

Partnership Southwark Overview

Our population

We have 307,000 residents. Our population is comparatively young, with the average age (32.4 years) almost two years younger than London, and almost seven years younger than England. 39% of residents are aged 20-39, compared to 26% in England. We have a large Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+) population – over 8% of our adults compared to 4% in London and 3% nationally. Latest estimates indicate that 51% of people living in Southwark have a white ethnic background compared to 81% nationally. Our diversity is greater among our children and young people, with roughly equal proportions of young people from white and black ethnic backgrounds. The latest population projections suggest that the population will continue to grow, with over 17,000 additional people living in the borough by 2030. Population growth is set to take place across almost all parts of the borough, but the largest increases are expected in redevelopment areas around Old Kent Road, Canada Water, and Elephant and Castle.

Health outcomes for our population

Strengths

- Residents are living longer and healthier lives than ever before, with life expectancy comparable or better than the national average.
- Levels of relative deprivation in the borough continue to reduce.
- Key risk factors such as smoking, alcohol and physical inactivity are comparable or better than the national average.
- Preventable mortality has reduced by half since 2001, narrowing the gap with England.

Challenges

- 1 in 4 children in reception are overweight
- 15,000 emergency attendances by children under 5 per year
- Second highest level of STIs and HIV in Eng.
- Around 2,400 admissions for ambulatory care sensitive conditions per year
- 55% of cancers diagnosed at stage 1 or 2
- Around 55,000 adults have a common mental health condition
- ASC provides support to 1500 unpaid carers
- Amongst the highest rate of emergency admissions for falls in London
- Highest rate of emergency admissions for dementia in London

Inequalities within our borough

- Approximately 21% of Southwark’s population live in communities ranked within the most deprived nationally. This increases to 23% among those aged under 18.
- Across a wide range of health, social and economic measures, from child poverty through to obesity, hospital admissions and life expectancy, outcomes are poorer in central and northern parts of Southwark particularly communities in Faraday and Peckham wards.
- Residents from a Black African and Black Caribbean background are more likely to live in communities with high levels of deprivation, develop a greater number of long-term conditions, have poorer mental health, and experience discrimination and racism when accessing services
- Southwark has the fourth highest LGBTQ+ population in the country, and we know that this group can suffer discrimination for access to services, as well as poorer health outcomes
- Southwark has the highest number of asylum seekers in accommodation centres in SEL. The population may have experienced conflict, violence, multiple losses, torture, sexual assaults, and/or risk of exploitation, as well as experiencing issues accessing health and care services.

What we've heard from the public

- Engagement has been undertaken through:
 - Southwark Stands Together
 - South London Listens
 - Southwark 2030
 - Partnership Southwark workshops around the 'Lived Experience Assembly' (working title)
 - Partnership Southwark outreach work
 - Centric and Social Finance work with both Partnership Southwark and public health
- The high level feedback has been as follows:
 - Discrimination and structural racism are impacting access and experience of services
 - Vulnerable people are falling through gaps in support
 - Mental health and wellbeing for children, young people and adults is a priority
 - Services need to be culturally appropriate and accessible for all
 - Concern regarding rising cost of living, food poverty and affordable housing
 - Local communities and community autonomy is high valued
 - Power sharing between communities and services is needed when considering, designing and testing plans and services

Southwark - Our objectives

Our key objectives - what we want to achieve over the next five years

The top things that we want to achieve over the next five years are outlined in our Joint Health and Wellbeing Strategy, 2022-2027. These have been committed to by all Partnership Southwark members:

A whole family approach to give children the best start in life

We want to ensure all families in Southwark receive access to good-quality maternity care, reducing differential outcomes between population groups. We want to build resilient families through holistic care in pregnancy and early years, improve mental health for the whole family and keep children safe through early identification and support for families at risk of adverse childhood experiences.

Healthy employment and good health for working age adults

Across the health and wellbeing economy, we want to increase access to good quality jobs, promote health through employment support, enable people to lead healthy lifestyles, building on the already strong work on the Vital 5, and promote and maximise access to leisure and physical activity.

