

Better Care, better quality of life in Southwark:

Our vision for integrated care and support for our local population through well co-ordinated, personalised health and care services.

This is a vision for the whole system, not just health and social care. It links key themes in Southwark CCG's Primary and Community Care Strategy, Adult Social Care priorities as set out in the Local Account, Southwark Council's Fairer Future priority to "support vulnerable people to live independent, safe and healthy lives by giving them more choice and control over their care", and the Housing Strategy which seeks to "help vulnerable individuals and families to meet their housing needs and live as independently as possible".

We want people to live healthy, independent and fulfilling lives, based on choices that are important to them.

Our vision for integrated care in Southwark is for people to stay healthier at home for longer by doing more to prevent ill health, by supporting people to manage their own health and well-being and by providing more services in people's homes and in the community. We want people to feel in control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs.

We will build upon our existing work to integrate services around people's needs, but recognise that we now need to transform the way we work together across health and care to really achieve this.

Our key aspirations for integrated care in Southwark are to deliver:

- More care in people's homes and in their local neighbourhoods
- Person-centred care, organised in collaboration with the individual and their carers
- Better experience of care for people and their carers
- Population based care that is pro-active and preventative, rather than reactive and episodic
- Better value care and support at home, with less reliance on care homes and hospital based care
- Less duplication and 'hand-offs' and a more efficient system overall
- Improvements to key outcomes for people's health and wellbeing
- Stronger, more resilient communities
- Southwark as a great place to live and work

We will know we have achieved our ambition for integrated health and care in Southwark when we need to rely less on hospital-based care and care homes, because more care that is better value will be delivered in people's homes and in their local neighbourhoods. People will be admitted to hospital quickly when they need to be, to access to the world class facilities and services. Hospitals will be able to discharge people quicker, because effective and pro active services at home and in the community will help people get back on their feet and stay healthy and independent for longer.

We will take a population based approach to health, so that rather than just treating sickness, we recognise and address the wider determinants of ill-health across Southwark and the role of different services in promoting the public's health. This is set out in Southwark's Health and Wellbeing Strategy.

Why do we need to transform and integrate services?

There is a strong national and local drive towards integration, supported by new funding arrangements which necessitate joint working. The Care Bill will place a statutory requirement upon local authorities to carry out their care and support functions with the aim of integrating services with health and housing, and the Health and Social Care Act requires the NHS to ensure organisations work together to improve outcomes.

The way services are currently commissioned and organised does not always achieve our aims and our ambition is to work together to achieve better outcomes for our population and improved quality of life for individuals.

Southwark is a richly diverse borough with a significant asset base in terms of its people, its public services, its business communities, local economy and its social capital. The challenges we face are however significant. We have some world class services and yet we know we can do more to improve individual experiences, to improve the health of our local population and tackle health inequalities.

Our aspiration to improve the experience of local people, the challenges of our changing population, the increasing demands on our system and the economic challenge all mean we need to change.

Experience of patients and public: People in Southwark have told us they want care and support delivered in, or close to, their own homes. They want a response that is integrated and personalised, as expressed by the definition created by people who contributed to the 'National Voices' work:

"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me"*

**This is an agreed national definition of integration from "Integration: Our Shared Commitment". It goes on to list a range of similar statements from the user perspective about what good integrated care should feel like.*

Population and demographic challenges: Southwark's population is younger, more transient, more ethnically diverse and more benefit dependent than is the case nationally and in many London boroughs. Although the older population is not increasing as quickly as in some regions, the over 85s population is rising. The number of hospital admissions and use of A&E has increased much more rapidly than the growth in population. People are living longer but in Southwark people's 'healthy life expectancy' is below the London average and poorer people continue to have lower life expectancy and lower healthy life expectancy. A very high proportion of older people in Southwark live in social housing, presenting an opportunity for valuable co-operation between health, social care and housing services.

Economic challenge: The unprecedented economic challenge means the need for health and social care to deliver better value is greater than ever. A significant proportion of the demand on our local health system and the council comes from increasing numbers of frail older people and people with multiple long term conditions, including mental health. Integrated care is most effective when it is focussed on support for those people who are identified as being at greatest risk of poor health outcomes without early intervention and much improved co-ordination of services.

Building on progress so far:

As partners of Southwark and Lambeth Integrated Care (SLIC) we have already taken some significant steps towards integrating care in the borough, including establishing more community based support for frail elderly people to respond quickly to prevent admission or facilitate early discharge. Community Multi Disciplinary Teams are in operation across the borough, and primary care services are beginning to be organised on a neighbourhood basis.

We have also taken steps to re-direct finances to support these new models of care, However, there is still much to do to transform the way that care is organised, experienced by citizens, and funded across the borough. Our plans for the future of integrated services will build on these successes but go further, focussing on delivering personalised, pro-active care to local communities.

