South East London Integrated Care System

Partnership Southwark Overview

NHS South East London

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.

Partnership Southwark

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 partnership's engagement approach to priority workstreams
  - 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

South East London Integrated Care System

Southwark - Our objectives

NHS South East London

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	Healthy employment and good health for working age adults	Early identification and support to stay well	Strong and connected communities	Integration of health and social care
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.	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.	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	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.	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 is 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, 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: Neighbourhood Integrated Care including a focus on frailty, dementia, lower limb wound care, deprived neighbourhood outreach and workforce development

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.

South East London Integrated Care System

Southwark – Our progress to date

NHS South East London

Key Successes in Delivery in 2023/2024

Increased maturity of Partnership Southwark as an effective driver of integration including:

- agreement of the Southwark Health and Care Plan and the strengthening of associated programme arrangements for Start, Live, Age and Care Well
- concrete progress in priority areas including delivery of mental health teams in schools, 1001 days and vital 5, hypertension and cancer screening
- lower limb wound care model developed reflecting world class best practice
- development of collaborative neighbourhood working in mental health
- deepening integration of health and social care as reflected by new structure with joint place executive lead
- significant investment in health inequalities fund targeting improved outcomes for marginalised communities
- focus on prevention through a series of successful community health and wellbeing events in schools and community centres promoting uptake of vaccinations and healthy behaviours in our most deprived neighbourhoods
- progress on the Community Southwark 'State of the sector report' recommendations relating to funding, estates and engagement
- transfers of care patient experience project using innovative ethnographic research approach provided valuable insights for discharge improvement

Key Challenges in Delivery in 2023/2024

System-wide demand pressures and financial constraints impact on our capacity to develop and deliver change programmes and invest sufficiently in prevention. Specific challenges included:

- adult mental health placement pressures leading to significant overspend across health and social care
- Children and young people's mental health 52 week waits reduction target impacted by growing demand
- supporting patient flow by ensuring sufficient community capacity to enable discharge from hospital
- financial constraints impact on potential for funding new models of care and programme resources
- data limitations arising from EPIC implementation and lack of analytics capacity impacted on development of comprehensive outcomes frameworks and population health approaches including Core20plus

Learning and Implications for Future Delivery Plans

- we need to further deepen our integration at place level to drive joined up solutions that help reduce demand on our health and care services through integrated neighbourhood models providing proactive multi-disciplinary care need further development
- we will build on the learning from our 2023/24 Health Inequalities Fund programme to improve impact and ensure robust monitoring and evaluation arrangements
- continued need to focus our joint investments supporting discharge from hospital and avoiding admissions to support the urgent and emergency care system
- we have established an approach to working together on our organisational Green Plans which we want to incorporate further into our decision making
- the management cost reduction process has created uncertainty about support for ongoing programme plans which requires careful planning
- we are working to develop a plan to put in place from April 2024 shadow delegation of the health aspects of our joint management of mental health complex care placements within a framework agreed across partners, provided by South London Partnership, our local mental health provider collaborative

Southwark priority 1: Strategic Collaboration

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. We want to make the most of this momentum to explore how a strategic collaborative could work, including through examination of aligned funding models delivered through integrated provider arrangements focussed on delivering agreed population outcomes.

How we will secure delivery

Actions for 24/25

- 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 overset 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).
- Investment of health inequalities funding in grassroots organisations to support those with mental health issues

Actions for 25/26

- To be determined based on outcome of 2024/25 discussion with partners.

Intended outcomes by 2028

- 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

Southwark priority action 2: Start Well 1001 Days Programme

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

Actions for 24/25

- Agree the core essentials of the 1001 Days Approach and steps to setting up within other neighbourhoods to enable spread and scale the programme.
- Select next neighbourhood(s) to launch the programme within.
- Map and initiate relationship building with key partners in selected neighbourhoods.
- Launch streamlined listening phase, and agile approach to development of interventions plan in chosen neighbourhoods.
- Share key learning from neighbourhood working & resident led approach with system and wider partners.
- Continue to build and maintain relationships with residents and community groups in focus neighbourhoods and across system partners.
- Explore needs and opportunities for data sharing between system partners.
- Link with existing planning around workforce development to align plans.
- Integrate the 1001 Days approach and learning with relevant system programmes to ensure sustainability.

25/26

- By 25/26 we expect to be ready to have the 1001 Days Approach actively working in all neighbourhoods of the borough and fully integrated into existing programmes of work such as the Family Hubs programme.

Intended outcomes by 2028

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.