Early identification and support to stay well

We want to ensure services prevent ill-health through early detection. We want to help people stay well through falls prevention, support for recovery from hospital admission, and wellbeing support for carers and families. We will have an enhanced focus on communities and neighbourhoods with poorer health to ensure better uptake of prevention and services to manage long-term conditions

Strong and connected communities

We want to ensure local people shape their local areas and services. We want to ensure that services are accessible to the most excluded groups and reduce social isolation and loneliness. We will develop strong collaborations between statutory services and the voluntary and community sector, undertake targeted work to remove barriers to services and focus work on addressing loneliness.

Integration of health and social care

The opportunities to deliver better outcomes for Southwark residents will be optimised through strengthening joined up care, exploring where care can be delivered at a neighbourhood level and strengthening how we involve local people in delivery of our work. By bringing NHS, council and voluntary and community organisations together, we can define the shared outcomes we want for our population and ensure the right leadership, accountability and oversight to support our work.

Southwark - Our priority actions

Our priority actions

The following priority actions demonstrate how we will deliver our objectives, and will also be detailed in our local Health and Care Plan.

Strategic collaboration

- Our most fundamental step towards true integration and better outcomes is embedding a new way of working. By this, we mean that we will be designing and producing services together with our community and across providers, to provide holistic and sustainable solutions
- We will start to explore what a “collaborative model” for Mental Health could be, including capitated budgets, and how this would fit with the agreed approach that we are taking, as outlined above.

Wells workstreams

- Our Wells workstreams reflect the life course of our residents – start, live and age well, with some relying on care homes when they can no longer live in their own homes. As part of the Health and Care Plan development, we have focused the delivery of the Wells to align with the ambition within the Health and Wellbeing Strategy and identify the areas with the most potential for integration.
- Start Well: First 1001 days and Children & Young People’s mental health
- Live Well: Adults Community Mental Health Transformation, Cancer and Vital 5 (exploring a family approach)
- Age & Care Well: Local Jobs for Local People, Neighbourhood Integrated Care and Deprived Neighbourhood Outreach

Principles

- Embedding an approach to tackling health inequalities across all our policy-making, services and delivery.
- Making sustainability and tackling climate change an integral part of protecting and improving health.
- Targeted place-based approach and population groups.
- Community empowerment and co-production.
- Delivering high quality, joined-up and person-centred health and social care.

Strategic collaboration – Mental Health

In Partnership Southwark, we are committed to reaching a place of true integration across the system. We recognise that this will not happen instantly, and will require significant work from all our partners in order to achieve our goals. We want to embed ourselves in communities, working at a neighbourhood level to support residents, identified populations and tackle inequalities. Residents are telling us that the system is too fragmented, with conflicting priorities and inequalities in terms of access and experience. As the demand for services increases, a lack of integration between services is going to exacerbate these concerns and mean that we are not giving the right focus on the outcomes for residents. We are already in a collaborative space for Children & Young People and Adults (particularly CMHT) due to the work which is being delivered by partners. Additionally other areas such as BCF are starting to examine how they could help to drive integration/joint working in the MH space. We want to make the most of this momentum to explore how a strategic collaborative could work.

How we will secure delivery

Actions for 23/24

- Undertake engagement workshops with key system partners. The aim of this work is to map what is already taking place, consider what we could do differently and think about a more formalised strategic form that could oversee this, leading to better performance and outcomes across the system. This will help to set our level of ambition for the strategic collaborative and create a delivery structure for getting there (e.g. an overarching steering group with a number of strands underneath this which feed in, such as MH Placements and substance misuse).

Actions for 24/25

- TBD depending on outcome of above conversations

Intended outcomes in 5 years time

- To reduce numbers of people reaching crisis point and give prompt and appropriate support for people in crisis
- To increase the number of people able to live independently
- To increase numbers of people living in stable and appropriate accommodation
- To improve mental health outcomes for people from black communities in Southwark
- To improve physical health for people with mental health issues
- To increase numbers of people in education, training, volunteering or employment

1001 Days Programme

Within the overall Start Well workstream covering residents aged 0-25 years old, a specific programme focused on the first 1001 days of life (conception to 2 years old) has been identified as a priority within Southwark. The programme is specifically targeted at families in the Camberwell Green area and is utilising a neighbourhood approach to allow for tailored and creative approaches to meeting need. Camberwell Green has been selected as the initial area of focus as it is an area of high deprivation (most of the area is in the second most deprived quintile nationally) and:

- evidence shows that socioeconomic deprivation increases the risk of maternal perinatal mental illnesses,
- 16% of mothers living in Camberwell Green did not breast milk feed at all, 31% partially breast fed compared with 11% and 24% respectively for mothers in the second least deprived quintile (maternal population in the least deprived quintile is very small),
- Camberwell Green has the highest prevalence of obesity in Reception aged children in the borough.

