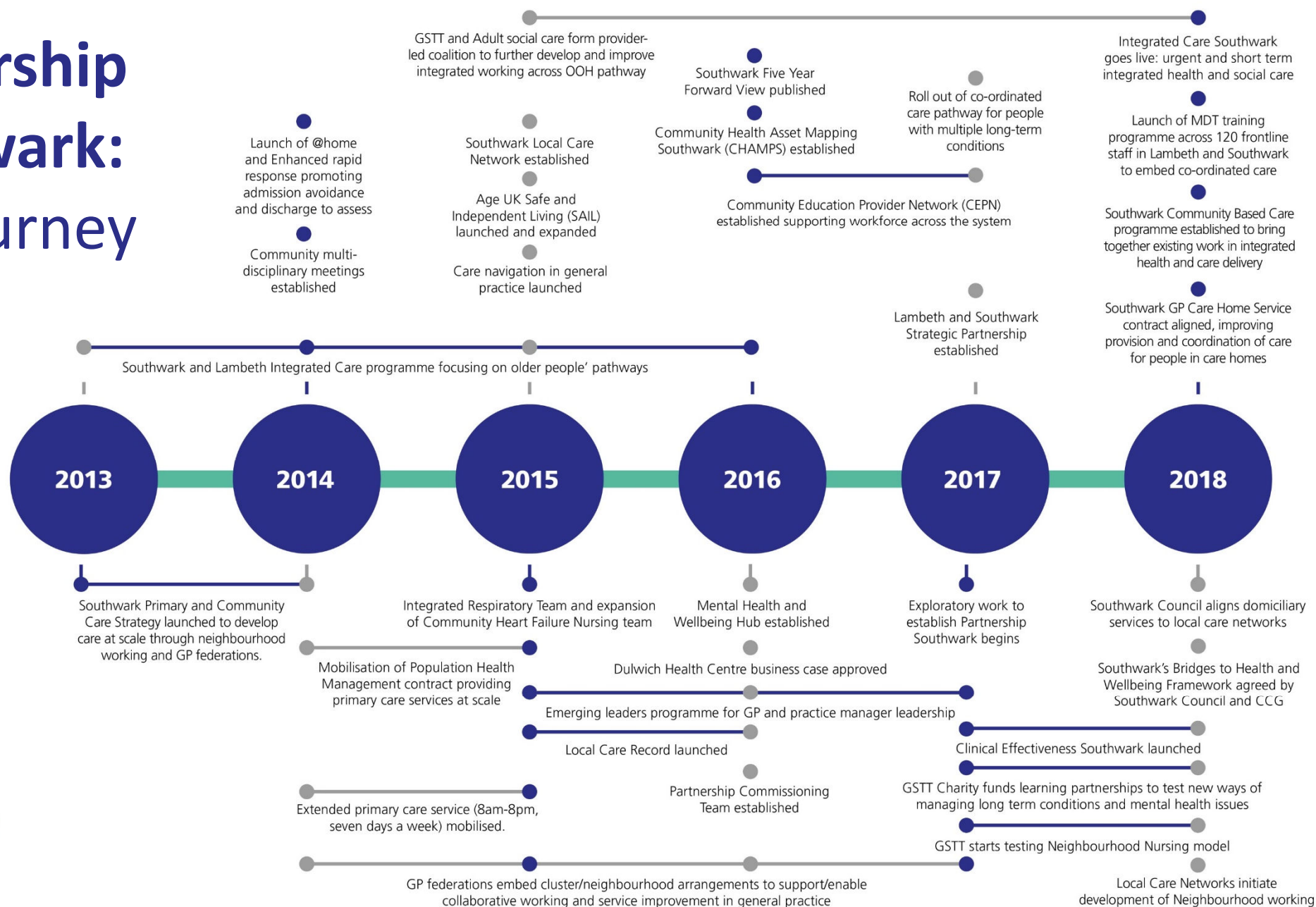
Over the next two to three years, health and care partners across Southwark will change the way services are commissioned and delivered in the borough.

Within Partnership Southwark we want to do things differently, with and for, our local communities

We will work with partners beyond health and care to tackle the causes of inequalities and prevent illness, and improve our use of data and digital technology so we can be more proactive in our approach to delivering care and support.



# Partnership Southwark: Our Journey so far



# Key health and wellbeing challenges for Southwark



## Diversity and deprivation

Southwark has a comparatively young population, with a lot of diversity. More than 120 languages are spoken and 39% of residents were born outside the UK.

It is the 40<sup>th</sup> most deprived of 326 local authorities in England and the ninth most deprived of 32 London boroughs. Around 15,000 children under 16 live in low-income families. The most deprived areas are Peckham through to Elephant and Castle; however, there are pockets of deprivation across the borough. The gap in life expectancy between people in the most and least deprived areas is 5.5 years for women and 9.5 years for men.



