NHS
Southwark
Clinical Commissioning Group

System wide approaches to tackling inequalities in Southwark

1. Context

The vision of our community-based care programme in Southwark is to enable every part of the health and care system in Southwark to make the borough an amazing place to be born, live a full healthy life, and spend one's final years.

Our population is looked after by world-class hospitals, and skilled and dedicated health and care teams and voluntary and community sector (VCS) organisations. Everyone who works in health and care in the borough is committed to helping people live longer healthier lives, where they exercise choice and control, and giving them the best possible care and support when they need it.

However, we are facing greater challenges than ever before. The population is ageing, more people are living with several long-term conditions, and we have significant inequality gaps within the borough. People's expectations of, and need for, health and care services continue to rise but funding remains constrained and we need to build on positive work to date but to do so at greater pace and scale and in a more joined up way.

The health and care landscape in Southwark is huge, complex and fragmented. Our population is diverse, which sometimes makes it difficult to focus resources on an individual's needs and for people to access the right care and support when they need it. We know that our current workforce is challenged, and we don't always make the right thing the easy thing to do; particularly for those people that interface with several different professionals or organisations. This can lead to poor outcomes for some people and inefficiency across the system.

Over the last few years, health, care and voluntary and community sector organisations have been working together to deliver services more effectively, embed new ways of working, and ensure care and support is centred around the needs of individuals and local populations. We have made progress and many of the building blocks we need for integrated population-based care are in place; however, these are not always joined up or coordinated to deliver best impact or to address the health and social inequalities that exist across our population.

The Strategic Case being developed by the CCG and partners for community based care in Southwark sets out how through **whole-system partnership** we are focusing on improving health outcomes and reducing inequalities through:

- Making best use of the Southwark pound to deliver improvements in health and wellbeing outcomes for local people
- Being inclusive, and wider than health and care organisations so that we can tackle the causes of health inequalities and prevent illness
- Ensuring every part of the health and care landscape is clearly focused on common goals of supporting self-management, keeping everyone well, providing resilient high-quality services, meeting individual and population-level needs, and making it easier for people to access the information, advice, care and support they need
- Viewing health, social care, housing, voluntary and community sector organisations, education and employment as of equal value and partners when working towards a healthier Southwark
- Equipping people to manage their own conditions, take part in activities that will help keep them well and to support others in their community.

Purpose of this document

The purpose of this paper is to explore how the CCG, Council and system partners are addressing inequalities through our work programme to deliver Southwark's Five Year Forward View and our broader work as part of Our Healthier South East London (OHSEL), our STP. It outlines our work across three main areas:

- **As part of a health and care 'system of systems'** supporting the 1.9m residents of south east London
- **At 'place' level** supporting the 319k residents in Southwark **and at a 'neighbourhood' level** supporting local communities or 30 to 50k residents
- **Through our developing approach to commissioning based on populations** and outcomes across Southwark.

The document is not intended to be exhaustive but rather to act as a summary of key developments as a prompt for further discussion and debate by members of the Southwark Health and Wellbeing Board.

3. Our approach at South East London 'System of Systems' level

The OHSEL strategy, published in 2016, set out the agreed approach to develop consistent and high-quality community-based care and prevention services, and to expand accessible, proactive and preventative care for mental and physical health problems outside of hospital that offers the best outcomes and value.

The strategy recognised that there is pronounced social inequality in SEL, with approximately 49% of people in SEL impacted by inequalities and/or putting their health at risk, and approximately 25% of people in SEL in the early stages of suffering from a long-term condition. For example data from Lambeth and Southwark indicates that although black communities make up 18% of our local adult population they account for 27% of people with multiple long-term conditions. Those living in the most deprived areas are developing conditions on average 10 years earlier than those living in the least.

A review of current data on the opportunities to reduce inequalities in health and wellbeing outcomes in SEL has highlight the following areas for consideration: cardiovascular disease, obesity and diabetes, respiratory disease, and older people's health outcomes.

Our priorities as an STP have also been informed by key insights from local research on long-term conditions supporting the notion of Diabetes as a "gateway disease" and highlighting the importance of wider determinants of health in addressing disease prevalence and management. A key challenge is not just to better understand how different vulnerabilities (for example behaviours and biological factors, such as obesity) contribute to differences in risk by social economic profile of type 2 diabetes, but what exposures (environments) underlie those vulnerabilities (socio economic position, the risk of pre and type 2 diabetes, and implications for prevention).

