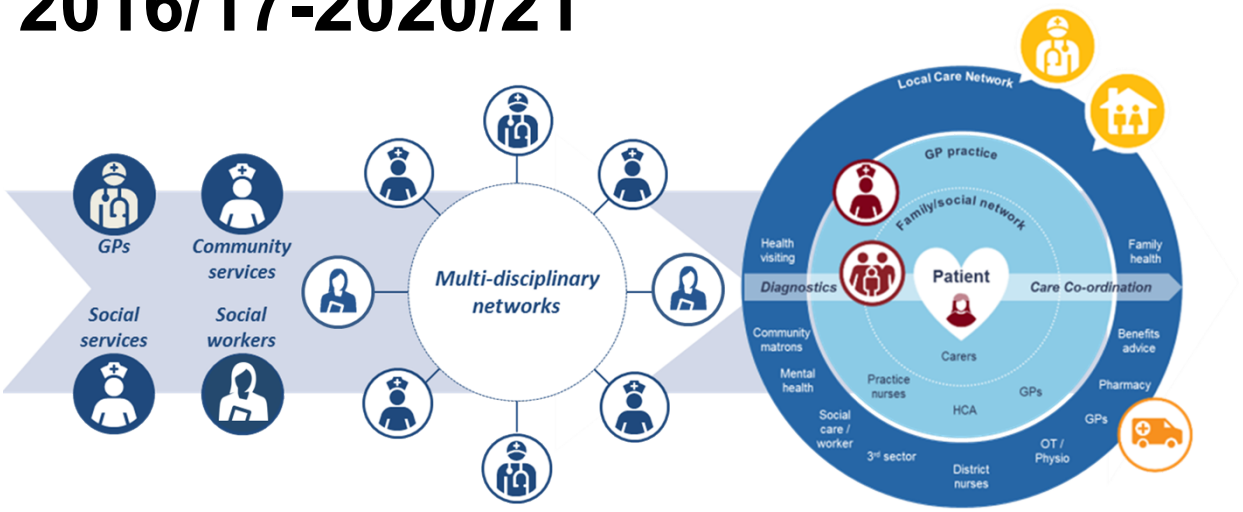
APPENDIX 1

Southwark Five Year Forward View:

Southwark Council and Southwark CCG Local Five Year Forward View of Health and Social Care

Version 5

2016/17-2020/21



NHS Southwark Clinical Commissioning Group

Southwark Council

Contents

Summary

We can improve the way that our local health and social care system operates to bring about better outcomes

- Southwark commissioners across health and social care are committed to improving the health and wellbeing of Southwark people. The experiences of people who use services, and their families and carers, shows that existing arrangements do not always deliver the best outcomes for people, and there can be significant improvements if we work together using new approaches.
- This is about improving quality and overall value, it is not about cuts**:** if funding wasn't an issue we would still want to radically improve outcomes.

Improving the system requires fundamental changes in how we all work

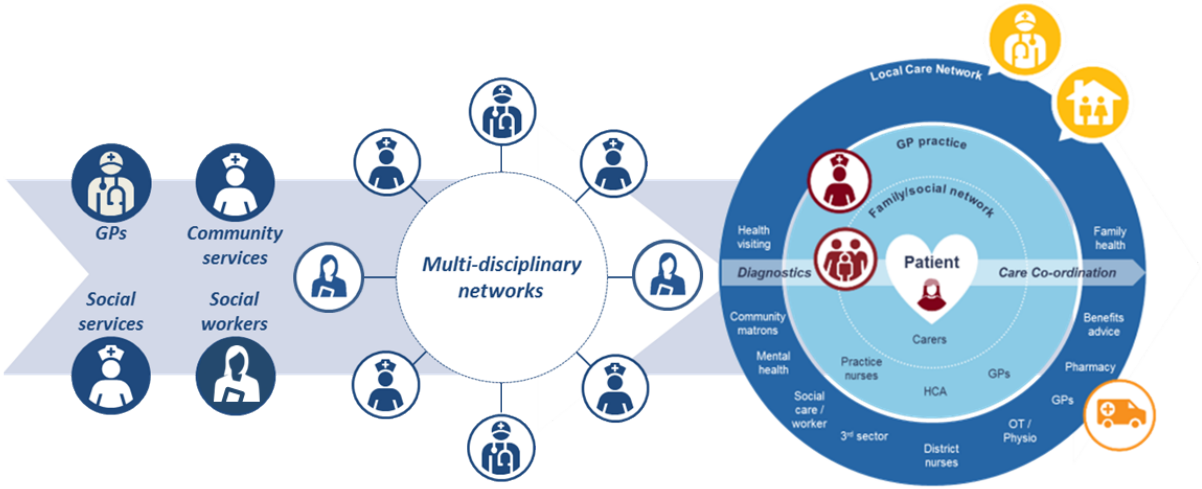
- We want a system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements.
- Our local ambition is to create a much stronger emphasis on prevention and early action as well as deeper integration across health and social care, and wider council services (including education).
- To support this change we will increasingly join together commissioning budgets and contracting arrangements to incentivise system-wide improvement. We will focus on specific populations, including particularly vulnerable groups. We will put ever greater emphasis on the outcomes achieved in addition to the quantity of activity delivered.
- This means moving away from a system with lots of separate contracts and instead moving towards inclusive contracts for defined segments of the population which cover all of the various physical health, mental health and social care needs of people within that group. These contracts will be available to providers who can bring together the skills required to meet these needs.
- Our aim is to empower the development of multi-specialty community providers serving populations of 100,000-150,000 people, with access to excellent specialist networks when required.

> ***We will contract on the basis of populations rather than providers.***
> ***We will focus on system value rather than contract prices.***
> ***We will emphasise that 'how' care is delivered is as important as 'what' care is delivered.***

We are confident we can enable this scale system-wide transformation

- Southwark Council and NHS Southwark CCG have been working on this agenda for several years with partners across Southwark, Lambeth and South-East London. As a result there are exciting examples that demonstrate new ways of working between providers of services and with the wider community of service users, families, carers and local residents. There is also a growing sense of system leadership and a recognition of the scale of change required across all parts of the health and social care system.
- We will develop an action plan and highlight the investment necessary to deliver the ambitions set out in this local Five Year Forward View. We will publish this detailed plan in March 2016.

Figure 1 – Over time we are developing better ways to work together, which is good for citizens, care staff and commissioners



What this mean for me as a…	Traditional models [Small molecules] *Working as isolated units*	More integrated working [Small cells] *Working as small joined-up teams*	Accountable care [Living system] *Working as a dynamic and complex system*
…service user	• Sometimes services are good, sometimes they are not, it's a bit of a lottery • I feel looked after in an emergency but at other times I'm left confused and disempowered • I have to fit around the system and it's inconvenient	• I know more about what is going on • Clinicians know more about what has happened in my care • People ask me about what I need • I'm feeling more confident about how to live well, and what to do when I start to feel like I'm getting unwell	• I feel in control of my life and the care I receive, and I know what's going on • Professionals work together to support me • The little but important things are thought about
…staff member	• I'm isolated with little opportunity to work in a team • I'm frustrated at the lack of coordination • There is little opportunity to sort things out creatively, at the root of the problem	• I get help from others when confronted with complex situations • I'm developing new relationships and connections • I can sort out the things that count	• I feel part of a team and I am learning new things that make me feel more confident in what I do • I feel I'm able focus on the things I'm good at and let others do what they are good at
…commissioner	• I try to take responsibility for detailed pathway design • I focus on the transactional rather than the transformational	• I can spend more time thinking about what people actually want from services (outcomes) rather than just tracking inputs, targets and expenditure	• I spend my time looking at whether we are really delivering quality outcomes for people for the funding we have. I can see the wood for the trees

1 Introduction

We want to enable the best possible health and social care outcomes for Southwark people and families. We set this out in this *Southwark Five Year Forward View*. It describes Southwark Council and NHS Southwark CCG's shared vision for local services, the changes needed in our health and care system, and the actions we will take to make this happen.

What do we expect to be different in five years?

Over the next five years we will support what already works well, and we will introduce more collaborative ways of working across the health and social care system. Many things will continue as they do now, but we are also aiming to support positive improvements both for local residents and for the formal and informal workforce within our health and care system.

We will continue to have a vibrant and diverse voluntary and community sector, working closely at the heart of communities with general practitioners and social workers as central professionals. We will also continue to benefit from the range of skills within major acute hospitals and our local specialist mental health trust. These are some of the vital and valuable foundations of our local system and they are the basis upon which a more person-centred and coordinated system will be built. But we do need the system to work differently. In five years our local system should feel better for service users and their families, and for people who work within it, as illustrated in Figure 1.

- This will mean a much more empowering experience for local people. We want people to feel that all services are working with them in a supportive way, be that about accessing better education support, better council housing, debt advice or about having greater self-determination and self-care in relation to health and social care services. It also means making the health and care system fit for the 21st century so that people can make use of everyday technology, as well as new assistive technologies, to feel in control of their health and wellbeing.
- This will mean much greater formal integration and coordination between the different providers of health and care services. Local providers will operate collaboratively within mature and robust multispecialty community provider networks, referred to locally as Local Care Networks. These networks will share accountability for the outcomes of their local population, and they will use evidence and experience to plan and organize the local delivery system, including by working together to develop and share the infrastructure required to provide residents with a 21st century service.
- This will mean much greater integration between local health and social care funding. Commissioners will be much better able to measure and track the health and care outcomes that really matter to people. They will also be able to allocate available resources to fund activities that maximize those outcomes for Southwark people.

What is the purpose and content of the rest of this document?

The purpose of this document is to stimulate a discussion about how to make this potential future a reality in Southwark. Transformation at this scale will only be effective if we approach it comprehensively. As commissioners we have an important leadership role in setting a direction and actively supporting this process.