## Childhood obesity

Typically persists into adulthood. Associated with increased risk of diabetes, hypertension and psychological problems. In 2017-18, Southwark had the 4th highest level of excess weight (overweight and obese) out of the 32 London boroughs for children in Reception (25.4%) and 11th highest for children in Year 6 (39.8%).

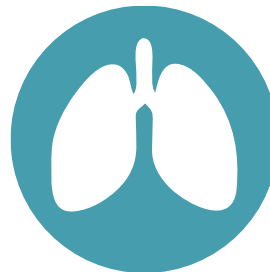


## Mental health

The estimated prevalence of mental health disorders among children and young people in Southwark is higher than the London average.

Almost 50,000 adults in Southwark experience a common mental disorder, such as depression and anxiety. Severe mental illness such as schizophrenia and bipolar affective disorder, affects 1.2% of Southwark residents (4,000 people).

Of adults with long-term health conditions, half will have experienced their first symptoms before the age of 14.



## Long Term Conditions

About 1% of the registered Southwark population have three or more chronic conditions (3,500 patients). In 2016/17, hypertension (11%), depression (8%), and diabetes (6%) were the most commonly measured diagnoses in Southwark as measured by the Quality and Outcomes Framework (QOF), mirroring the national picture.



# Engaging with local people



*Seeing family and friends is very important, and people want to be mobile and independent, being free to go out and staying connected*

*"I used to talk to the neighbour, but nowadays the only person I talk to is my community nurse."*

*"My home isn't great. I have to spend all day here looking at these walls".*

*"It [singing] uplifts me after my husband died ... it really did get me over it. They are such a jolly lot [at the choir]."*



# What local people have told us they needed:

Support to find services and help stay involved in their community, such as befriending

Services to be easily accessible, efficient and innovative

Clear information and an identified person to answer questions

Services to be more person centred

Services to be more joined up

Services and staff both within, and beyond, health and care to know how best to support people



# Financial challenge

Like many other parts of the UK, the health and care system in Southwark is financially challenged, and no organisation in isolation can address this gap.

We are not achieving best value for money and need to better manage increasing demand and complexity.

This is impacting our ability to transform at the pace and scale required to ensure sustainability and resilience of providers and commissioners.

Collaboration through Partnership Southwark, as part of a South East London Integrated Care System (ICS), will enable us to reduce growth in demand through better integration and by shifting resource to invest in prevention, self-management and early action.





# Through Partnership Southwark we will:

- Make best use of the Southwark pound to deliver improvements in health and wellbeing outcomes for local people.
- Be inclusive, and wider than health and care organisations so that we can tackle the causes of health inequalities and prevent illness.
- Ensure every part of the health and care landscape is clearly focused on common goals of supporting self-management, keeping everyone well, providing resilient high-quality services, meeting individual and population-level needs, and making it easier for people to access the information, advice, care and support they need.
- Support resilient and sustainable general practice, including enabling practices to work together within Primary Care Networks, and with other local health and care providers, through our neighbourhood model.
- View health, social care, housing, VCS organisations, education and employment as equal value/partners when working towards a healthier Southwark.
- Equip people to manage their own conditions, take part in activities that will help keep them well and to support others in their community.



# Our priorities for the next two years are:



- Accelerating the **development of neighbourhoods** supporting circa 30,000 to 50,000 people. These neighbourhoods will involve primary, community and social care, wider council (e.g. housing) and the VCS; and better join up care and support for people with complex health, care and wellbeing needs.
- Helping more people with **long-term conditions/frailty** to be supported in their community and their own home, which will reduce unnecessary time spent in hospital.
- Providing focused support for **residents of care homes and nursing homes** to ensure better outcomes and reduce avoidable hospital admissions.
- Supporting people with **mental health issues in a primary and community care** setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.
- Increasing focus on **prevention and self-management**, supporting people to live healthier for longer and working to prevent deterioration.
- Improve our **population health analytics** capability to better understand and proactively respond to population need at a neighbourhood and place-based level by sharing and linking data.
- Supporting people to have **greater control over their own health and wellbeing**, connecting them, to the community and **reducing social isolation**.
- Developing our approach for **children and young people** bringing together work within the Children and Young People's Health Partnership (CYPHP) and the development of population-level outcomes using Southwark Bridges to Health and Wellbeing.



## How we will begin to deliver on these priorities:



Work with local people and frontline staff to co-design and develop Southwark's **neighbourhood model** to better join up care and support within the community, and respond to the health and wellbeing needs of local populations.



**Formalise collaborative alliance arrangements** enabling system partners (initially Southwark CCG, GSTT, SLAM, GP federations, and Adult Social Care) to deliver integrated primary and community-based health and care. At the same time we will develop partnerships with non health and care agencies so that there are opportunities and experience which narrow the gaps in inequalities.



Join-up strategic commissioning between the Council and CCG which, over time, will move towards a **population-based approach to commissioning for outcomes** using **Bridges to Health and Wellbeing** segmentation framework.