The changes we want to achieve:

We want to create a sustainable system that supports the most vulnerable and delivers value for money. To achieve this we need a significant cultural shift across the whole system. This means a different set of relationships between the NHS, the Council and the community, moving to a model where local citizens are seen as people who can contribute and exercise control over their own lives, improving their own health and well-being.

We want to tackle health inequalities and develop a more effective approach to preventing poor health and supporting people to better manage their own conditions. We need better integrated early interventions so that people get the right help when they need it and we need to ensure that people who have more complex conditions receive an integrated and personalised service.

We recognise the vital role that carers play both in delivering care and in helping prevent further deterioration, so that people do not need more intensive packages of support over time. This means we need to ensure that carers can access the right support to maintain their own health and well-being and to continue in their caring role, wherever they seek help.

We recognise we need to invest in the development of social capital across the borough, with a particular focus on enabling people to take control and giving them the tools to manage their conditions effectively. To help build community networks and a more personalised approach we will organise health and care services on a neighbourhood model around groups of primary care practices. This means that doctors, nurses, social workers, therapists, housing support workers and home carers will be able to build a strong set of relationships and work in a more integrated way, with common objectives to improve health outcomes for their local population and to offer a good experience that promotes better quality of life for local citizens.

The role of the third sector will be vital in driving forward the approach for building strong community engagement and the experience of the sector will be invaluable as we look to put the vision for effective prevention into practice.

We will mobilise our communities and recognise their assets, strengths and abilities, not just their needs. We will build on the assets in our community to support active self management by people, and support between peers, carers and families to take control of their own health and well being to address issues such as smoking, loneliness, exercise and eating.

Integrated care and support is about partnerships beyond the NHS and social care – involving individuals, communities, voluntary and private sectors and the Council's wider services, particularly employment and housing.

Healthwatch will help ensure that we are on track, and in particular that we provide services in a compassionate way that maintains people's dignity.

What does it mean for how we will commission services?

The Council and CCG are committed to using our joint resources to achieve our shared vision. The way that services are currently commissioned and organised does not always achieve these aims, and there are many 'hand offs' and differential incentives that work against our vision of services working together to support better health and more independence.

This will mean realigning finances to commission more pro-active support that offers continuity of care and is joined up around people's needs. Our plans, if successful, will mean less reliance on care in hospital or care homes, and more care in people's home or delivered in community based settings. We will work with partners in SLIC and the acute sector to enable this shift of resources to happen.

We will use our resources differently to remove organisational impediments to the provision of person-centred care and financially incentivising prevention, earlier intervention, recovery and re-ablement with our providers.

The pattern of services will be different in a number of ways:

The focus for the whole system is to enable people to live independently and well for as long as possible, using the widest range of mechanisms and support options possible. Some of the key aspects of change we want to see are:

- more care for older people and people with long term conditions will be delivered through locality based community multi-disciplinary teams with a lead professional responsible for co-ordinating the care of individuals, ensuring an integrated and personalised approach to case management by all services working with each person - GPs, Community Health, Social Care, Housing, Mental Health workers and hospital services.
- there will be less care needed in acute settings. A&E attendance and avoidable emergency admissions will reduce as community teams provide more targeted support to those at risk.
- When people do need acute care they will stay in hospital for shorter periods, returning home safely with the help of services such as @Home (Home Ward) and enhanced discharge support.
- re-ablement and intermediate care will increasingly provide effective short term interventions that rehabilitate people, restoring health and independence
- the balance of social care will shift away from care homes towards support in people's own homes and supported housing schemes including Extra Care.
- home care services will be funded with a view to radically improving quality and outcomes, with home carers linked in with other health and care professionals through the multi-disciplinary team approach
- there will be enhanced support for carers
- there will be a greater role for technology through using telecare to help people live safely at home
- a more integrated and coherent approach to preventative services including the voluntary sector tackling issues such as social isolation
- services will be responsive and accessible 7 days a week, including social care and admission avoidance community services as well as primary care
- new focus on developing dementia related services
- developing a neighbourhood health champions model

Achieving genuinely integrated care will have far reaching implications for the health and social care workforce and for the way that staff are trained and work together. Our **workforce** will need to be well-informed, appropriately skilled and clear of its common purpose in delivering person-centred care. We are committed to investing in the workforce so that they are appropriately skilled and trained for new ways of delivering care, and have a shared approach to coordinating care around people's needs. Staff will need to work increasingly flexibly in integrated teams, with more staff working in the community and in people's homes. We will ensure that we have the right range of staff to respond flexibly to people's needs and that all staff across our system feel valued for their contribution to keeping Southwark people as healthy and independent as possible.

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