With this in mind, the STP is increasingly focusing on prevention as a means of keeping people healthier for longer and reducing health inequalities. Recent progress in this area has included:

1. Adopting a systematic approach to **leadership and delivery of the public health and prevention agenda** at an STP level. Adopting a four tiered prevention approach consisting of:

- Addressing the wider determinants of health
- Population level prevention (health promotion and protection)
- Community interventions (prevention in primary and secondary care)
- Clinical interventions (evidence based intervention across secondary, tertiary and quaternary prevention)

2. Raising the profile of prevention under the governance of the STP, to a **Clinical Leadership Group** and by expanding the membership and scope of this group to include senior representation from commissioning and provider organisations including Directors of Public Health

3. Embedding the '**Vital Five'** prevention approach developed by Kings Health Partners to support our understanding for the focus and impact of local activity to address the health and care needs of the population in SEL. This has been incorporated into commissioning intentions for FY 2019-20 (see Appendix I for further detail)
4. Using end to end pathway review to identify further opportunities to reduce health inequalities, focusing on **diabetes** and **obesity** in the first instance, before moving on to examine other prioritised health issues.

4. Our model for community based care within and across neighbourhoods

Over the next two to three years, health and care services will transition to the delivery of integrated population-based care through Partnership Southwark. Services and support will be population focused; delivered *within* and *across* nine neighbourhoods of 30,000 – 50,000 people, aligned to Primary Care Networks.

Within the neighbourhood model, an expanded primary care team will be combined with more integrated multi-disciplinary support from acute and community services, social care, and the VCS. Neighbourhood networks will comprise professionals and services that are either core or aligned to the neighbourhood; recognising that not all services are appropriate to operate or configure at a 30-50,000 geography. These networks will also work with partners that provide services related to the wider determinants of health, through a community of commissioners across the Council and the CCG.

The model will drive a consistent approach to the delivery of integrated community-based care across the borough, but with the ability to tailor and focus resources and delivery to the needs and priorities of particular neighbourhoods, and in doing so to address and respond to inequalities across our population.

Our approach to neighbourhood working will be developed with input from frontline staff, people with lived experience and their carers/families; and will seek to better join up care and support within local communities, understand and respond to population health and wellbeing needs through a more proactive and data driven approach. This means a step change in how we share and analyse information across partners to drive both insights and understanding about our population; and to provide more effective and joined up direct care.

Partnership Southwark will lead and drive this transition through more formal collaborative arrangements through which system partners, including the Local Authority, CCG, and local health, care and VCS providers will come together as a strategic partnership to provide oversight and strategic direction for Southwark's integrated care system.

This model will be underpinned by:

- An **Alliance** overlaying existing provider contractual arrangements, with the scope and scale of transformation and new place-based delivery models within this alliance expanding over 19/20 – 20/21; and
- A move towards **population-based commissioning and delivery for outcomes** using the Southwark Bridges to Health and Wellbeing segmentation framework; reflecting our desire to not just look at health and care but also the wider determinants such as housing, education and employment. See Section 5 below.

Strategic priorities for 2019-21

The programme will deliver on a series of shared system objectives for 19/20 – 20/21.

1. Helping more people with long-term conditions/ frailty to be supported in the community and their own home, which will reduce unnecessary hospital admissions and time spent in hospital once admitted for these patients
2. Providing focused support for residents of care homes and nursing homes to ensure better outcomes and experience and to reduce unnecessary, unplanned and avoidable hospital admissions and sub-optimal medicine regimes
3. Improving the support that people with mental health issues receive in a primary and community care setting, reducing the need for people with stable moderate to severe mental health to be seen unnecessarily in specialist mental health services
4. Supporting people to have greater control over their own health and wellbeing, enabling community connectedness and reducing social isolation (for example by connecting people to local community assets through social prescribing and community hubs)
5. Increased focus on prevention and self-management aligned to our commitment to the 'Vital Five' that supports people to live healthier for longer and works to prevent deterioration and the transition from one to many long-term conditions
6. Developing our approach for children and young people bringing together work within the Children and Young People's Health Partnership (CYPHP) and the development of population-level outcomes using Southwark Bridges to Health and Wellbeing.

Priorities 1 to 3 above focus on support for long term conditions, frailty and mental health – health issues that correlate closely with areas of significant inequality across the borough. Priorities 4 and 5 will further support and enable this action, with systematic approaches to change how we support residents to take more control over their own health and to stay healthier for longer.

On Priority 6, Children and Young People will come formally into scope for our model during FY 2019-20 and will be tailored to key health issues and health and social inequalities across the CYP population in line with the Phase 1 of our Southwark Bridges to Health and Wellbeing approach.