We will build on work we have done to date; providing a foundation to go further faster in delivering tangible benefits for local people and reducing pressure on the system. *See Appendix A for our Partnership Southwark implementation plan.*

# Developing neighbourhoods

- Neighbourhood working will connect people to services as close to their home as possible, to enable new ways of working for improved outcomes.
- We want to create neighbourhood teams with strong relationships that improve the health, social wellbeing and lives of local people. The neighbourhood teams will make best use of the skills, resources and energies in our local communities.
- Neighbourhoods will be the natural way of working, focusing on the needs of local people, understanding the impact of the wider determinants of health in the neighbourhood. They will not be constrained by organisational or professional boundaries.
- We have been testing neighbourhood principles and ways of working through four test and learn partnerships in Dulwich, Peckham, Rotherhithe and Walworth Triangle. Co-design with front-line staff, managers and people with lived experience has contributed to an emerging neighbourhood model and the next phase of this work (*see Appendix C*).
- Primary Care Networks will be the building blocks for neighbourhood working. They will enable an enhanced primary care team to integrate in multidisciplinary way with other health, care and voluntary and community services to deliver care and support and improve outcomes for specified population groups.





# Formalising collaborative alliance arrangements

- A Southwark Strategic Partnership Board will be established from May 2019, with inclusive representation from all partners. This will provide strategic direction and oversight of the Partnership Southwark programme (*see Appendix B*).
- During 19/20, we will formalise Partnership Southwark through an alliance initially made up of Southwark CCG, Southwark Council, GSTT, SLAM, IHL and QHS; working closely with wider partners including KCH, the VCS and other agencies involved in supporting Southwark residents.
- The scope and scale of partnership arrangements is intended to increase over time, as we move to strengthen our approach to outcomes-based commissioning and embed place-based models of care.
- The alliance is underpinned by a Memorandum of Understanding from 01 April 2019 with the intention of moving to a more formalised alliance agreement by the end of September, which will overlay existing contractual arrangements.
- A Partnership Southwark Leadership Team will lead the alliance and oversee the delivery of workstreams against agreed priorities within scope.

The benefits of the Partnership Southwark alliance include the ability to accelerate the delivery of our shared system priorities by:

- ✓ Working to an agreed, co-produced set of deliverables and expectations.
- ✓ Embedding a shared governance and accountability structure (in line with scope), minimising impact of competing priorities/incentives
- ✓ Having the ability to pool resources and funding, and make shared decisions about how best to deploy it to drive more coordinated, integrated and sustainable services; as well as redirect funding towards more proactive preventative care.



# Moving to a population-based approach to commissioning for outcomes

- **Southwark Bridges to Health and Wellbeing** is the framework Southwark CCG and Southwark Council commissioners have agreed to develop their approach to population-based commissioning for outcomes.
- The first phase of this work will focus on priority population segments to test our approach before scaling up across the whole population.
- We will co-produce outcomes with local people and providers; including those beyond health and social care.
- The outcomes developed through this work will support service/pathway redesign and the development of new models of care at a neighbourhood and borough level, a greater focus on prevention and early intervention, and the shift towards establishing integrated care arrangements to deliver these outcomes.

The phase 1 priority segments for implementing **Southwark Bridges to Health and Wellbeing** are:

- Dementia, frailty and end of life
- Protecting vulnerable children (0-18 years) – keeping families strong; and maternity and children's services (up to 5 years) including those with specialist or complex needs

**Shifting to a population-based approach to commissioning for outcomes will allow us to:**

- ❖ Match care models to people's holistic needs rather than one size fits all.
- ❖ Understand people's wants and needs holistically not by setting.
- ❖ Give parity to mental, physical and social care.
- ❖ Align incentives to support providers to work better together, focusing on outcomes that matter to people
- ❖ Ensure the best use of resources available across Southwark by shifting the focus to prevention.





# Benefits you will see...

**Wider range of professionals working effectively together within neighbourhoods**

## **Will enable:**

- Improved patient/service user experience.
- Improved staff satisfaction and retention.
- Reduction in unnecessary referrals and investigations ordered.
- Better communication and relationships between the different professionals working within, and across, neighbourhoods.
- Reduction in GP and other health and care professional workload; releasing time to care.
- Greater awareness of people, teams, services and assets within neighbourhoods.
- Increased capacity to proactively identify people with high need/at risk of deterioration or disease progression.



# Benefits you will see...

**Helping more people with long-term conditions/frailty to be supported in their own home, and providing focused multi-disciplinary support for residents of care and nursing homes**

## **Will deliver:**

- Higher patient/service user satisfaction, increased independence and more holistic care.
- Increase in patients/service users receiving care closer to home.
- Reduction in unnecessary, unplanned and avoidable hospital admissions and time spent in hospital once admitted.
- Increased capability to proactively identify people with high need/at risk of deterioration or disease progression.
- Reduction in prescribing costs and medication side effects for people with multiple long-term conditions.