Camberwell is also a community asset rich area with strong, well embedded, and trusted community groups and leaders making this an ideal area to trial the resident led, neighbourhood targeted programme approach. Proposed focuses for the programme are perinatal, parental and infant mental health; looking at local workforce development; and breast feeding and infant nutrition.

How we will secure delivery

- Map current programmes that have interdependencies and relationships with 1001 Days programme.
- Develop and deliver a coproduction plan to shape the future of the programme
- Develop & maintain a learning log to track learning from neighbourhood working & resident led approach.
- Asset mapping of Camberwell Green in collaboration with residents and partners.
- Continue to expand the delivery group membership as necessary to ensure all relevant partners and teams are part of the programme. Continue to build relationships with residents and community groups in Camberwell Green and across system partners.
- Prioritise referrals from 1001 day workforce at Camberwell Green
- Coproduce outcomes framework with residents and system partners.
- Explore needs and opportunities for data sharing between system partners.
- Link with existing planning around workforce development to align plans.

Actions for 23/24

We will use the learning from the Camberwell Green 1001 days pilot to spread and scale across the borough. Further plans and actions to be coproduced with residents and partners as the programme develops.

24/25

Intended outcomes in 5 years time

Through the areas of focus that have been proposed, our aim is that:

By 2027, all women and their partners who live in Southwark will feel equipped and empowered to provide the best start in the first 1001 days of their children's lives through the provision and access of family-centred, integrated support and services that meet their specific needs.

Specific outcome measures will be determined through coproduction with partners and residents within the first half of 23/24.

CYP Mental Health

The Southwark Partnership is known to serve children and young people at an elevated risk of mental health issues. Southwark young people are at a higher risk than the national rate of being first time entrants to the Youth Justice system, of homelessness and of attendance at Accident and Emergency. There are high rates of prevalence of being at risk of the ‘toxic trio’ (adult mental health, domestic abuse, alcohol / substance misuse) being amongst the highest rates in the country where all three risk factors are present.

How we will secure delivery

Actions for 23/24

- Active management of waiting lists and reduction in waiting times for service users
- Improving equality of access
- Supporting 16-25 year olds to access the right support
- Improving parental mental health to keep families strong
- Support for Southwark schools – universal and targeted offer for pupils, staff and parents
- Supporting children responding to trauma and distress and crisis stepdown
- Supporting the emotional and mental wellbeing of young offenders (including prevention)
- Develop a seamless pathway for children and young people with eating disorders
- Ensure that the mental health needs of those attending Accident and Emergency are better met
- Improving the responsiveness of perinatal mental health support

24/25

- On going delivery of 2023/24 programmes

Intended outcomes in 5 years time

- Young People are able to access holistic services which are structured around need rather than age
- Southwark system can demonstrate seamless, system wide collaboration in a joined up vision and clear, sustainable investment through transparent decision making and collective accountability
- Families are able to access support for their mental health and wellbeing in a way that supports improved family outcomes
- Resilient and representative groups able to improve service users experience
- Improved connectivity and pathways between SEL commissioned services and local services to increase uptake
- Improve the mental health and wellbeing of families, children and young people, ensuring 100% of children and young people who need support can access emotional wellbeing or mental health services
- Keep children and young people safe through early identification and support for families at risk of adverse childhood experiences

Community mental health transformation

Working collaboratively with residents, Voluntary, community and social enterprise sector (VCSE) and local authorities, expand the provision of early intervention and community-based mental health support offers for adults through both statutory and non-statutory organisations, and across health and care services.