In this document we describe the reasons we think that change is needed, we set out the direction in which we want the system to develop, and we describe what this will mean in practice for service users and people who work within the system, particularly as part of the newly emerging Local Care Networks.

In further developing our approach we will work closely with our wider partners, including local residents, service users, families and carers, local service providers and the local voluntary sector. This will inform the development of a plan to bring about practical change.

2 We think we need to do things differently

This section describes our reasons for thinking that change is both necessary and possible. We start by describing the common purpose that unites the Council and the CCG and but then highlight that our common purpose will only be achieved if we do more to improve the health and wellbeing outcomes and inequalities within our system, and if we do more to protect the financial sustainability of health and social care services. We end the section by reflecting on why we are confident these imperatives can be achieved, highlighting that some fantastic work has already begun which demonstrates the motivation and capability of residents, professionals and commissioners to improve services in Southwark.

2.1 Our common purpose is to improve health and social care outcomes for Southwark people within available resources

Southwark Council and Southwark CCG have a common purpose to enable the best possible health and social care outcomes for Southwark people and families. This is about much more than the absence of disease. Ours is a very positive shared purpose that takes the absence of disease as a starting point and recognises the wider and more fundamental importance of wellbeing. We will know that our vision is being achieved when we see:

- An increase in healthy life expectancy, adding life to years as well as years to life
- A reduction in health inequalities across communities in Southwark
- More people engaged in their own healthcare, so that individuals and families are directly involved in maintaining and improving their own health and wellbeing
- A greater proportion of people reporting better experiences when they use health and social care services

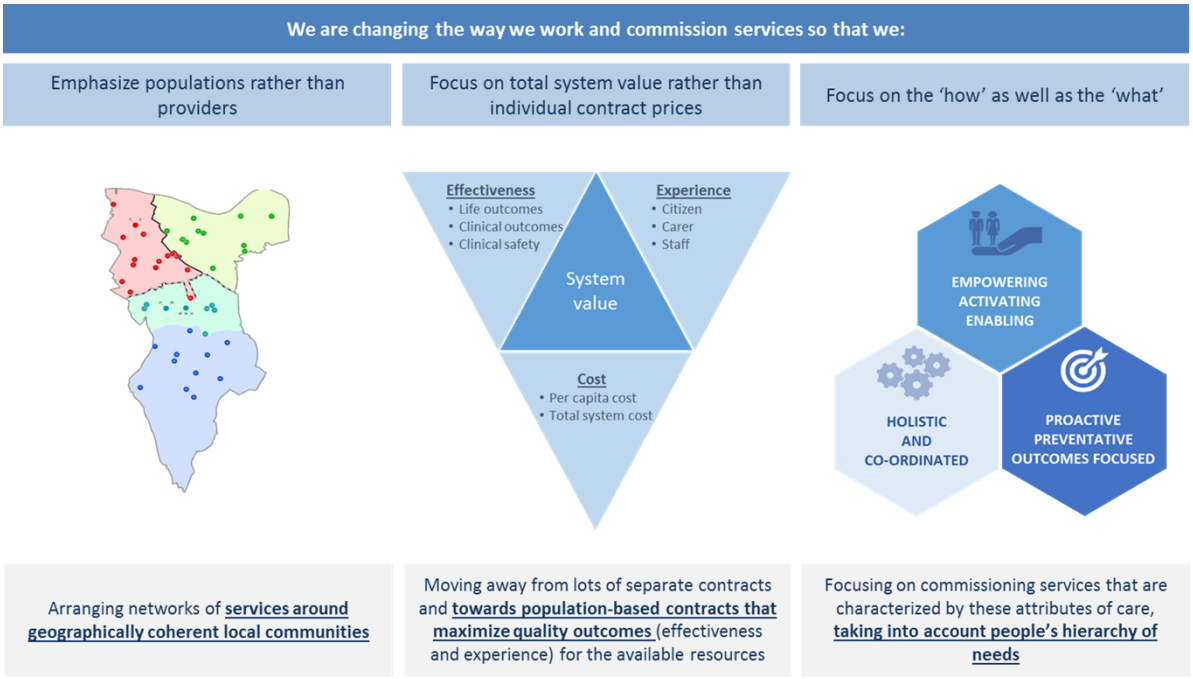
Improving people's wellbeing is about more than medicine and health care. A focus on wellbeing is about recognising the positive interrelationship between our social connectedness and our psychological and physical development. In addition to health and social care services, our shared agenda must also prioritise the importance of everyone's everyday social networks in relation to our health, our identity, our sense of self-determination and our overall quality of life. To achieve this we recognise the need to develop resilient and flourishing communities, which are supported by health and social care services that are genuinely person-centred and coordinated. That is not the type of system that we commission at present.

To commission a system that is aligned to our purpose we will apply three main principles:

1. We will focus on population outcomes (and outcomes for particular groups) rather than on the arrangement of existing service providers
2. We will focus on the whole system and its value rather than individual contract prices
3. We will be clear about the characteristics we expect services to demonstrate recognising that these must take into account people's health and social care needs and be sensitive to the social, environmental and cultural context within which a person lives

These are described in more detail below and illustrated in Figure 2 and Figure 3.

Figure 2 – The three main pillars of our approach



We want to focus on populations

Our common purpose is simple to present but hard to deliver. To achieve the best possible health and care outcomes for Southwark people we must move away from concentrating just on what quantity of activity we need to purchase from existing providers in current models of care. Instead we need to move towards new ways of working that creates within the collection of health and social care providers a shared responsibility to proactively manage and improve the wellbeing of the local population. This will mean that providers will need to work together to really understand the needs of the local population, and the holistic needs of any one individual, and to then bring together services which can serve those needs best.

We want to focus on value

We want to achieve the best health and social care outcomes for Southwark people using the funding resources available across health and social care. This requires us to really understand and measure the outcomes we want to achieve (in terms of safety, effectiveness and the person's experience of care services), and to fully understand the total cost of support across all settings of care. It also requires commissioners and providers to assess how resources are currently allocated and to shift those resources away from low value activities and towards activities that create better outcomes.

We want to focus on the characteristics of good care

How health and social care is delivered is very important to people, particularly so because the services we commission are often received when people feel unwell and vulnerable. At these points we want Southwark people to feel cared for with dignity and respect, and to feel informed about their options in relation to treatment and support. We think this is best achieved when services are designed to empower people to be in control of their own health and wellbeing, and when services work with people as 'whole people' taking into account the full range of a person's capabilities and needs. We also recognise the importance of dealing with problems before they reach crisis point: our approach must increasingly support early intervention and prevention, rather than simply waiting to deal with the consequences of poor health. All of these

concepts can be illustrated with reference to Maslow's hierarchy of needs and the wider social determinants of health.

- *Understanding our hierarchy of needs* – we all have a range of social needs, from the most basic and fundamental need for food and warmth through to feeling confident and reaching our full potential in life. Resourceful communities empower citizens to meet these needs. Meeting basic needs creates wellbeing and can reduce the dependency that many people feel on health and social care services. Good health and social care services recognise people's various needs and address them in partnership with the person. The best services also recognise people's own capacity, and help them to develop independence and self-confidence, for example by empowering people to feel capable and confident enough to manage a long term medical condition.

- *Understanding the social determinants of health* - Social, economic and environmental conditions influence the health of individuals and populations. They include the homes and communities people live in, their pay and working conditions and the education they have access to. These factors are themselves shaped by the distribution of money, power and resources at a local, city, regional, national and international level. They can determine the extent to which a person has the right physical, social and personal resources to achieve their personal goals, meet their needs, and those of their family, and deal with changes to their circumstances. It is these social determinants of health that drive many of the inequalities we see in Southwark. This is recognised by the Council and the CCG and work is already underway to make Southwark a healthy place to live and work, and to ensure equality of opportunity for all Southwark residents.

Figure 3 – A person's health and wellbeing is related to the needs and assets they have, and these are influenced and to a large degree determined by wider social, political and economic factors

Maslow's hierarchy of needs

Social determinants of health

Some of these principles are already being tested in action through innovative work in the borough. Examples of these can be seen in the appendix. In addition, Section 4 describes what this will all mean in practice in the future, highlighting the difference that these approaches can make for individuals as well as the practical changes that this represents for people who work within local services.

2.2 More needs to be done to improve care outcomes for local people

2.2.1 We know that outcomes and equality can be improved across the borough

Southwark is a diverse and vibrant borough of almost 300,000 people, and it's growing significantly: we expect a population increase of 21% over the next ten years[1]. The Southwark Joint Strategic Needs Assessment[2] shows that local people's health outcomes have improved in a number of important areas, including reductions in infant mortality; better, more comprehensive care for people at the end of their life; and improved outcomes for people living with HIV. Since 2010 life expectancy has continued to rise for people living in Southwark. But there are real challenges too: health inequalities remain stark. Too many people live with preventable ill health, or die early.