5. Southwark Bridges to Health and Wellbeing

NHS Southwark CCG and Southwark Council are developing a new joined up approach to commissioning known as population based commissioning which moves away from individual services towards commissioning to ensure delivery of outcomes based on people's needs.

We have adapted a tool known as Bridges to Health and Wellbeing, reflecting our desire to not just look at health and care but also the wider determinants such as housing, education and employment as part of getting the environment right, where the Council and CCG can provide information, advice, support, care or treatment for the presenting and underlying needs of an individual and/or their family.

At the centre of this is a consistent focus on early intervention, prevention and self-management / self-care across all segments and acknowledging the voluntary and community sector's important role in this.

Taking the whole Southwark population as our starting point, the original Bridges to Health and Wellbeing model was adapted and will be used as a tool to help understand the needs, health inequalities, common characteristics and best possible outcomes relevant to service users in the population, within individual population segments.

Segmentation aims to categorise the population according to health and wellbeing status, health and social care needs and priorities. This tool recognises that groups of people share characteristics that influence the way they interact with health and care services. To optimise outcomes, service user experience, efficiency and care costs, care delivery systems should respond to the needs of different population segments in different ways.

A fundamental feature of this approach is to ensure that inequalities across the local population are addressed, through:

1. Focusing on improving outcomes for the whole population, including improving the outcomes for those people with the worst outcomes in each population segment who have "fallen through the gaps" under current services and commissioning arrangements
2. Incentivising providers to collaborate to deliver agreed outcomes that will include targets to reduce health inequalities, both directly and indirectly
3. Focusing on social needs as well as health needs, including the social needs arising from inequalities
4. Adopting a person-centred approach will help to ensure specific needs of groups with protected characteristics are addressed which may not be the case with 'one size fits all' services model approaches
5. Empowering service users and local communities and promoting independence
6. Incentivising the shift of resources towards prevention, which will benefit those groups within the population who experience poor outcomes.

After careful development of the agreed model – which is recognised as a whole population approach – we have selected two key population groups to test the methodology in phase 1 (see Appendix II for further detail):

- **In Adults**: Frailty, Dementia and End of Life
- **In Children and Young People**: Protecting vulnerable children (0 to 18 years) – Keeping Families Strong; Maternity and All Southwark Children (up to 5 years) including those with Specialist or Complex needs.

The above population groups were all identified as comparatively higher priorities to mobilise in Phase 1 than other potential options and they all incorporate a vital overlap with mental health and wellbeing which – across the life course – cuts across all segments and identified priorities, for Phase 1 and beyond. Our Phase 1 priorities support the delivery of improved outcomes for a number of groups with protected characteristics – older people, people with disabilities, and pregnant women – as well as placing an emphasis on ensuring children throughout the borough have the best start in life.

6. Next steps

There are clear next steps to progress work on each of the above strands as we move into FY 2019-20.

At a 'system of systems' level:

- Continuing work to mobilise the Prevention Clinical Leadership Group within the STP
- Progressing end to end pathway approaches in relation to diabetes and obesity and using this to drive interventions across the STP
- Supporting the rollout of the 'Vital 5' across all providers with the STP – as well as linking this to our local community based care arrangements.

At a place and neighbourhood level, through our model for community based care within and across neighbourhoods:

- Finalising development of the strategic case for Southwark's community based care model and supporting programme for April 2019
- Achieving signature of the Memorandum of Understanding for the Partnership Southwark Alliance for March 2019 and subsequent Alliance Agreement for quarter two of 2019-20
- Standing up formal programme arrangements focusing on the delivery of shared system priorities from April 2019 (currently running in shadow form).

At a place level, through our Southwark Bridges to Health and Wellbeing commissioning approach:

- Agreeing the engagement and co-production model
- Defining population outcomes associated with Phase 1 segments

- Mapping and analysis of the services and resources associated with these segments.

7. Questions for consideration by the Southwark Health and Wellbeing Board

Members of the Southwark Health and Wellbeing Board are asked to consider the following points in addition to any general feedback:

- Do our strategic priorities need to be further augmented in order to ensure these are addressing inequalities – and if so how?
- Where are the most significant opportunities to ensure greater join up between local teams and resources as part of the neighbourhood model?
- How can we ensure the most effective system oversight and ownership of this agenda through the Health and Wellbeing Board and other local arrangements?