How we will secure delivery

- Delivery of year 3 of the adult community mental health transformation programme:
- Embed service user and carer involvement into service design and review across the system e.g. through the launch of a Service Users Network.
 - Neighbourhood team structures designed, tested and implemented, incorporating multi-disciplinary teams and capitalising on the combined resource of MH professionals across primary care, secondary care and local VCSE professionals.
 - Review of referral processes between CMH services and secondary care with a view to streamline and reduce rates of unsuccessful referrals. Work with service users and residents with lived experience to ensure simple points of access across the system for self referrals and referrals from other professionals.
 - Develop improved relationships and systems for SMI health checks to take place with the most appropriate health care team.
 - Finalise a proposal to measure outcomes across the system using the national outcomes framework metrics and existing system measures.
 - Link with CYP Emotional, Wellbeing & Mental Health Steering and Delivery Groups to join up work around young people's transition from CAMHS to adult services

Actions for 23/24

- Current funding until ends March 2024

Actions for 24/25

Intended outcomes in 5 years time

- Each neighbourhood in Southwark to have a fully established integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of the local population.
- Reduction in the inequality of service users' access, experience and outcomes around CMH services. In particular Southwark's Black, Asian and Minority Ethnic communities and other groups that have previously been underserved.
- Care is continuous: service users have an 'easy in, easy out' experience when stepped up/down between primary and secondary care and vice versa.
- Mental health care is largely preventative and reduces the number of residents experiencing a mental health crisis.
- Links with the VCSE are improved, service-users are able to get support with wider issues such as housing.
- Improved mental and physical health and reduction in mortality, particularly among residents with SMI.

Vital 5 – exploring a whole family approach

The starting focus of the Live Well programme is hypertension; one of the Vital 5. Hypertension cuts across and impacts all the other Vital 5 areas and is also one of the five clinical areas within the Core20Plus5. Hypertension is the most important risk factor for premature cardiovascular disease, being more common than smoking, dyslipidaemia, and diabetes and accounting for an estimated 54% of all strokes and 47% of all ischemic heart disease events globally. Evidence also suggests there are significant numbers of residents with undiagnosed hypertension. Our aim is to ensure residents have the best possible blood pressure, and 80% of those with high blood pressure are detected and treated to recommended guidelines, in line with the national ambition.

How we will secure delivery

Actions for 23/24

- A review of local intelligence regarding the prevalence and management of hypertension including an analysis on health inequalities across our boroughs.
- Identify where blood pressure is taken across the system, and how these measurements are being fed back appropriately.
- Undertake a gap analysis of work already underway surrounding the vital 5 to diagnose and manage hypertension in the borough and identify future opportunities and actions.
- Ensure alignment at a borough level with Vital 5 programme at GSTT and KCH
- Ensure alignment a borough level with Vital 5 programme across South East London
- Evaluation of digital health kiosks in the community
- Incorporate awareness and screening of the Vital 5 in the public health promotion and campaign programme

Actions for 24/25

- An equivalent approach for the other Vital 5 areas (smoking, alcohol, mental health, obesity) will be adopted once work on hypertension begins to advance, building on the iterative and developmental model of working.
- Building on previous year's work, lessons learnt and round up

Intended outcomes in 5 years time

Local ambition:

- A minimum of 50% of NHS Healthchecks are undertaken by residents from Black, Asian and other ethnic minority backgrounds.
- All residents in Southwark to be aware of what the vital 5 is, and what their own measurements are.
- Fully embedded 'Making Every Contact Count' approach to maximise interactions with patients.

National ambitions:

- 80% of the expected number of people with high BP are diagnosed by 2029
- 80% of the total number of people diagnosed with high BP are treated to target as per NICE guidelines by 2029

Cancer

The reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

We also aim to improve quality of care in the community for those living with cancer by promoting community services, social prescribing and the importance of physical activity.

How we will secure delivery

Actions for 23/24

- Utilising the inequalities funding over the next financial year, to ensure a targeted approach to inequalities reduction.
- Working with public health colleagues to align project aims to their JSNA documents.
- Ensure we use a people centred approach, conducting community engagement when necessary for successful project delivery.
- Work with South East London Cancer Alliance colleagues to ensure we are aligning with their forward view and strategic aims to ensure a joined up approach.
- Working through project actions and forward view in our council and ICB cancer working group.
- Working closely and sharing learning with other boroughs in SEL.

Actions for 24/25

- As above

Intended outcomes in 5 years time

Our 5 year aim, is to ensure that Southwark is benchmarked similar to SEL, London and national levels of uptake. Furthermore, we hope to be well underway to achieving national targets for cancer screening across the breast, bowel and cervical programmes. Whilst we aim for screening rates to increase, we are keen to ensure an even coverage of uptake across Southwark with a greater reduction of inequalities across the borough.