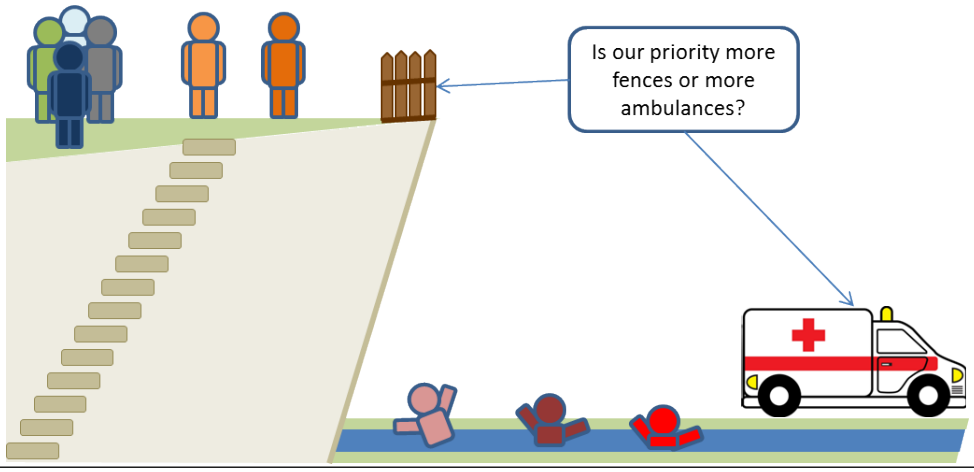
- ***Health inequality:*** In the borough there is a difference in healthy life expectancy between the richest and poorest in our population of 9.6 years for males and 7.7 years for females.
- ***Heart disease:*** Southwark people are more likely to die prematurely from cardiovascular disease than people living in similar parts of London.
- ***Respiratory disease:*** Chronic obstructive pulmonary disease (COPD) and lung cancer cause relatively high numbers of preventable early deaths and ill health in Southwark.
- ***Diabetes:*** There is significant variation in the management of patients with diabetes in Southwark and a high number of people are living with undiagnosed diabetes.
- ***Alcohol and liver disease:*** Rates of preventable early deaths from liver disease and alcohol-related hospital admissions are significantly higher in Southwark than they are in similar London boroughs.
- ***Mental illness:*** Southwark has a high prevalence and comparatively poor outcomes for people with low and medium-level mental ill-health. There is significant unmet need too.
- ***Obesity:*** Childhood obesity levels in the borough are amongst the highest in England. Adult obesity is also higher than the London average.
- ***Dementia diagnoses:*** Only about two-thirds of the predicted numbers of patients with dementia are diagnosed, and effective management of patients is highly variable.
- ***Admission of older people to acute hospital:*** Hospital admission rates and health related quality of life for older people is higher than in similar areas of London with rates of falls-related admissions particularly high.
- ***Access to GP appointments:*** Patients and members of the public consistently tell us that they often find it hard to get an appointment with their GP.

Whilst we know that services do often respond well to crises, we know that too little focus is given across the system to prevention and early intervention. It is not sufficient to just deal with the consequences of illness. We have to find ways of reducing the volume of people who need crisis support in the first place. Prevention and early intervention is the best way to achieve this, and over time much more of our resources need to be invested into such activities. As Figure 4 illustrates, this is about taking the right preventative approach 'upstream' to avoid having to deal with the consequences of crises 'downstream'.

[1] Southwark Demography Factsheet, May 2014

[2] www.southwark.gov.uk/jsna

Figure 4 – We need to find more approaches that are successful at dealing with existing demand for services, whilst reducing future demand. That means building more fences, rather than simply purchasing more ambulances.



2.2.2 We know that people's day-to-day experience of health and social care services can improve

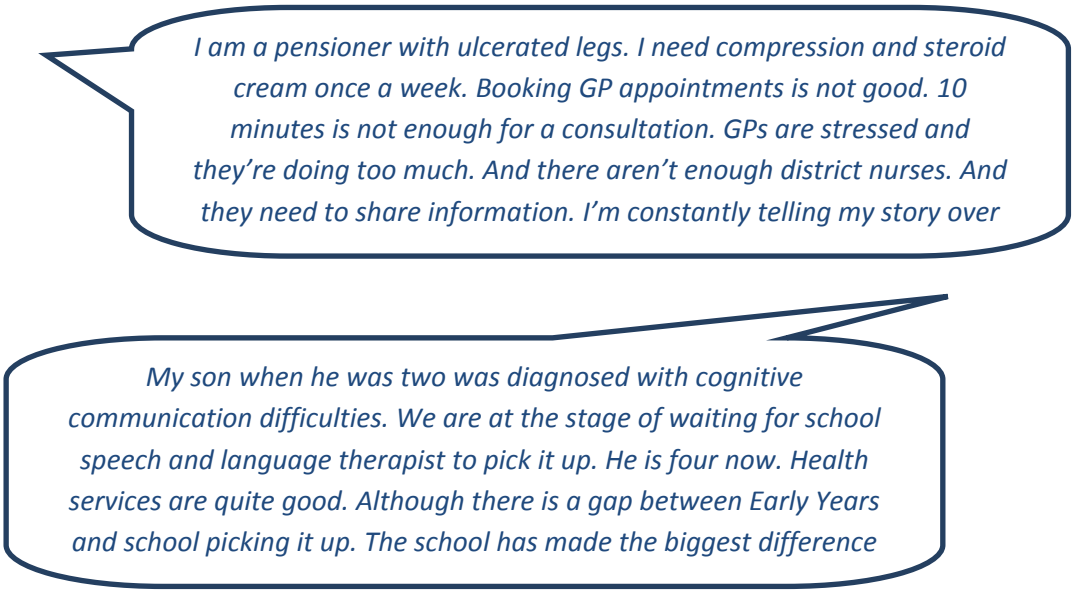
We have health and social care services that achieve great things on a daily basis, and which are staffed by skilled and committed people. It is also true that on a daily basis there are residents who are left feeling confused and frustrated by the inconsistent way that services currently operate. For example, a recent Special Inquiry by Healthwatch found that[3]:

- People can experience delays and a lack of coordination between different services
- People can feel left without the services and support they need after discharge
- People can feel stigmatized and that they are not treated with appropriate respect
- People don't always feel involved or informed in decisions about their care
- People can feel that their full range of needs is not being considered

These are experiences that are all too common across the country. When individual cases are looked at in detail they point to poor experiences, poor effectiveness and inefficiency, and often they result from systemic arrangements rather than isolated mistakes. We know that our providers of health and social care can, and do, deliver life-saving and life changing services that are safe, effective, respectful, empowering and coordinated. We now need to ensure that this is delivered consistently, particularly at a time when services are facing significant funding challenges.

[3] Safely Home, Health Watch England Special Inquiry, 2015 – accessed at: http://www.healthwatch.co.uk/safely-home

Figure 5 – The voices of Southwark people: statements from Healthwatch's 1000 lives research



2.3 More needs to be done to protect the financial sustainability of the system

If funding wasn't a challenge we would still want to radically improve the system

Improving outcomes for people is the burning ambition that inspires and guides our work: if funding wasn't a challenge we would still want to radically improve the system. This is because many of the things that cause frustration are things that we can do something about – either by making better use of new technologies, or by changing the way we work together within and across organisations. However, there is a very large financial challenge across the system, and this makes the improvements not only desirable but absolutely necessary.

As commissioners our choice is about how we invest the significant resources in our local health and social care system to maximise the quality of services for our citizens. We don't believe that 'more of the same' is the best option. Our challenge is to ensure people are supported and treated in the right place at the right time according to need, with much more care delivered closer to home in local communities.

However, the answer is not as straightforward as simply moving resources out of hospitals. As the size and needs of the population grows, our real challenge is to deal with growing demand within existing capacity. Based on current trends this would represent a great achievement and it would enable us to invest efficiency savings and funding growth in new models of community based care rather than in additional hospital capacity.

2.4 We have confidence we can improve value across the system by building on the good progress already started in Southwark

Whilst our ambition is significant we are not starting from scratch: already local residents, commissioners, care professionals and managers have begun to demonstrate new ways of working together.

- We have brought CCG and council budgets together in our Better Care Fund, and we were one of only six areas nationally to have those plans assured without conditions. This fund has been invested in admission avoidance, better supported discharge, and more coordinated and proactive care delivery.
- Collectively we have made tangible progress towards developing the foundations of a Local Care Network model. In particular there has been significant collaboration between federations of general practices in both the north and the south of Southwark. Through these federations GPs have a way of working together at scale to improve and enhance core services. The two federations have been established, licensed by the CQC, and they have both begun to deliver extended access to primary care (7 days a week 8am-8pm).
- Collectively we have strongly supported innovative work on developing and implementing new models of diabetes care. This has improved care for local residents and it acts as an exemplar for how we should support people to manage when they have multiple long term conditions. Our local approach with partners has developed a model that addresses the medical, psychological, and social needs that a person has. 98% of our GP practices signed up in 2013/14. Independent evaluation shows significantly improved detection and HbA1c control. Over two years Southwark practices achieved a ten percentage point increase in detection and have moved from the bottom to the top of comparison groups.
- Collectively we have made real progress in developing a functionally integrated information technology system. We now have a comprehensive use of the EMIS Web system in primary care. This system enables primary care and commissioners to share data. We have also supported providers to develop a Local Unified Care Record using linked clinical data systems across the three foundation trusts and into primary care. This hugely powerful development allows a hospital and general practice care teams to see, at the point of care, patient data from the other local trusts and specific aspects of the primary care record.[4]
- Collectively we have supported the emergence of a strong, vibrant and energetic network of residents who are actively involved in supporting changes in the health and social care system. Within the borough each general practice has established a Patient Participation Group (PPG) to enable regular engagement with people on the practice register, and there are locality PPGs that support the sharing of information and experience across a larger network. These groups are also connected with the Southwark and Lambeth Citizens' Forum and Citizens' Board which supports people to meet, discuss and influence the way that the local system works, for example through active participation in service improvement initiatives such as the Southwark and Lambeth Integrated Care (SLIC) Programme.

[4] We know that many people assume that care teams already share information about them in order to provide high quality care. Unfortunately that is not always the case in the current system. This lack of communication can compromise a person's care. Our new Local Unified Care Record system makes data sharing much more timely, systematic and secure. Access to this data is for the purpose of providing better care, and care teams will seek consent to view records (unless the situation is life-threatening or a person is incapacitated). Each participant provider has information available about the fair processing of data, and patients are able to express a preference about whether to benefit from this service. More information can be found here: [DN. Insert link]

3 We think that we have to address some complex issues and adopt a thoughtful approach to change

Section 2 describes our reasons for thinking that change is needed. This section describes our understanding of the problems that we must address and describes the approach that we think is needed in creating the conditions within which this system-wide transformation can happen in practice.