Southwark priority action 2: Start Well
Children and Young People Mental Health

Children and Young People 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 24/25

- 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 linked to 1001 programme
- 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 with link to 1001 programme

25/26

- On going delivery of 2024/25 programmes

Intended outcomes by 2028

- 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

Southwark priority action 3: Live Well
Community Mental Health Transformation

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

Actions for 24/25

- 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 children and young people's Emotional, Wellbeing & Mental Health Steering and Delivery Groups to join up work around young people's transition from CAMHS to adult services

Actions for 25/26

- The 3-year implementation period of the CMH Transformation programme formally concludes on the 31st of March 2024 with service models incorporated into business as usual from 2024/25 onwards.
- Based on programme feedback explore preventative community based early support (health inequality fund investment) via grassroot organisations to reduce the number of residents experiencing mental health issues & requiring mental health crisis services.

Intended outcomes by 2028

- 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.

Southwark priority action 3: Live Well Vital 5

Vital 5 – exploring a whole family approach

The Southwark Vital 5 programme aims to increase prevention and early detection in these five areas, as we know that identifying, recording, and sharing the Vital 5 data between all relevant partners and our patients, and acting on the results would make the biggest difference to people's health and wellbeing and to the sustainability of health and social care. The Vital 5 programme will enable residents to know their Vital 5 status through accessible screening, having access to pathways of care and intervention that proactively meets their needs, reducing variation and inequity.

How we will secure delivery

Actions for 24/25

- Lead the aims and objectives of the vital 5 programme within the Live Well workstream and strengthen alignment at borough level with SEL Vital 5 programme
- Increase uptake of NHS health checks by those with greater risks along with risk reduction interventions
- Work with colleagues across South East London and in Southwark to understand and share good practice and develop recommendations for piloting locally.
- Complete evaluation of digital health kiosks in the community.
- Embed agreed service delivery model incorporating the awareness and screening of the Vital 5 in the public health promotion outreach programme.
- Work jointly with primary care and data leads to facilitate a viable solution to enable safe data transfer of Vital 5 measurements and conversations into resident's primary care records.

Actions for 25/26

- Building on previous year's work, lessons learnt and round up
- To be agreed in Q3 24/25
- Link health & wellbeing events to the Health Inequality funded grassroots organisations to accelerate focus on prevention through a series of community health and wellbeing events in schools & community centres promoting uptake of vaccinations & healthy behaviours in our most deprived neighbourhoods

Intended outcomes by 2028

Southwark system in collaboration with SEL providing a seamless, system wide joined-up approach to delivery to screening and interventions, risk factor documentation and communication between services.

Local ambition:

- Residents in Southwark to be aware of what the Vital 5 is, and what their own measurements are
- A minimum of 55% of NHS Health Checks are undertaken by residents from Black, Asian and other ethnic minority backgrounds
- Fully embedded "Making Every Contact Count" approach to maximise interactions with patients across health and care system
- To provide culturally sensitive services for residents, offering easily accessible and exciting options for improving individual and family health.
- To have improved BMI monitoring that has enabled targeted action to reduce obesity rates

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

Southwark priority action 3: Live Well Cancer

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 24/25

- 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 25/26

- As above

Intended outcomes by 2028

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.

Southwark priority action 4: Age & Care Well (1)

Age & Care Well – Programme priorities

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 scaling up the lower limb wound care model for Southwark, improving care and support for people with frailty through the development of 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

Actions for 24/25

- Develop and test an improved integrated frailty pathway and develop recommendations for neighbourhood prototyping to test new service models
- Embedding service user and carer involvement in the design of new models of care
- Developing an outcomes framework which takes the system, workforce and individual service users and carers into account
- Implementing phase 1 & 2 of the lower limb wound care model that was successfully developed by the workstream in 2023/24, embedding new roles to develop a system led, more comprehensive model of practice
- Working with colleagues across SEL and in Southwark to understand good practice Align the Falls implementation and dementia care with the frailty pathway to help ensure a holistic approach
- Ensure the views of carers are fully reflected in the development of new care pathways

Actions for 25/26

- Develop the frailty workstream including technology as an enabler of integrated services to older people incorporating telehealth, telecare, equipment and other digital solutions
- Working with community mental health services to ensure older people's mental health services are optimised in the revised neighbourhood model.