In addition, we hope for high quality cancer care reviews to be conducted routinely in the community. The promotion of local services, support and the importance of physical activity will be a routine part of cancer care in the community.

Age & Care Well

With an eye to Prevention, Strength based approaches and self-management, the aim is to help older people to remain active, productive, independent and socially connected for as long as possible and recognising whether it's between hospital and home or from one community services to another, services need to be consistently joined up and responsive to the individual needs of older people. The specific areas of focus will be developing a lower limb wound care model for Southwark, improving care and support for people with frailty through an integrated model, and better coordination of services for those living with dementia. We also want to align with the ambitions of the Community Mental Health Transformation model to address mental health of older people, aligned with neighbourhood development initiatives.

How we will secure delivery

- Strengthening strategic alignment for planning and delivery across Age and Care Well workstreams, bringing community and care homes closer together
- Embedding service user and carer involvement to the design of new models of care and approaches
- Developing outcomes framework to be developed which takes the system / workforce and individual service users into account
- Developing a system led, more comprehensive model of practice for lower limb wound care. Currently working with Accelerate on a needs analysis to inform a detailed business case.
- Refreshing the Dementia strategy and delivery plans in partnership with residents and service users.
- Working with colleagues across SEL and in Southwark to understand good practice around integrated frailty pathways and develop recommendations for piloting locally

Actions for 23/24

- To be agreed Q3
- Working with CMHT leads to explore a developing programme with Older People

Actions for 24/25

Intended outcomes in 5 years time

- There is improved access to specialist and comprehensive physical and mental healthcare & wellbeing services/support and to community activities where required.
- We have an integrated lower limb wound care pathway which achieves better outcomes, including:
 - Better quality of care
 - Proactive management
 - Higher detection rates
 - Early intervention approach and reduction in crisis management
 - Fewer hospital admissions
- We have developed the Community Mental Health model to include older people, stopping people reaching crisis and ensuring they receive care closer to home
- An agreed frailty definition and pathway in Southwark

Age & Care Well – Workforce Development

The workforce across the health and care sector is a major priority and challenge for our local system, including individual providers as well as the large institutions. There is a keenness to optimise interprofessional practice and integration opportunities through neighbourhood approaches, also working innovatively to develop new and diverse roles and career pathways, apprenticeships and connecting further with communities and capitalising on the skills and passion of local people in Southwark.

How we will secure delivery

Actions for 23/24

- Establishing links with wider Workforce planning strategies and collaborate where it makes sense to do so
- Work in partnership with Bermondsey and South London Mission to explore opportunities to develop an apprenticeship programme
- Developing neighbourhood champions to support healthy living initiatives and develop skills/professional opportunities for the community

Actions for 24/25

- To be agreed Q3
- Working with CMHT leads to develop programme with Older People

Intended outcomes in 5 years time

- We have implemented our workforce initiatives which include a range of Voluntary and Community Sector partners to create a sustainable local workforce.
- There is proactive collaboration and recruitment into local care & health sector with local people (placements, apprenticeships, local training/engagement opportunities, tailored support in deprived neighbours to support into work)
- We have established neighbourhoods champions who outreach into their local communities.
- There is evidence of interprofessional practice – which moves beyond multi disciplinary approaches.

Partnership Southwark delivery of SEL pathway and population group priorities

It is recognised that delivery of our local forward view priorities depends on a combination of place level and system-wide plans. For a number of key pathways, population groups and enablers the benefits of geographical scale are recognised and SEL programmes are in place, and Southwark is committed to ensuring its place based plans are fully aligned to these. This alignment is particularly important where there are substantial system level and place level workstreams such as in mental health, CYP and primary care. All of our priorities are partnership focused and resident centred, working across Partnership Southwark to understand the best outcomes for the borough.