# Benefits you will see...

## Improving the support that people with mental health issues receive in a primary and community care setting

### Will enable:

- Enhanced parity of esteem between physical and mental health, and increased whole-person emphasis.
- Encouraging recovery focused, strengths/asset-based approach to increase independence and ability to self-manage.
- Reduced need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services.
- Increased confidence in primary care setting to manage a range of SMI and LTC patients/service users as part of a broader offer
- Reduced need for service users to attend multiple appointments at various sites (e.g. to receive physical and mental health reviews/treatment).

## Increased focus on prevention and self-management, including embedding the 'Vital 5'

### Will support:

- People to live healthier for longer.
- Ability to prevent deterioration and slow the transition from one to many long-term conditions.
- People to manage their own health and wellbeing, reducing pressure on health and care services.



# Benefits you will see...

## Optimising the involvement of non health or care agencies such as voluntary sector, housing and education

### Will deliver:

- Improvements in social and emotional wellbeing.
- Stabilised growth in health and social care costs.
- Increased social connectedness and individual agency.
- Improvements in health literacy and skills in self care.
- Reduction in GP visits.
- Return on investment in the longer term.

## Better understanding of and responsiveness to population need through improved information sharing and linked data analytics

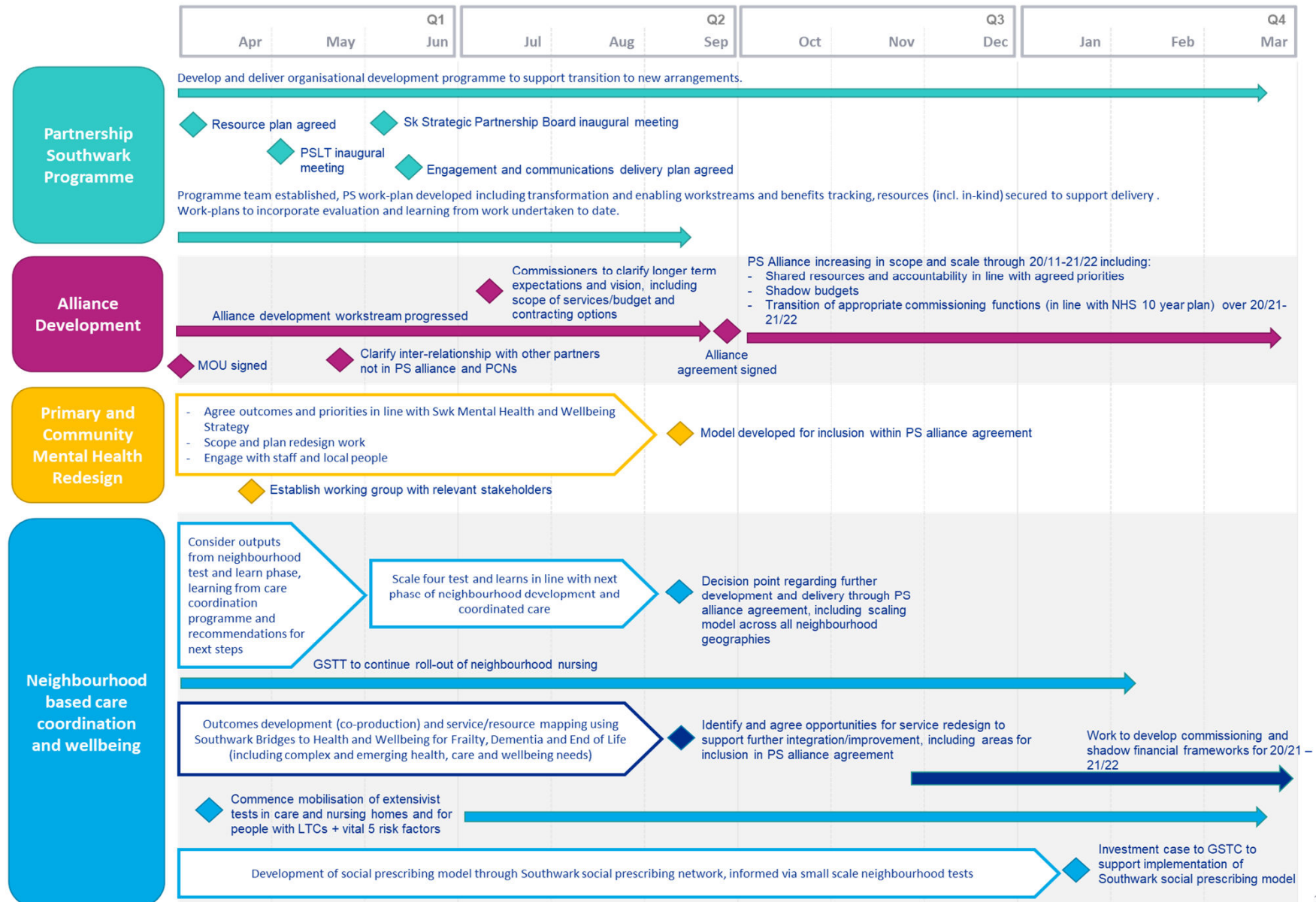
### Will support:

- Capability to proactively respond to population needs at a neighbourhood and borough-level.
- Improved collective understanding of health and care needs, rather than current fragmented understanding of data from a single organisational perspective.
- Greater ability to address health inequalities and to tailor outcomes for groups of people with similar needs.
- Our approach to integrated care locally; building trust between partners and with patients/service users.