3.1 The issues we are facing

Transformation of the current system will require us to tackle a variety of complex and interrelated issues, but there are three major root-causes we need to address, recognising that there is not a 'one size fits all' solution.

- **The fragmented arrangement of organisations and professions can reinforce boundaries and can make it too difficult to work together and to work consistently**
- **The fragmented contracting arrangements can make it difficult to move resources to where they are needed to deliver what really matters to people**
- **The disempowerment of service users and carers can create confusion and risks making people passive recipients of care**

This section looks at these root-causes in turn. For each issue we describe the problems we face, the way we are going to tackle them, and the partnership offer we are making within the system to enable that change. These high level commitments start with what we are already working on and where we expect to make important developments in the short term (the next one-to-two years), and some are more developmental leading to change in medium term (three-to-five years).

3.1.1 We face a fragmented arrangement of organisations and professions which reinforces boundaries and that can make it too difficult to work together and to work consistently

The problems we face

Changing demands on the workforce: long term trends are changing the functions needed in the health and care workforce. New technology and knowledge opens up new possibilities for diagnosis and treatment of severe or rare conditions, meaning that we need to nurture the development of people in sub-specialist roles; but demographic changes, and in particular the increase of frailty and complex health or care needs, mean that we also need to develop a local workforce who are "expert generalists". These factors occur at a time when we are facing significant reductions in the number of people in key professions like general practice, emergency medicine and community nursing, for example as people retire. There is also growing recognition of the opportunity for new roles to develop that make much greater use of people's skills, including both the qualified/professional workforce, as well as self-management and self-directed support by individuals experiencing significant health and social care needs themselves.

Cultures of isolation – rather than cooperation: there is less value created when professionals and organisations work in comparative isolation rather than in collaboration, where there is much greater scope to develop and deliver high quality services for people and fulfilling careers for staff.

- General practice is the foundation of the local NHS system because of the range of skills that practice teams can offer to their patients, and because of the deep local and personal

knowledge that informs GP care. However, the current operating model of general practice acts to exacerbate the quality and financial challenges faced by practices in Southwark because it can isolate professionals from one another and reinforce operating models that are too small to be financially or operationally viable. Encouragingly, practices in Southwark have begun to work together as formal federations so that they can benefit from greater collaboration and scale to address some common challenges, for example:

  - There has been underinvestment in staff development. Our workforce is our greatest asset yet GP practices working in isolation find it very difficult to release staff members for training or to invest in their development. It will take collective action to coordinate investment in the development of shared staffing arrangements (for example, a staff bank) but this type of development is required to help general practice to develop the necessary capacity and flexibility required by new ways of integrated working.
  - Investment in new ways of working and new infrastructure can be more easily afforded it is done together– for example, sharing additional capacity such as the Extended Primary Care Access Service, or sharing 'back office' functions and IT systems. Working together presents new opportunities to think creatively about new ways of doing things and to share the resources needed to develop new capacity and capabilities.
  - Challenging variation in general practice – some people get fantastic primary care and others do not. This demonstrable variation needs to be understood and acted upon. It is easier to do this when practices work together to analyse what is happening and to inform collective quality improvement projects.

- Delivering high quality care is often a team activity requiring people with different specialist skills to work together, and often for specialist equipment being available in the same place at the same time. In addition, in some specialties, there is strong evidence that the outcomes for people are better when care is provided by a professional or team that undertakes high volumes of that work and/or in an environment that is dedicated to that activity (for example lengths of stay are shorter, and rates of revision and rates of infection are lower, in 'elective centres' for planned orthopaedic surgery in which beds are ring-fenced for patients receiving planned surgery)[5].

Fragmentation and complexity: Health and social care organisations are staffed by highly skilled and passionate people but, because of the way organisations and responsibilities have developed over time, people have ended up working within an array of organisations that work independently of one another. The resulting complexity of the total system can leave staff and residents feeling confused and disempowered. Direct consequences of this include:

- Variation in clinical practice and care delivery because there are too few agreed pathways or care standards consistently used by providers of care;
- A lack of active coordination across services (in times of need or during transfers of care) leaving people at risk of confusing duplication or of "falling between the gaps";
- Professionals often working in isolation from others, reducing a sense of team-working and making it difficult for people to retain and develop their skills; or
- Operational management systems being developed for organisationally specific purposes which then reduce the ability of different organisations to work together.

[5] Getting It Right First Time (GIRFT) – A national review of adult elective orthopaedic services in England, available at: http://www.boa.ac.uk/latest-news/press-release-girft-report/

How we are going to tackle this

At a local level we recognise that developing new relationships takes time and investment. In Southwark we have already seen success in change through the Primary Care Development Programme which has established a group of 'Emerging Leaders' in primary care, and supported the development of two GP federations across the borough. We will continue to take this approach to support the development of new relationships across a broader range of providers. Importantly this emerging model of primary care will bring the benefits of working together at scale, whilst protecting the essence of high quality and local general practice and the clinical relationship between people and their local care professionals.

> ***Our aim is to support the development of multi-specialty community providers serving populations of 100,000-150,000 people***

Our aim is to support the development of multi-specialty community providers serving neighbourhood geographies of 100,000-150,000 people, which are structured around high quality primary care, community care, and social care. We expect that these Local Care Networks (LCNs) will bring together doctors, nurses, social workers, therapists, housing support workers, home carers and voluntary sector groups to work together with a shared ambition to support the needs of individuals and improve health outcomes for the population.

We will also actively participate in work across south east London to describe the standards of care we expect for our populations, focusing on six care pathways: Community based care (the delivery of coordinated services through Local Care Networks); Children and young people; Maternity; Urgent and emergency care; Planned care; and Cancer.

Specific actions:

- We will continue to invest in and support the development of local GP federations to enable better joint working across primary care, particularly in relation to GP access, the delivery of preventative services, and the development and delivery of proactive and coordinated population health management for people with multiple long term conditions. This will include the establishment of a Clinical Effectiveness Group (CEG) to support practices to identify priority areas for quality improvement and to establish practical ways of analysing and addressing these issues to reduce variations in practice and outcomes.
- We will provide developmental support to the two newly emerging Local Care Networks in the borough, ensuring that the Community Education Provider Network (CEPN) and our work on IT interoperability practically supports the workforce and systems development required to deliver person-centred and coordinated care. This includes the widespread implementation of a new Local Unified Care Record, which will enable care teams in health and social care to access integrated electronic patient records at the point of care delivery. We also plan further development to create an integrated care record that is directly accessible to patients and service users.
- We will work with other local commissioners and providers to develop a comprehensive and coordinated approach to estates development across the borough. This will include completion of the Dulwich hospital redevelopment by 2019 and consideration of other large scale strategic developments in the north-west of the borough (Blackfriars, Elephant & Castle, and the Aylesbury Estate), and in the north-east of the borough (Rotherhithe, Surrey Docks & Bermondsey) which together will experience a 35-40% population increase by 2030.

3.1.2 We face a fragmented contracting arrangement that can make it difficult to move resources to where they are needed to deliver what really matters to people

The problem we face

Care services in the NHS and local authorities have for a long time been commissioned on the basis of existing institutions and the services they deliver, with funding and incentives based on the amount of activity undertaken and the cost of specific units of activity. This has created a very complex system of contracting with different contracts held by different organisations for the delivery of specified inputs and outputs. In practice this arrangement reflects and reinforces unhelpful boundaries and incentives at the interfaces between different providers of care. Looking back, this type of arrangement can be explained as a consequence of historic funding arrangements and provider structures. Looking forward, this type of arrangement is an active barrier to the greater integration and coordination of health and social care services.

Faced with the level of complexity in the commissioning system, professionals and providers can find it difficult to deal with the holistic needs of the people they support. Professionals are too often left feeling constrained in the support they can provide because they can only perform the task that they are commissioned to deliver, even when that creates unhelpful duplication or where there are better ways to address someone's needs. In addition this often excludes voluntary groups and services that could offer support can't make a contribution; and service users - particularly the most vulnerable - are too often left navigate the system themselves or risk falling between the gaps.