Learning Disability & Autism

Southwark has a Learning Disabilities and Autism local lead role that supports the local delivery of the SEL programmes objectives, by, for example:

- supporting cases where mental health has deteriorated and there is a risk of admission to an inpatient unit
- operation of Dynamic Support Registers to identify risks of admission
- discharge planning for people who are inpatients in mental health hospitals back into community living with range of appropriate support
- inputting into SEL operational and strategic LeDeR pathways

Cancer

Our focus is reducing late diagnosis rates through the reduction of cancer screening inequalities across the borough of Southwark, with a particular focus on cohorts of patients with low uptake and engagement rates. We have been successful in securing cancer inequalities funding, which we plan to spend on numerous project and pilots. Our key target cohorts are patients with learning disabilities, SMI and patients who choose to not engage with screening programmes for a variety of reasons.

Urgent and Emergency Care

Southwark has a key role to play in helping maximise system capacity by reducing the number of preventable admissions, and ensuring the prompt discharge of people from hospital who are medically fit for discharge. Southwark's Better Care Fund and the associated Adult Social Care Discharge fund will be expanded in 2023/24 and set out the approach to providing integrated out of hospital health and care services that deliver these objectives. A discharge improvement programme will be part of the approach. Southwark will also seek to ensure we consistently meet or exceed the 70% 2-hour urgent community response standard.

Primary care

Working in neighbourhoods has provided the population of those practices access to specialist care from the different roles in an accessible way, both in the local area and within a short waiting time. Practices working together in the neighbourhoods and PCN have enabled a supportive environment for staff, clinical supervision and development pathways and opportunities within the workplace. This in turn has meant that staff retention has increased and bolstered the workforce. An example from a patient perspective would be presenting at the practice with a musculoskeletal symptom and being offered an appointment within 1 week with a first contact physio. Being seen by the right person at the right time would then prevent further decline in symptoms and with an early treatment plan lead to better outcomes for the patient.

Southwark enabler requirements (1)

Workforce

Our Local Care Partnership has a demonstrated record of developing new roles that drive forward integration, for example our mental health support workers that bring together primary and secondary care. The individual members of our partnership are also at the leading edge of educating and training our future workforce.

As a partnership our aim is to continue to develop innovative roles and ways of working that support integration, including multi-disciplinary teams, and make best use of our constrained resources. We also have an ambition to explore areas of staff development that might benefit from doing more together, for example apprenticeships, where each partner has a successful programme.

However, workforce is one of our system's most pressing issues and for important practical reasons, many of our partners look beyond our borough-level arrangements for collaboration and joint working on workforce. We would welcome a productive dialogue between the partnership and system wide forums on workforce plans, we would also like to see system collaboration inculcating a supportive environment for the cross organisational ways of working that are at the heart of integration. Issues relating to key worker housing also to be considered.

Estates

The 2021 ICS South East London Estates Strategy update and SEL PCN Estates Reviews identify our current priorities and baseline for the NHS community and primary care estate in Southwark. As a rapidly growing borough these priorities include development opportunities arising from regeneration and renewal.

The Local Care Partnership has a Local Estates Forum with wide engagement from partners and the SEL Estates team work alongside the Forum to maintain relationships and seek out opportunities for joint working.

The focus for development for Partnership Southwark is to use this work and priorities to support integration and effective use of the Southwark estate. This includes making the best use of the opportunities presented by the Tessa Jowell Health Centre, where a Lead Integrator is being appointed, and to make use of wider opportunities from the availability of parts of the Council's estates portfolio.

Southwark enabler requirements (2)

Digital

Partnership Southwark will work closely with the emerging ICS Digital Programme to ensure place level delivery. Priority requirements for Southwark include:

- (1) developing a single view of the digital estate;
- (2) replacing outdated digital infrastructure so that our workforce have the ability to access a person's health and care record, and other data and information, with ease and from any location;
- (3) investing in our analytics expertise and information governance processes, including data sharing arrangements, to ensure the optimal use of data to inform population health programmes, research programmes, strategic planning, clinical improvement and prevention schemes, and new payment mechanisms;
- (4) embedding fully integrated approaches across our local care partnership including when developing new digital solutions, digital delivery plans, and financial investment and cost saving strategies;
- (5) identifying shared workforce training opportunities;
- (6) developing shared digital exclusion strategies; and
- (7) ensuring compliance with information governance across the estate.

Finance

Partnership Southwark has an ambition to have an integrated financial plan and a strong financial standing that will enable us to deliver our collective priorities. Ensuring a collaborative approach to planning and contracting, as well as delivery, the Partnership recognises the very real challenges the local health and care economy faces and the need to work together to find solutions to jointly manage these issues across the LCP.