# Appendix A: Partnership Southwark implementation plan (1/2)

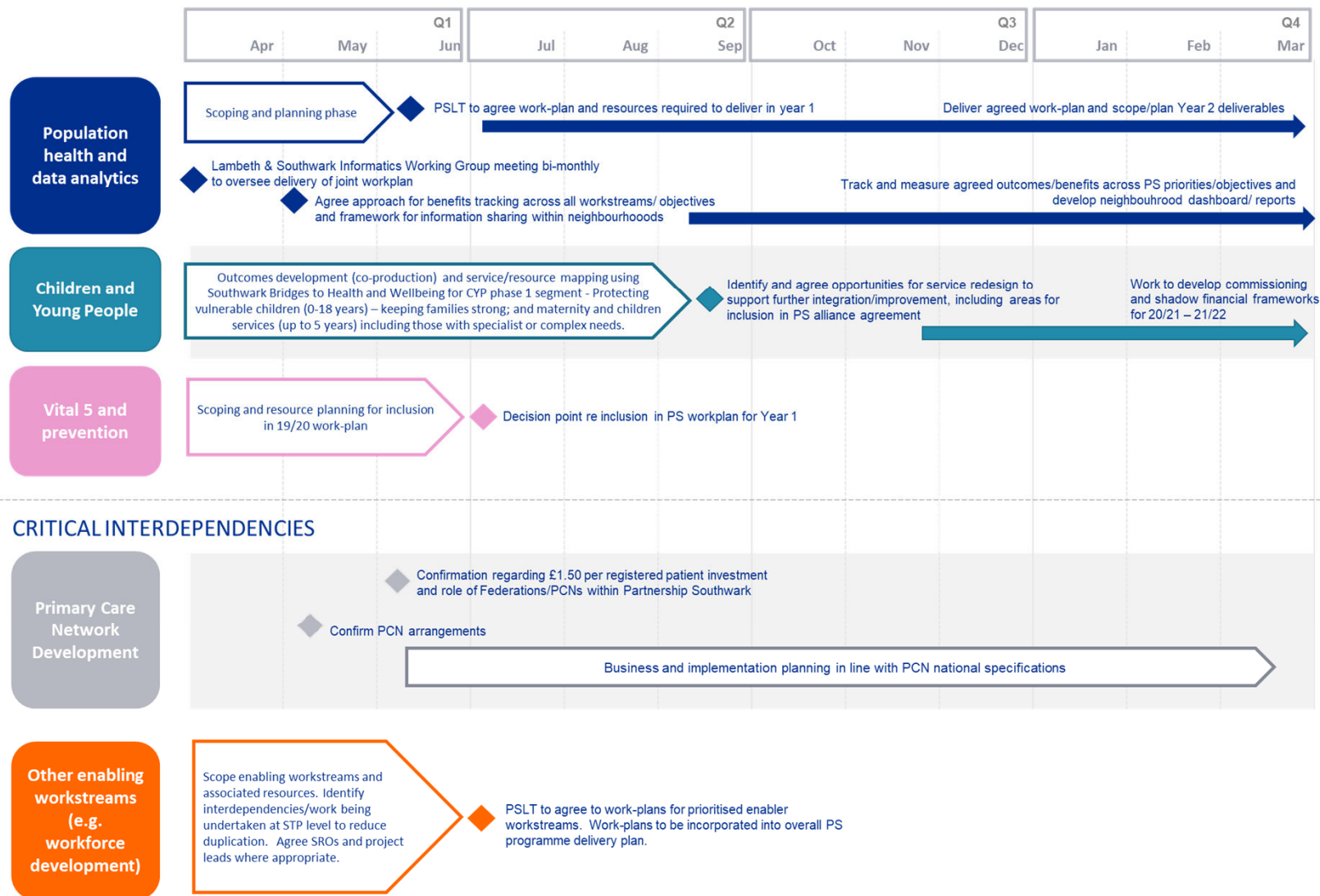
## Partnership Southwark Alliance Shadow Year, 2019-2020