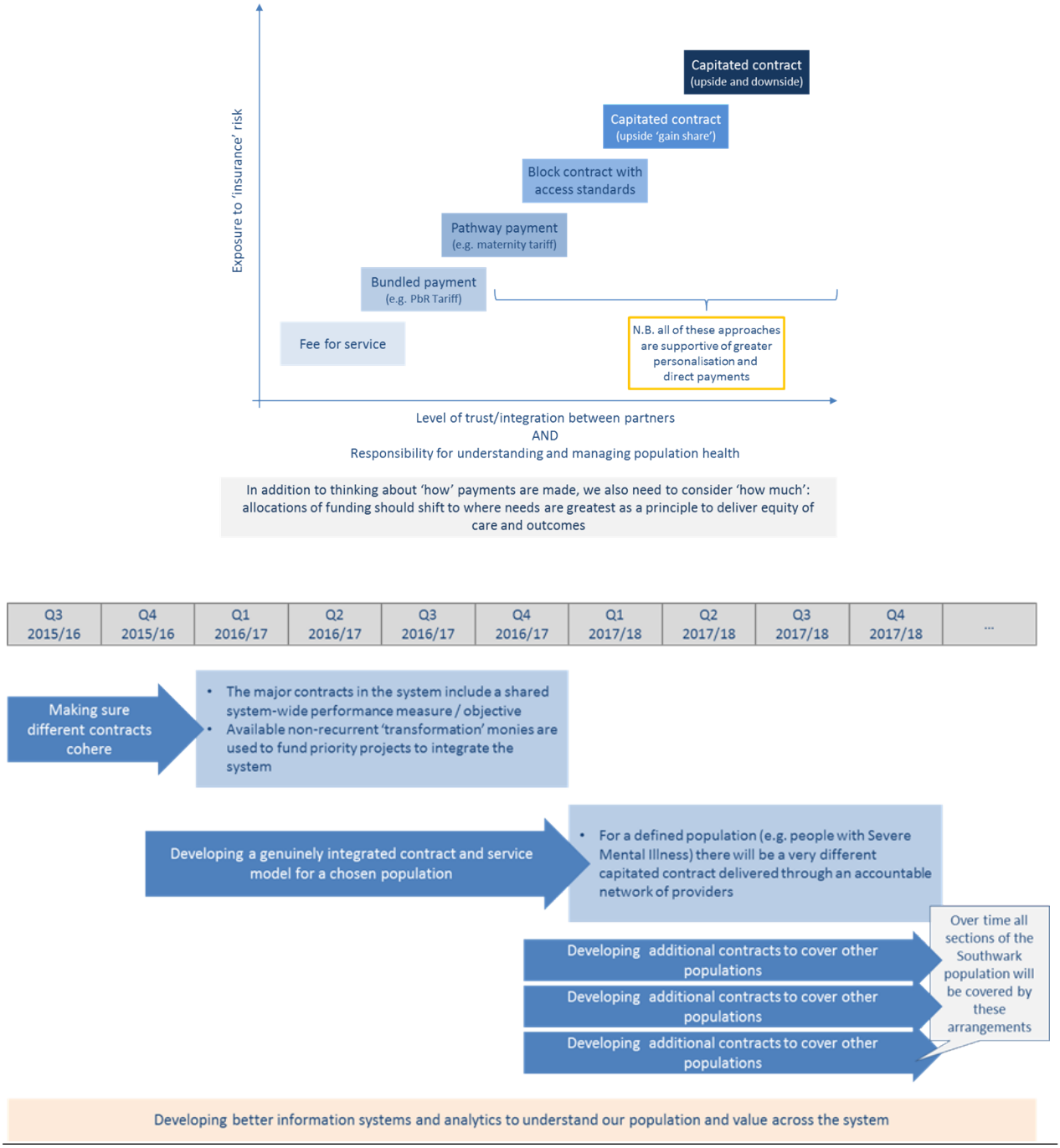
How we are going to tackle this

To support the transformation described in this *Southwark Five Year Forward View*, the Council and the CCG will establish a Commissioning Partnership Team. Over time, and with a jointly agreed remit, this team will become the vehicle for developing and delivering joint strategic intentions across health and social care with strong links to education, public safety and public health. This development will help us to achieve greater equity and better outcomes for Southwark people by addressing the social as well as the physical determinants of health and wellbeing. The Commissioning Partnerships Team will support the pooling of resources and the alignment of decision-making so that we achieve progressively more integrated health and social care commissioning, and the development of increasingly population-based provider contracts. This new team will begin work in 2016/17.

In addition we will continue to play a full and active role in developing a transformation partnership across Southwark and Lambeth. The purpose of this partnership will be to coordinate and commit to collective strategic priorities and to oversee the delivery of those commitments. This will be aligned with the development and implementation of the South East London Commissioning Strategy: *Our Healthier South East London*. The plans we are developing at a borough, cross-borough and sub-regional level must align and mutually reinforce one another. This will be supported by the development of a single Sustainability and Transformation Plan (STP) across the six boroughs of South East London.

In future we will explore the options to formally bring together service contracts either through lead contractor arrangements or through alliancing approaches, to fund services on the basis of an agreed per-person amount (capitated sum), and to offer those contracts for an extended duration to give providers incentives to integrate and invest in service development. And we will make contracts increasingly performance related, with increasing amounts of the total contract value being contingent upon the achievement of specified outcomes. As Figure 6 illustrates, these proposed changes in contracting cannot and should not happen in one single step, a phased transition is required.

Figure 6 – Description of the stepwise movement towards capitated budgets for our populations



Specific actions:

- In developing contracts for the forthcoming year (2016/17) we will work with providers to refine existing bilateral arrangements to support greater systemic coherence. This includes seeking changes to primary care contracts through the PMS Review, a re-tendering of home care services by the Council and a coordinated approach to acute, community and mental health contracts. In all of these contracts we will seek to encourage more collective incentivisation and to align investment in priority areas that help to improve performance in relation to specific system-wide goals, for example the reduction of emergency bed days, and the reduction of delays at the point of discharge from hospital. As part of this approach we will make available non-recurrent transformation investment to help providers turn aspirations into action (for example in the development of Local Care Network projects).

- In 2016/17 we will undertake focused work to develop new strategic approaches to specific population – such as Children & Young People and adults with multiple long term conditions – and we will explore the potential to develop new capitated and outcomes-based contracts in some areas, for example for adults with serious mental illness, or people with learning disabilities. We will invest in the development and measurement of outcomes (for example building on the user experience "I" statements described in Section 4) and we will work with providers to establish a baseline and to subsequently agree improvement ambitions. We will also explore the options to formally bring service contracts together either through lead contractor arrangements or through alliancing approaches.

3.1.3 We recognize that the disempowerment of service users and carers can create confusion and risk making people passive recipients of care

The problem we face

Too often people do not act with confidence in managing their own health and during their interactions with the health and social care system. This represents a real problem given how much we rely on people themselves to make sense of the fragmented services they receive. The problem is biggest for the most vulnerable people in Southwark and it is further complicated when adding in people's interactions with housing, employment and social care services. This problem is made worse because all too often people are kept in the dark: people are unable to see, add to, or control their health records and too often experience services that talk about them rather than with them.

People should play an increasingly active role in determining their health outcomes and begin to work in partnership with care teams rather than being as passive recipients of services. This means supporting a culture change for care professionals so that we focus on what people can do rather than what they can't do. Similarly it necessitates a culture change in our residents and service users so that people understand what to expect from the services they receive and are confident enough to take control of their health and care.

In addition, the wider communities in which people live – and which make such an important contribution to people's lives – are underused as a resource to enhance wellbeing. This means that we spend time dealing with the symptoms of illness (such as depression) rather than dealing with some of the root causes (such as social isolation). There are vibrant and diverse communities in Southwark with passionate and skilled people: we need to make use of that valuable asset to a much greater extent than we do at present.

The way we are going to tackle it

Already there are service users, carers, professionals and voluntary sector workers who are putting people at the centre of care. We know, for example, that parents play a central and skilled role in looking after children with severe health needs; some of our local general practices and hospitals ensure that people can access their care information and see the referral and discharge letters sent between clinicians; and increasingly people with complex needs are working with professionals to receive a direct payment or personal budget and to develop proactive care plans and care coordination. We want to build on this so that health and care services systematically seek to:

- **Activate and support individuals:** supporting informed choices and self-management through empowerment, changing the style of clinical consultations (for example by using decision support tools) and providing appropriate education and skills development; enabling a step change in the use of technology; and increasing the use of personal budgets.

- **Activate communities to build social capital and resilience:** letting people know what services are already available and how to access them; and supporting the development of a wider network of voluntary and community support
- **Change professional cultures:** supporting professionals to change the nature of their conversations with people, especially those with long term conditions who can and do develop expertise in their health conditions; and supporting professionals to feel part of multidisciplinary teams that have relationships with, and access to, the additional voluntary support within our communities

Specific actions

- We will continue to invest in the development of our Patient Participation Groups and work with them and other partners, like our local Healthwatch, to amplify the voice of our patients so that services are developed with local people, and we will strengthen the role that local citizens can play within our overall approach to transformation
- We will continue to invest in the development and availability of structured support for self-management, and we will continue to support the development and testing of innovative referral and care navigation services, such as Southwark SAIL (Safe And Independent Living)

3.2 We need to learn from local experience to effectively support transformation on this scale

3.2.1 We will take a supportive and developmental approach to transformation

We have learnt that neither 'top-down' nor 'bottom up' approaches to change can work on their own. At its heart, ours' is a strategy of relationship building, culture change and community development that will create clarity and freedom for people to work together in new ways alongside the system leadership to commit resources and implement lasting change.

- **Ours is a strategy about relationships and culture change.** This will require us to work differently and in a way that will energise and liberate our staff and citizens to put resourceful communities and individuals at the heart of health and social care.
- **Professionals need to be supported to think creatively** about a wide range of responses to a person's needs; and in order to do so they will need support to operate across our distributed local networks and settings of care, rather than through orthodox hierarchies and within the traditional confines of buildings
- **We need to reimagine our 'workforce'** and engage with the fact that our citizens – as service users, parents of carers and members of resourceful communities – have significant capabilities and want to feel in charge.

In practical terms this will be supported by a variety of tasks which will require investment and system-wide working in order to*:*

- **Support organisational development and wider citizen participation** – this work cannot be successful if it is always an 'add-on' to the day job, but embedding service transformation within core roles requires investment to release people's time. It also requires considerable support for organisational development and communications at a transformational scale.
- **Support workforce development** – we need to fundamentally redefine what we mean by 'workforce' so that we can really make use of our local professional and informal resources. We will need to work with a variety of partners to undertake a systematic analysis of the functions that are needed in the delivery of different types of care, and to determine how best to use and develop a formal and informal workforce to have the skills, capabilities and behaviours needed to deliver those functions effectively.

- **Create an explicit mandate to be bold and to 'reimagine the rules'**, both real and perceived, that currently force retrenchment to narrowly defined interests. This will involve working through detailed technical minutiae as well as confronting large strategic choices, for example balancing means-testing and universal provision, or resolving funding coverage for registered or resident populations.