We are working to ensure Partnership Southwark LCP members (ICB, council and provider partners) plan and delivery services together in transparent ways as close to local people's homes as possible to deliver social value and mitigate our collective and individual financial risks for the benefit of the whole system.

We are working to increase ownership and accountability at a local level to achieve our shared priorities. We will aim to ensure there is flexibility to develop, test and implement new contracting and delivery models to support integrated care. This will provide opportunities for improvements by working in collaboration to redesign services, including with our local VCSE and residents.

We are currently looking at a local provider collaborative model for Mental Health. We will use the new NHS payment scheme mechanisms in line with guidance ensuring payment arrangements support productivity and efficiency.

Southwark enabler requirements (3)

Sustainability

Individual organisations will implement their green plans in line with the Partnership Southwark Environmental Sustainability policy statement agreed at the strategic board in January 2023. For the ICB this specifically includes the commitments in the ICS Green Plan and the Primary Care Green Plan.

A Partnership Southwark green champions network will be established for sharing best practice and identifying opportunities for collective working. A commitment to ensuring that sustainability implications are systematically considered in all decision making will be implemented.

Our ambition is to have made clear progress towards the NHSE targets of a net zero carbon footprint by 2040 and the interim target of 80% reduction by 2028 and the council's climate change plan and target for a carbon neutral Southwark by 2030. This will be measured through progress on key domains of the ICS Green Plan including: workforce and system leadership, air quality, travel and transport (staff and patients), estates and facilities, sustainable models of care (including prevention and lean service delivery), digital, medicines (20% of NHS carbon footprint), supply chain and procurement, food and nutrition, adaptation, green spaces.

Quality

Place based quality arrangements and joint working with system-level quality forums still require development to reach full maturity, taking into account the different loci of capacity, work and influence as well as the move away from the traditional assurance-based approach to quality to a collaborative quality improvement approach.

Our ambition is to build a community of learning and shared focus on quality that takes full advantage of the experience and skills of our diverse partners to help quality improvement drive our programme of integration and that supports a shared accountability for the wellbeing and experience of the population in their interactions with our services.

Partnership Southwark requires a range of support to make this change, including subject matter expertise for facilitation and development, the flow of intelligence to support quality improvement as well as a clear strategic steer representing the ambitions of the ICP as a whole.

Additionally, our ICS's response to quality escalations has yet to be tested. Partnership Southwark would appreciate a discussion about the role that Local Care Partnerships can play when areas require additional focus on quality so that we have established ways of working in the event that such systems are needed.

Southwark enabler requirements (4)

Medicines optimisation

Medicines prevent, treat and manage many illnesses and conditions and are the most common intervention in healthcare. Successful implementation of medicines optimisation relies on close collaboration and engagement, with shared-decision making between the residents in Southwark and all partners involved in medicines including all of our providers and community pharmacists who can play an important role in optimising adherence and reducing waste. Patient safety is paramount and should not be compromised at the expense of other factors influencing medicines choice. Clear communication is needed between SEL and place regarding delegation of this budget at place level.

Safeguarding

Safeguarding Adults at Risk and Children and Young People should be the golden thread that runs through all activities of the ICB/ICS. The above cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect. This approach is being embedded across all of our services, whilst focusing on developing evidence based approaches to safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm. Safeguarding is complex and challenging and our plans for the 5 years ahead within this Joint Forward Plan year are ambitious but they are achievable and underpinned by strong partnership working across the health economy and wider system.

Communications and engagement

Public engagement is a key cornerstone of our approach in Southwark. Ensuring we dedicate resource and time to public engagement to work towards a co-production approach will be vital in securing the best services for people and communities in the borough. We will seek to have people and communities within the partnership at every level to support involvement at the Strategic Board and Executive team to ensure we are able to listen to and learn from lived and learned experience as we develop, maintain and monitor services.

We will use the information from this meaningful engagement to inform our work to provide health and care services. We will also apply it to our communications activity to support the development of Partnership Southwark and to make sure that people across the borough are aware of, and understand what support is available to them. Our communications and engagement activity will also strive to support our work to tackle health inequalities in the borough by involving people from a broad range of communities and tailoring our communications to communicate effectively with our key audiences using the channels most suited to their expectations and needs.