# Appendix A: Partnership Southwark implementation plan (2/2)

## Partnership Southwark Alliance Shadow Year, 2019-2020



# Appendix B: Partnership Southwark governance structure

## Partnership Southwark

### OUR SHARED SYSTEM OBJECTIVES FOR 19/20 and 20/21:

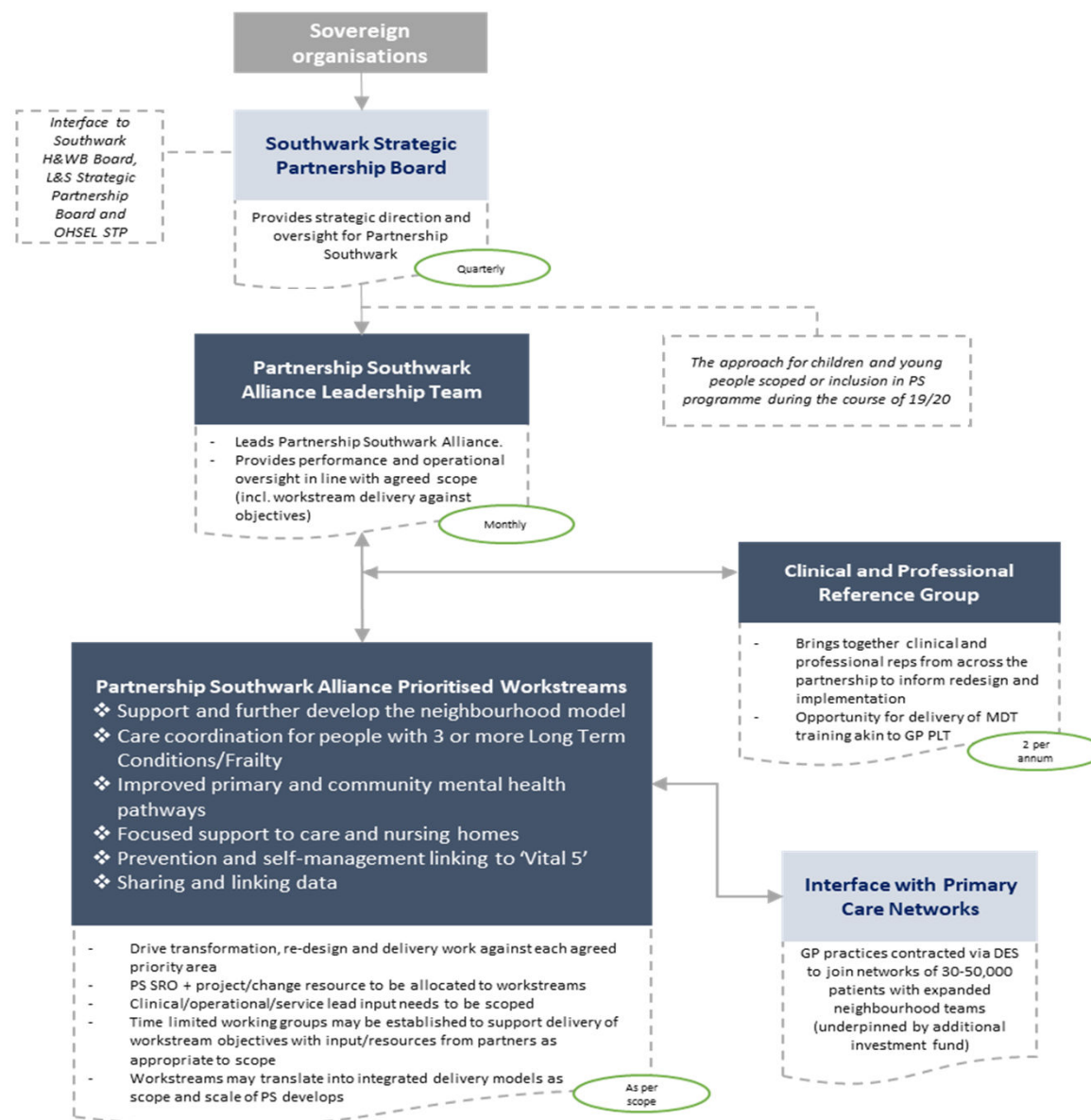
#### One vehicle for Southwark integrated care to:

- ❖ Make best use of the Southwark pound to deliver improvements in health and wellbeing outcomes for local people
- ❖ Be inclusive, and wider than health and care organisations so that we can tackle the causes of health inequalities and prevent illness
- ❖ Ensure every part of the health and care landscape is clearly focused on common goals of supporting self-management, keeping everyone well, providing resilient high-quality services, meeting individual and population-level needs, and making it easier for people to access the information, advice, care and support they need
- ❖ Support resilient and sustainable general practice, including enabling practices to work together within Primary Care Networks, and with other local health and care providers, around geographically coherent neighbourhoods
- ❖ View health, social care, housing, VCS organisations, education and employment as equal value/partners when working towards a healthier Southwark
- ❖ Equip people to manage their own conditions, take part in activities that will help keep them well and to support others in their community