3.2.2 We will build a strong local partnership to oversee and govern this system-wide transformation

Working within the mission and constitutions of the CCG and Council, we will seek to enable the realisation of this plan by establishing a strategic partnership with citizens, commissioners and providers of health and social care services. This partnership will work together to develop, practically support, and to oversee a programme to transform how care is commissioned and provided. In practice this means:

- Bringing together partners with a common vision and a desire to work together
- Aligning partners´ individual strategic intents to develop a shared partnership strategy for system-wide transformation in Southwark and Lambeth, within which there is: prioritisation of what changes are needed to commissioning and service delivery; agreement about what we will each do as individual organisations or in partnership, including changing the distribution of resources (money and people), changing processes of working together, and changing the way we manage risks; and coordination of our various activities so that they happen in concert and are mutually reinforcing and collectively identifiable as a common programme
- Supporting and resourcing changes in the practice of commissioning and the practice of service delivery, including but not limited to leadership development, stakeholder engagement and 'on the ground' help to try new ways of working
- Holding each partner to account for doing what we said we would do
- Assuring ourselves that our collective actions are improving care for our local population

Our general expectation is that this strategic partnership will, first and foremost, practically support the development of Local Care Networks within Southwark. In this model, LCNs will represent both a locus of activity and of accountability, and transformation investment will be made available where LCNs can demonstrate a joint-commitment to deliver on specific priorities.

Where transformation projects and activities would benefit from coordination or support at a borough level, across Southwark and Lambeth, or across south east London and London geographies we will put in place mechanisms to do that, for example:

- agreeing at a borough level specific work on integrated 'Out Of Hospital' services relating to, for example, domiciliary care and community nursing or enhanced care home support
- agreeing at Southwark and Lambeth level to undertake joint work on technical issues associated with commissioning development (population analytics and the development of new contracting models), or to do with infrastructure development and the establishment of new interoperable information systems; or specific service developments relating to, for example, admission avoidance, improvements in inpatient care pathways, and changes to specialist clinic models for long term conditions
- agreeing at a south east London level to the various priority service developments for LCNs, for example establishing multi-disciplinary working to actively manage people with complex needs
- agreeing at a London level to prioritise transformation work on helping general practices to work collaboratively and at scale to improve access, coordination and prevention.

4 We think delivery of this Forward View will make a real and felt difference to local people and staff

4.1 We hope to see different services and different relationships developing between professionals and with service users

4.1.1 Current services struggle to respond to a persons' complex needs

An illustrative example of a person's story

M is a man in his early sixties living in South London. He moved into London ten years ago to find work. He has had a variety of jobs in that time but he has recently been made redundant. He lives alone in rented accommodation. Most of his social network and friendships were gained at work. Since losing his job, M is meeting fewer people. He has become worried about his rent, growing debt and making ends meet.

M has insulin-dependent diabetes and experiences depression. He knows he should manage his diabetes, for example, his doctor has advised him to monitor his blood sugar levels, eat better and exercise more. M thinks he should do this but in practice it feels hard: going to a gym would be another expense and it is quick and easy to eat take-away food, particularly when you are living alone. Recently M has been feeling like things are getting a bit too much. His only real comfort has been alcohol and he has been drinking more lately.

M has been feeling like things are getting out of control in terms of his health. He has been taken to A&E by the police on four occasions in the past six months because he had collapsed in the street following particularly heavy drinking. They were very nice in A&E, letting him sober up and then giving him a sandwich before being discharged. His diabetes has been a real problem too and he called an ambulance twice in the past month where he has been seen in the A&E department at the local hospital and admitted into the acute assessment unit. The doctors told him he had experienced hypoglycaemia because he'd had too little food. When he was in hospital he saw other people around him who also had diabetes. They were a bit older than him and had more serious problems: one person next to him had had a heart attack related to her diabetes, and she told M that she had had to have an amputation last year because her leg ulcers got really bad. She told M that the operation had been very good and the staff had been very kind, but she was sad because she wished someone had helped her before it was too late. When M was discharged he was very worried; he didn't want to have a heart attack or end up needing an amputation but he didn't know what to do.

In today's health and care system a large amount of the resources are used to purchase high quality amputations or to provide crisis and recovery systems for people experiencing heart failure and heart attacks. These are provided by highly skilled and dedicated professionals and the care is needed because there are ever more people needing treatment for these complications of poorly managed diabetes.

Nationally we spend £7.7 billion per year on dealing with complications associated with type 1 and type-2 diabetes. Of this more than £3 billion is spent on treating myocardial infarction, ischaemic heart disease, heart failure and other heart and circulatory problems. Almost £1 billion

is spent on treating kidney failure; another £1 billion is spent on treating neuropathy, stroke, foot ulcers & amputations, and other conditions such as retinopathy.[6]

There are also some excellent examples of services trying to do things in a more supportive and preventative way, but collectively we spend much less on these services. In this current system many people are left asking whether this is the best way to use the available resources we have, or is there a better way?

4.1.2 We think that Local Care Network services will work with people differently

A system that genuinely focuses on populations and total value would seek to behave proactively and to identify M early and to support him as a 'whole people', understanding his needs and capabilities. This would mean:

- GPs, nurses, social workers and hospital consultants bringing existing data together to identify groups of people with high needs, including individuals like M. They would then act on that information to provide people like M with appropriate support.
- A care team would have time to really understand M's life and his needs, getting to know what is important to him and what goals he has. Using techniques such as motivational interviewing, goal-setting and proactive care planning, care teams would be able to help M to take some positive first steps in taking control of his whole life. For M, this would feel like working with an expert care team, rather than just being treated or being told what to do. Importantly, M's mental health and emotional needs are considered as being just as important as his physical health needs. This would mean that psychologists and psychiatrists form an integral part of the local multi-disciplinary care team.
- Depending on his personal care plan, M could then be supported to access peer-support groups so that he can meet and hear from other people who are going through similar things (see the appendix for a case study on SAIL); he could access structured education resources and self-management support to feel more confident in living well with conditions such as diabetes; with the assurance that if things do go 'off-track' that there is a care team member that he can contact quickly.
- In addition, he would find it much easier to access social activities and local groups, not necessarily related to health improvement but just to feel more connected in the community, and better able to meet people and make friends. This would also include finding really practical advice so that he has support to address non-medical issues such as housing, debt-management, benefits advice, and employment.
- And it would be easier to live a healthier life because our communities will increasingly recognise and support health and wellbeing, for example: M would find it easier to exercise because he would know where the local parks are and know they are safe and he can access free gyms and swims; and he would find it easier to cycle or walk to the shops because the roads are safe, the pavements repaired and streets are well lit (see the appendix for a case study on Southwark Healthy High Streets).

4.1.3 We think that delivery of this LCNs approach will change the arrangement of professionals and teams across organizational boundaries

To provide care and support in the way that this *Southwark Five Year Forward View* envisages will require a change in the ways that professionals work together, and in how those professional groups work with residents. Put simply we need to move to an arrangement where staff from different disciplines work together as part of a team, with a shared responsibility for

[6] From Health Innovation Network Structured Education Toolkit, referencing Hex N et al [D.N. add full reference]

the health and wellbeing of a local population covering natural and coherent localities of 100,000-150,000 people. This relies on the presence of multi-specialty community teams operating as the practical delivery system of a Local Care Network (LCN).

Figure 1 provides an illustration of the journey towards Local Care Networks, and of the progressive integration of the professionals that constitute an LCN's multi-specialty community team. As that diagram sets out, 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, and mental health) who can provide accessible outreach and support and who can act as a point of contact when resident 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.

A multi-specialty community team is just that: it is a team not a meeting. That means that these teams are composed of named people who know one another, who work together in pursuit of a shared goal, who operate using a clear, explicit and mutually agreed approach, who communicate with one another, and who recognise their shared responsibility and accountability for improving the health and wellbeing of the locality population. As part of their development multi-specialty community teams will need to agree and adopt effective joint processes to help to:

- **Provide improved prevention:** promoting health and wellbeing and reducing the onset of disease
- **Provide improved access:** identifying need early and providing timely access to services and effective treatment
- **Provide improved coordination:** Actively identify people with additional need or complexity (for example people with three or more long-term conditions) and work with them to effectively manage their health and achieve personal outcomes. This will require agreed processes to identify people with high need, to work with that group to stabilise and maintain people's health, to respond proactively to any escalation in needs, to plan for and respond to the onset of crisis, and to plan for and support effective and timely post-acute care when people leave the hospital.

4.2 We hope to see different outcomes and experiences of care

Both Southwark Council and Southwark CCG have worked closely with local residents, service users and their families and carers to understand the things people would like to be able to say about their experiences of a health and social care system. These "I" statements are the outcomes that people say are important.

In a population focused system that aims to deliver value and thinks about more than medicine and more than healthcare, people will be able to say:

- *I have systems in place to help at an early stage to avoid crisis and as small a disruption as possible if a crisis happens.*
- *I can manage my own health and wellbeing (or condition) and I am supported to do this (including having access to information and being able to stay healthy).*
- *I can plan my care with people who work together to understand me allow me control and bring together services to achieve the outcomes that are important to me.*
- *I (am able to) live the life I want (and get the support I need to do that).*
- *I feel (am) safe, secure and protected from harm.*

Similarly, in work done in preparation for retendering of Southwark Homecare services, the following "I" statements were developed with people currently using Home care. In a population focused system that aims to deliver value and thinks about more than medicine and more than healthcare, people will be able to say:

- *I want you to be honest with me.*
- *I want to feel safe and protected from abuse.*
- *I want to be treated with dignity, empathy and respect at all times.*
- *I want regular and replacement carers who know me and respect who I am, my culture and my beliefs, and what is important to me.*
- *I want suitably trained and supported care staff.*
- *I want to receive clear good quality information right from the beginning.*
- *I want to know where to go for advice.*
- *I want to know how much this will cost me right from the start.*
- *I have the right to choose how I live my life and be as active and go outside as I want.*
- *I want to stay living in my own home and maintain my community, social, cultural and religious networks.*
- *I want to be able to speak to someone who I can understand and who understands me, in the way that I have agreed works best for me.*
- *I want my family and friends to be involved and consulted with my consent.*
- *I expect that the quality of my care does not depend upon me having family or friends who advocate on my behalf.*

If we are successful, the system we will commission and support will be able to deliver services that allow an increasing number of Southwark people to say that these 'I' statements have been met.