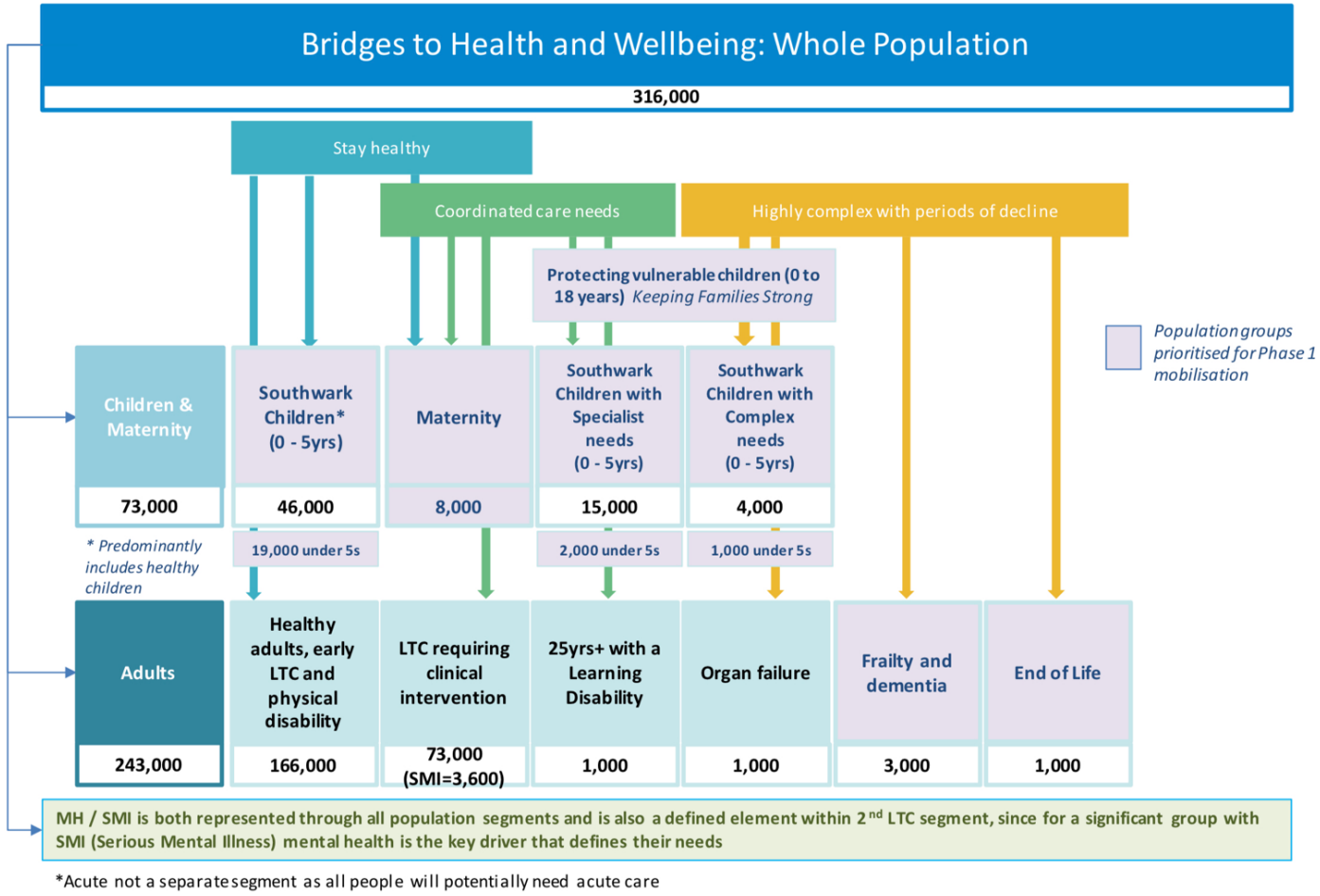
Appendix I – Overview of the 'Vital Five' approach

Overall Aim: Improve the population's health and reduce health inequalities by focusing on the Vital 5 to support prevention, detection, health promotion, management and treatment wherever there is an opportunity to do so.

Vital 5	Aim	Measured through
Blood pressure	to reduce stroke and heart attack, and improve well being	BP recording
Obesity	to reduce diabetes, renal dialysis, liver transplants, amputations and other comorbidities, and improve well being	BMI from height/weight recording
Mental health score	to reduce the burden of mental illness, improve physical recovery and well being	GAD or PHQ-9 score
Alcohol intake	to reduce liver transplants and malignant disease, to improve well being	volume and frequency questionnaire
Smoking habits	to reduce respiratory and malignant disease, and improve well being	volume and frequency questionnaire

Standardised, routine recording and clinical management of these five measures for all our patients should be a vital component to delivering consistent, high quality care to all our patients.

Appendix II – Southwark Bridges to Health and Wellbeing – mapping of Phase 1 segments



*Acute not a separate segment as all people will potentially need acute care