### CROSS-CUTTING ENABLERS:

- Southwark Bridges to Health and Wellbeing segmentation framework
- Population health and data analytics
- Workforce, training and development
- Clinical effectiveness, embedded evaluation and quality improvement
- Estates and assets of place
- Digital innovation
- Communications, co-production and engagement

Potential to coordinate some areas across L&S (e.g. data analytics) or STP (e.g. estates)



## Appendix C: Emerging neighbourhood model

### Primary Care Network

Teams are embedded within the neighbourhood and the majority of their work happens within that PCN. The workload is predominantly driven by and delivered in the neighbourhood network

### Core Neighbourhood Team

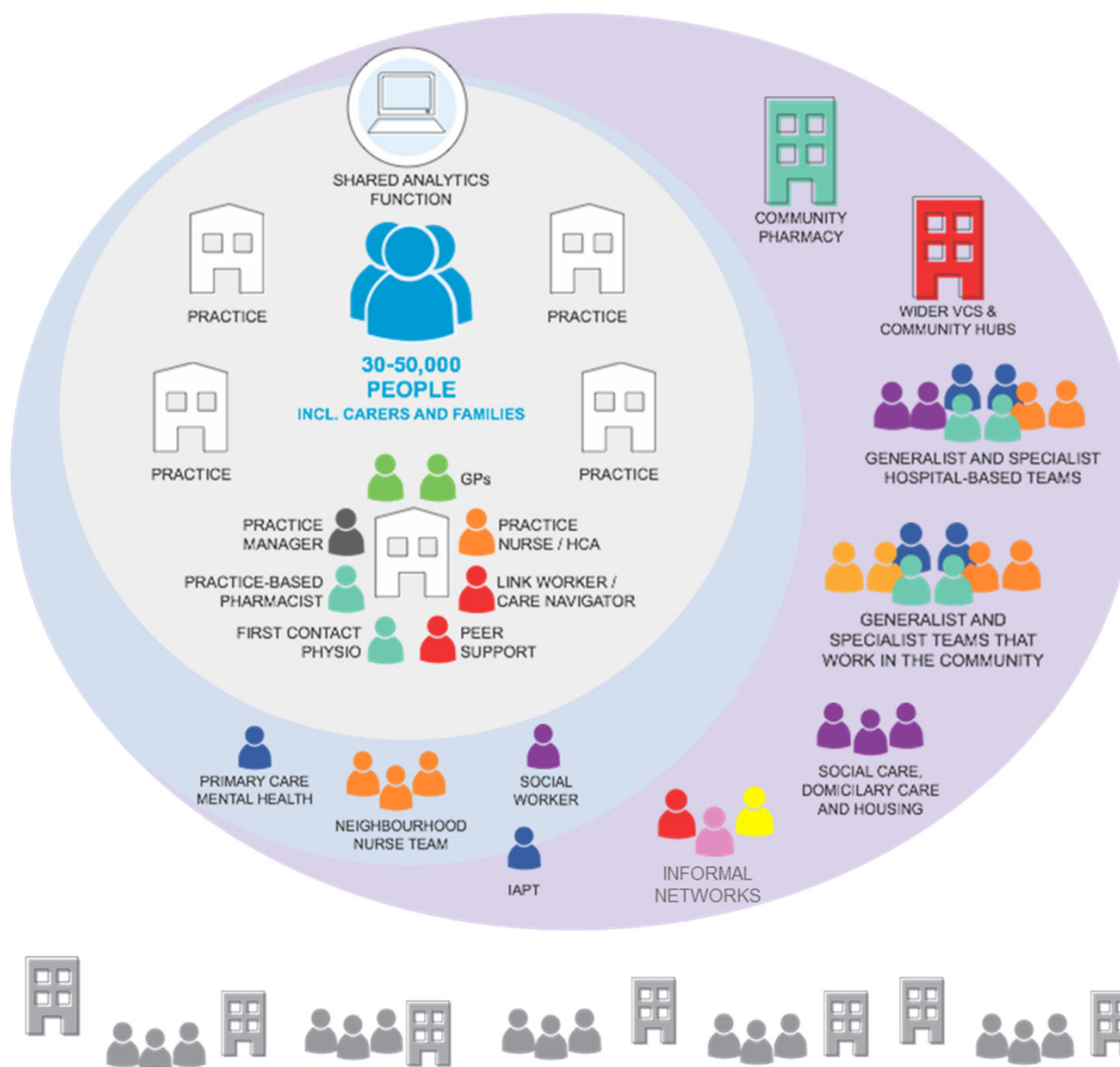
There is a named person assigned to neighbourhood responsible for coordinating between the services; teams are not embedded or configured within the neighbourhood network but will work closely with the PCN; the workload is driven by and delivered in a range of different routes

### Services and Teams Aligned to Neighbourhoods

Teams are not embedded within the neighbourhood but will interface with/across neighbourhoods. Mostly reacting and responding to referrals

### Wider Services and Teams

All other health, care and wellbeing services available to residents





# Glossary

**NHS Southwark Clinical Commissioning Group** – responsible for commissioning NHS services on behalf of the people in the area.