5 Next steps

5.1 We will use our Forward View as the starting point for all of our organizational strategies

As we describe in section 3.1.2, the Council and the CCG will work closely together to develop and deliver our commissioning responsibilities. This will involve the development of commissioning strategies for particular population groups. It will also involve the development of plans to create supporting infrastructure, such as IT and estates. All of these plans will take the vision and principles describe in this document as their starting point so that everything we do on this agenda is focused on delivering the actions we have set out in this document.

An illustrative depiction of this relationship is shown in Figure 7. Further summary information about the specific plans that are referenced can be found in the appendix.

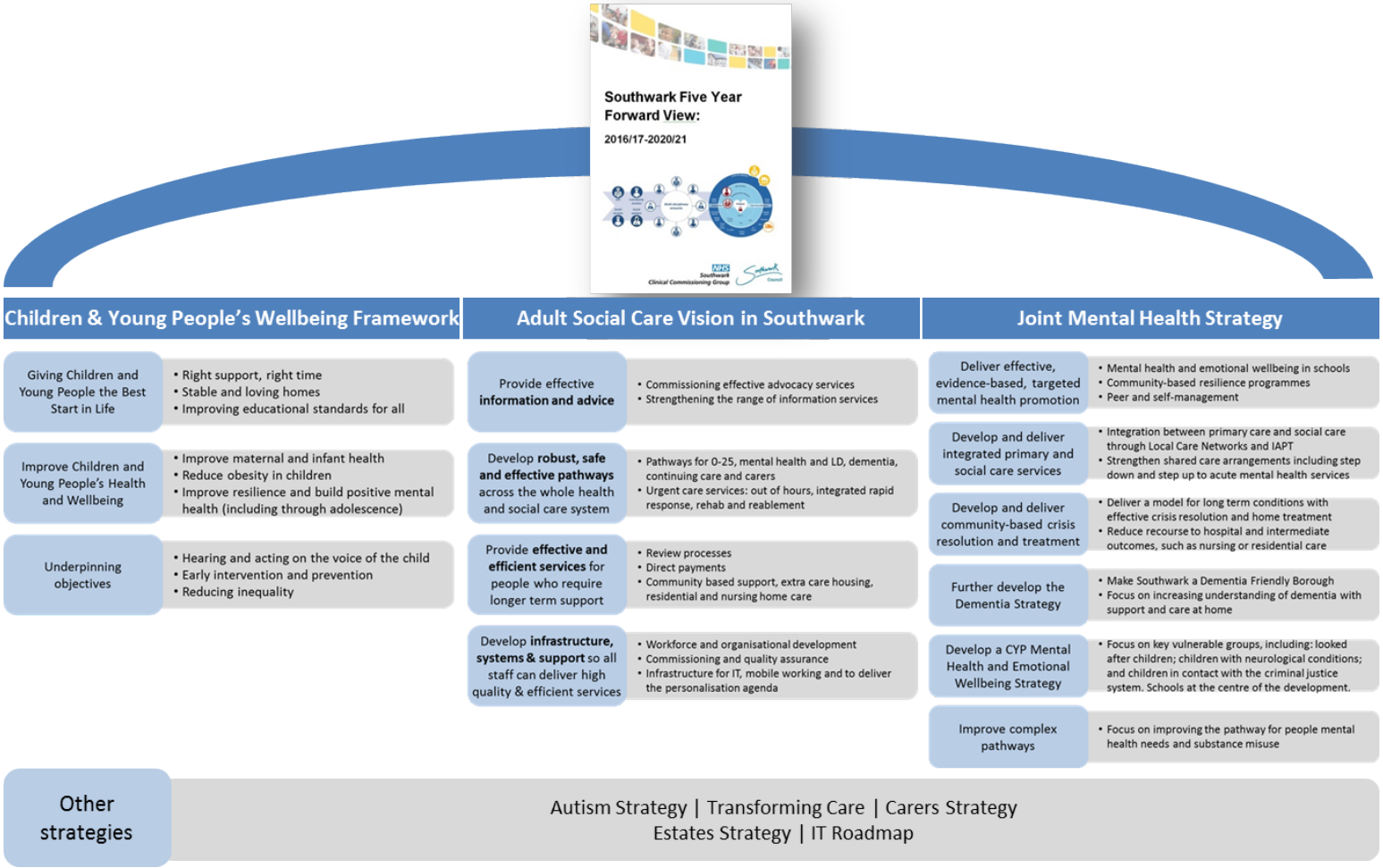
5.2 We will develop an 'Into Action' document to describe our detailed plan for 2016/17

This Forward View is intended to stimulate discussion to inform and structure a programme of meaningful change with the Council, the CCG and with our wider partners.

In this document we have described the need for a transformation to improve health and social care outcomes for Southwark residents, by increasingly integrating commissioning, forming wider partnerships. We have also described how providers of services will be supported and incentivized to work together and with service users to co-produce good outcomes for Southwark people.

We have set out the main aspects of our strategy but recognise that we must continue to develop this Forward View into a specific action plan. To that end our commitment is to share and discuss this strategy with our main partners and citizens and to follow this document with an accompanying plan, *'Southwark Forward View: Into Action',* in March 2016.

Figure 7 – Description of the relationship between the Southwark Forward View and our other strategic documents



Appendices

Local Case Studies

Taken from the Early Action Commission

Case study: Safe and Independent Living

Safe and Independent Living (SAIL) is a social prescribing scheme that is being delivered in partnership with Age UK, and aims to build and maintain a list of activities and services offered by the local Voluntary and Community Sector. SAIL works through a simple yes-or-no questionnaire, which acts as a guide for anyone working in the community to quickly identify an older person's needs. Each question is associated with a partner agency, so a 'yes' to any question operates as a flag to bring that person to the attention of that particular organisation. All partner agencies have agreed to accept all referrals through SAIL and to contact the client within two weeks of being notified. Age UK acts as the hub for the scheme, receiving completed SAIL questionnaires, forwarding them to the appropriate partner agency within 24 hours of receipt and following up the referral with the older person to ensure their needs are met. In this way, SAIL integrates health activities and services offered by the public and voluntary sectors. It is a good example of how partnership working can contribute to early action through signposting and communication.

Case Study: Southwark Healthy High Streets

Southwark Healthy High Streets (SHHS) aims to bring together public health, planning, licensing, trading standards and transport, as well as work with local communities, to explore ways of changing Southwark's high streets to help make people's lives healthier. Its key objectives include: promoting a healthier eating and living environment through restrictions on the number and distribution of fast food and licensed outlets, betting shops and pay day loan companies; promoting active travel through high street design – including good cycling infrastructure, bike hire and walking opportunities; supporting communities to make use of underused public spaces and supporting the high street revitalisation programme in Southwark.

These work-streams are a good example of upstream ambitions because they look at the high street holistically. SHHS illustrates place shaping ambitions in that it moves beyond an understanding of problems arising from decisions of individuals, to the local conditions that shape their behaviours and choices. It is also an example of partnership working and building on assets: the initiative brings together and co-ordinates people and organisations from different sectors and provides funds for community organisations to develop and implement ideas for healthy high streets. As such, SHHS place-shapes by bringing together the regulatory power of local bodies (e.g. in restricting certain shops) and creativity of the community through funding local initiatives.

Population-based commissioning: an overview

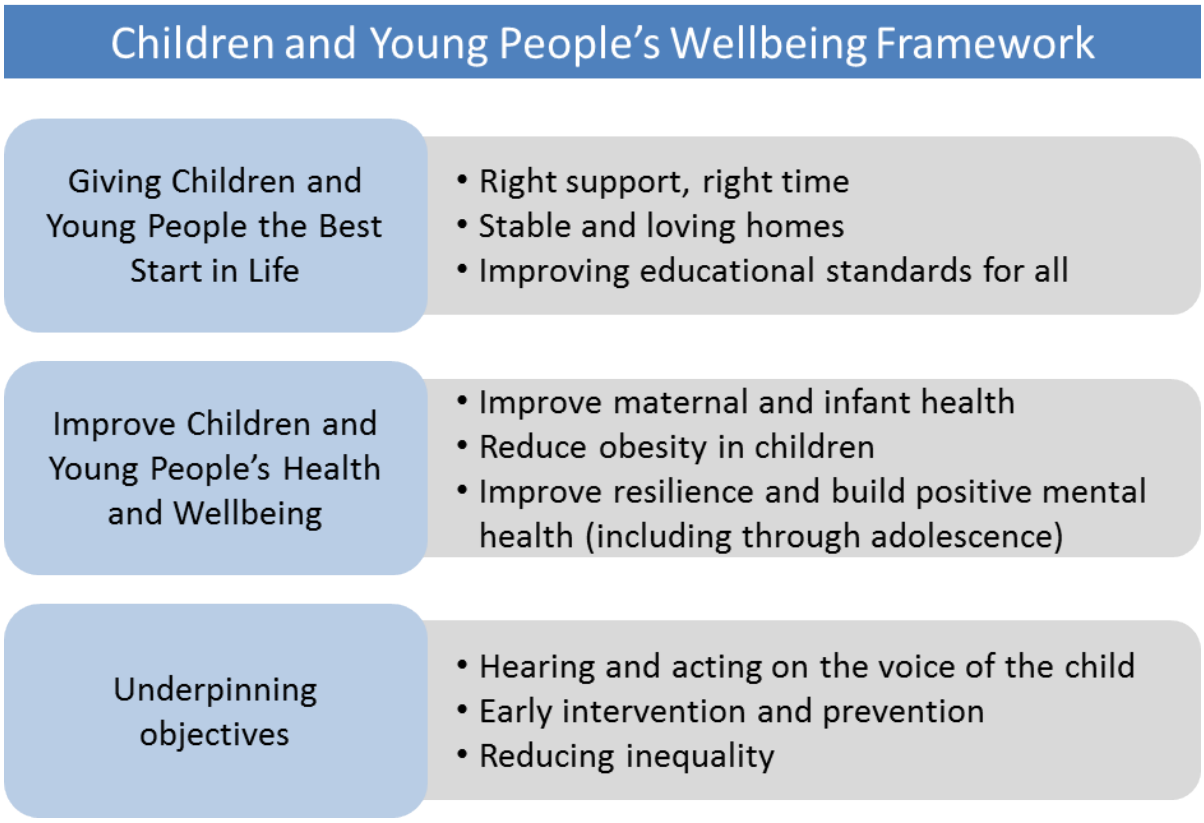
To move to a system where commissioners can offer population-based contracts that focus on the improvement of outcomes, a variety of steps need to be undertaken. These generic steps will be an important part of the approach taken by all of the CCG's commissioning programme boards.

- **Segmentation**: overall we need to determine how we – as commissioners – can describe our total population so that we can put people into groups based upon the similarity of their needs. These groups need to be mutually exclusive and collectively exhaustive.
    - We have already made some progress in identifying relevant population groups, for example people with Serious Mental Illness, people with learning disabilities, and people with frailty and multiple long terms conditions.
- **Resource availability**: for any given population segment we need to determine the resources that we have available to spend on their care. This involves an analysis of total system spend on each group, linking together information from all parts of the health and care system, and thinking about the shift in resource required to genuinely invest in prevention and early interaction.
- **Outcomes identification**: for any given population segment we need to determine what outcomes matter to people in the group and how we would measure those outcomes in practice. This work should be centered on service users and involve clinicians, commissioners and public health experts. Outcome indicators should cover the entire pathway but be relatively few in number to ensure a clear focus for delivery and improvement.
- **Service specification**: for any given population group we should be able to describe – at a high level – the core components of support that we think defines high quality care.
    - This specification should be informed by work with existing providers to understand the barriers within existing models.
    - It is important that this specification focuses on the attributes or characteristics of care and avoids overly detailed specification of inputs, processes or outputs; the detailed service descriptions should be described by providers and it is the job of a commissioner to appraise providers on the credibility and value of the models they propose.
- **Provider development and market testing**: commissioners can only expect a positive response to new contracts if there are indeed providers or networks which are able to respond effectively. Commissioners will work proactively with providers (both incumbent and potential new entrants) to support the development of relationships and an understanding of new ways of working and new operating models.
- **Approach to contracting**: for any given population segment we will need to define what contracting model(s) we want to offer. This includes options appraisals of the different contracts available, a description of the mechanisms for incentives and risk-sharing that it would include, and a description of the contract duration.
- **Approach to procurement**: for any given population segment we will need to develop detailed descriptions of our planned procurement process, ensuring compliance with regulatory requirements. Within the process our assessment should take into account an understanding of the feasibility of delivery, for example by seeking a view on workforce availability and development plans during the delivery phase.

Over the next five years we will use this generic approach to commissioning in order to develop several capitated outcomes-based contracts. Ultimately, when taken together, we anticipate capitated contracts will cover the total population of Southwark.

Supporting Local Strategies

Children and Young People's Wellbeing Framework

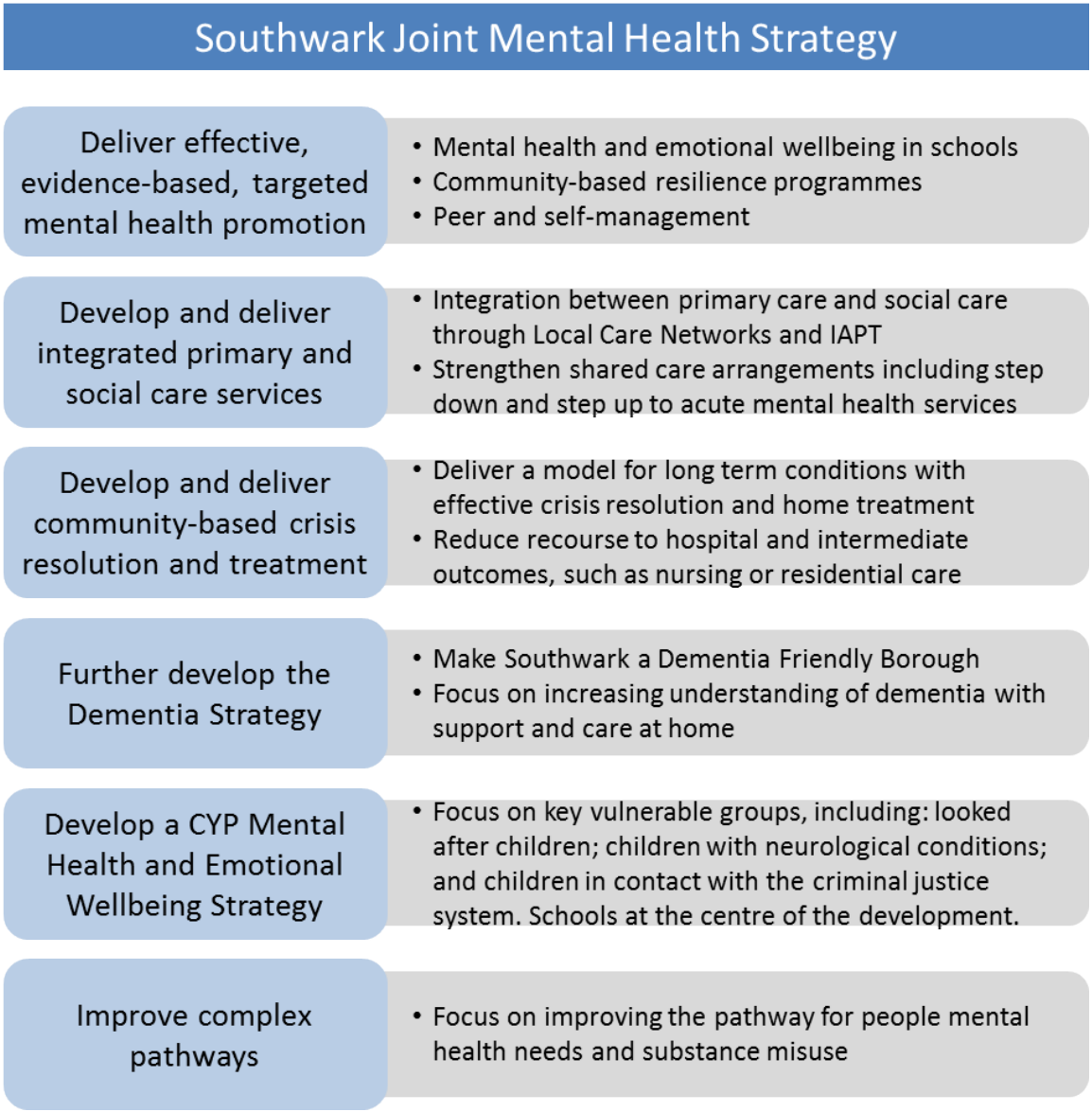


Adult Social Care Vision

Adult Social Care Vision in Southwark

Provide effective **information and advice**	• Commissioning effective advocacy services • Strengthening the range of information services
Develop **robust, safe and effective pathways** across the whole health and social care system	• Pathways for 0-25, mental health and LD, dementia, continuing care and carers • Urgent care services: out of hours, integrated rapid response, rehab and reablement
Provide **effective and efficient services** for people who require longer term support	• Review processes • Direct payments • Community based support, extra care housing, residential and nursing home care
Develop **infrastructure, systems & support** so all staff can deliver high quality & efficient services	• Workforce and organisational development • Commissioning and quality assurance • Infrastructure for IT, mobile working and to deliver the personalisation agenda

Joint Mental Health Strategy



Glossary

[DN. To be completed]

Word or phrase	What we mean when we use it
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•	•
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•	•
•	•
•	•

References

These references are intended to inform the Southwark Five Year View and set some of the context in which it is written:

1. **Michael Marmot (2015)** *The Health Gap*
   Succinctly sets out on a local, national and international context the social determinants of health and how empowerment and social action can address limitations to wellbeing.

2. **Southwark Council (2015)** *Together we can deliver a better quality of life in Southwark: Our Vision for Adult Social Care*
   Sets out the overall operating vision for adult social care delivery in Southwark.

3. **NHS Southwark Clinical Commissioning Group & Southwark Council (2015-16)** *Children and Young Person's Joint Wellbeing Strategic Framework*
   This Strategic Framework for the period 2016-2012 is a collaborative piece of work between Southwark Council and NHS Southwark CCG to bring into a single framework commissioned services across Education, Health and Social Care.

4. **NHS SE London CCGs (2015)** *Our healthier South East London: Help us improve your local NHS.*
   A paper published in May 2015 setting out the health and related social care issues facing SE London and introduces the idea of Local Care Networks (LCNs).

5. **Southwark Council (2015)** *Southwark's Families Matter*
   The 2015-2020 Early Help Strategy, empowering every child, young person and family to live happy, fulfilling lives in their local community.

6. **The Early Action Commission (2015)**
   An in-depth review of the system-wide shift that is required to support a proactive system that is effective in preventing and reducing ill health