**IP: Children and Young People's Health Partnership** – a programme funded by Guy's and St Thomas' Charity which aims to deliver significantly better health, better healthcare outcomes, and better value for children and young people.

**Clinical Effectiveness Southwark** - a programme funded by the Health Foundation and Southwark CCG, which aims to help general practice improve and reduce unwarranted variation in outcomes through trusted local advice, facilitation and support tools.

**LE: Community Education Provider Network** – supports primary and community care workforce development and learning, through continuing professional development and projects that help to increase capacity and capability in primary care. Receives funding through Health Education England (now referred to as Training Hubs following the NHS Long Term Plan).

**ST: Guy's and St Thomas' NHS Foundation Trust** – provide hospital and community physical health services to the boroughs of Lambeth, Southwark and Lewisham; as well as specialist services across a wider catchment area.

**Whole person approach** - this approach takes into account the whole person, considering mental and physical health needs as well as social factors. It also recognises that people have capabilities as well as needs.



# Glossary

**Improving Health Ltd** – a collaboration of GP practices in south Southwark (GP Federation) who support member practices to work at scale, deliver population-based enhanced services to improve outcomes for patients, and work in partnership with other health and care providers.

**Integrated community-based care** - this means that the out-of-hospital system works in a joined up way. People should have confidence that their care teams all have a shared understanding of what is going on. In practice it means health, social care and other professionals and agencies work better together and deliver as much care and support in the community (as opposed to in a hospital setting) as possible.

**Integrated care system** - in an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. In South East London, our ICS will be a system of systems as it is a complex system and requires many different interacting system partnerships as opposed to a single South East London ICS.

**King's College Hospital** – provide hospital physical health services to the boroughs of Lambeth, Southwark, Merton, Wandsworth, Croydon, Sutton, Epsom and Bromley; as well as specialist services across a wider catchment area.

**Local Care Network** - networks which brought together a range of health, care and voluntary sector professionals to look at how we might do things differently to improve the outcomes for the population. The work that has been undertaken through LCNs to date will transition to Partnership Southwark from April 2019.



# Glossary

**Multi-Disciplinary Team** - a group of health care, social care and voluntary and community sector professionals who work together for the purpose of planning and implementing care; particularly for people with complex health, care and wellbeing needs.

**Neighbourhoods** – will bring together health, care and voluntary and community assets to provide care closer to home and better join up care; particularly for people with emerging and complex health, care and wellbeing needs. We have started to explore what neighbourhoods might look like geographically (*see Appendix C*); however, it will not be appropriate for some teams and services to be configured to work at a neighbourhood level.

**Primary Care Network** – will consist of a grouping of GP practices within an area, covering a registered population of 10,000 to 50,000 patients. PCNs will be the building block for our neighbourhood model and are a key component of the NHS Long Term Plan, with all areas in England expected to be covered by a PCN by July 2019.

**Place-based** - aims to address issues at a neighbourhood or borough level, such as poor housing, social isolation, poor coordinated service provision that leads to gaps or duplication of effort, and limited economic opportunities.

**Populations** - groups of people with something in common. This might be geographic, or by characteristic. For example, the population of Bermondsey, or the population of people living with three or more long term conditions.





# Glossary

**Population health management** – moves away from managing disease in siloes to an approach based on defined populations of people, who may have multiple ‘disease conditions’ or life challenges. It is supported by:

- a whole system approach where commissioners work together to define, measure and improve population outcomes
- redesigning, organising and integrating care around the needs of a population group by moving away from organisational silos towards jointly accountable care

- a strategic approach to commissioning which measures and values the delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities

- fully utilising data and informatics solutions to direct care interventions to where they are most needed and to better support professionals in joint/MDT working.

**Prevention and early action** - this approach doesn't wait for people to get ill or escalate into crisis but instead actively identifies people who need additional support and provides it before crises occur. Includes health promotion and self-management support.

**Example: Quay Health Solutions** - a collaboration of GP practices in north Southwark (GP Federation) who support member practices to work at scale, deliver population-based enhanced services to improve outcomes for patients, and work in partnership with other health and care providers.



# Glossary

**SLM: South London and Maudsley NHS Foundation Trust** – provide hospital and community mental health services, as well as substance misuse services for people who are addicted to drugs and alcohol, to the boroughs of Lambeth, Southwark, Lewisham and Croydon; as well as specialist services across the UK.

**Social Care** - the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

**Southwark Council** – has 63 councillors elected across 23 wards. It oversees a range of local services including environment and leisure, children's and adults services, public health and regeneration.

**Voluntary and Community Sector** – includes a very diverse range of charitable trusts, community groups, tenants' and residents groups, faith groups, housing associations and not-for-profit organisations that deliver services, activities and support within the community.