Intended outcomes by 2028

- There is improved access to specialist and comprehensive physical and mental healthcare & wellbeing services and to community activities where required.
- We will 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 will have implemented a transformed frailty pathway focusing on prevention and proactive care which covers mild, moderate and severe frailty. The model will be aligned to our improved dementia care pathway.
- We will have fewer avoidable admission to hospital for older people in relation to falls.
- Neighbourhood development approaches ensure good connectivity across the system.
- The Community Mental Health model will include older people, stopping people reaching crisis and ensuring they receive care closer to home.
- We will be able to demonstrate improvements across the range of measures in the outcomes framework that we have developed.

Southwark priority action 4: Age & Care Well (2)

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 24/25

- Progress and test neighbourhood service delivery
- Ensure workforce consideration are central to all workstreams, and reflected in the learning cycle of development, prototyping and evaluation of service improvements, including a focus on workforce equality and diversity objectives
- Maximise local employment opportunities, including through consideration of apprentice roles and VCSE roles
- Maximise opportunities for career development and advancement in integrated service models
- Establishing links with wider workforce planning strategies in Southwark, SEL and nationally and collaborate where it makes sense to do so
- Further developing neighbourhood champions to support healthy living initiatives and develop skills/professional opportunities for the community

Actions for 25/26

- Seek opportunities to fund innovative posts and VCSE roles supporting integrated services
- Ongoing development and delivery of workforce development plans

Intended outcomes by 2028

- We will have implemented our workforce initiatives which include a range of Voluntary and Community Sector partners to create a sustainable local workforce.
- There will be a 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)
- Establish neighbourhood networks of champions who outreach into their local communities.
- Evidence of interprofessional practice – which moves beyond multi-disciplinary approaches.
- We will have made demonstrable improvement in recruitment and retention rates in Southwark's services for older people

Partnership Southwark: local delivery of SEL priorities

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, children and young people 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 2024/25 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 will provide the population access to specialist care from a range of services in an accessible way, both in the local area and within a shorter waiting time. Practices working together in the neighbourhoods will enable a supportive environment for staff, clinical supervision, development pathways and opportunities within the workplace. This in turn will mean that staff retention will increase and bolster the workforce. An example from a patient perspective would be presenting at the practice with a musculoskeletal symptom and being offered a first appointment within 1 week with a 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.

As 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 ICS South East London Estates Strategy 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 growth in the health estate, and to make use of wider opportunities from the innovative use of the collective estate in Southwark.
- Continue to make progress towards the goal of reducing estates related emissions by 80% by 2032 in line with the ICS Green Plan. This will be achieved by optimising the use of our estates and identifying resources to enable our buildings to move towards net zero carbon emissions.

Southwark enabler requirements (2)

Digital

Contribute towards the delivery of the ICS and ICB digital plans and strategies; including roll out of the SEL Digital First programme, stock take of GP practice digital tools, review of social prescribing software, and promoting the use of the NHS App.
Provide proactive support for the development of business intelligence analytics to ensure robust data collection, to ensure the availability of data aligned to the achievement of national and local ambitions, and to feed into planning activities, including local identification of opportunities to tackle health inequalities.
Provide support to GP practices and the Southwark Primary Care Digital Group to inform a view of the digital estate across both Primary Care Networks (PCNs); ensure compliance with information governance across the estate; and replace outdated digital infrastructure so that the workforce can access a person's health and care record, and other information, with ease and from any location.
Deliver workforce training to ensure development and retention of organisational expertise in the use of digital tools, including ongoing work to embed Atamis contracts management and oversight of the procurement pipeline, improved supplier management, and compliance with statutory requirements.

Finance

Contribute towards delivery of the ICS and ICB financial plans as set out in the Medium Term Financial Strategy (MTFS). Ensure Place delivery of a balanced financial plan and efficiencies expected as an ICB.

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. Working collaboratively as six SEL places to manage financial risks across boroughs.

We are working to ensure Partnership Southwark LCP members (ICB, council and provider partners) plan and deliver 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. This will provide opportunities for improvements by working in collaboration to redesign services, including with our local VCSE and residents.

Build on the local provider collaborative model for Mental Health. Implement the new Provider Selection Regime for procurement of NHS contracts.

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 2032 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

The role of Partnership Southwark in promoting quality was discussed at a board development session in February 2024. The approach to quality within individual organisations was considered and the best approach to adding value through the partnership was explored.

There was consensus that the initial focus needed to be on quality within the health and care plan priorities, for example within the frailty deep dive and the continued development of the health and care plan outcomes

We will continue 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. This work will be aligned to our Health and Care Plan priorities, the needs and experiences of our population and underpinned by collaboration and mutual support between services.

Southwark enabler requirements (4)

Medicines optimisation

Medicines optimisation is a key golden thread that runs through all our workstreams. 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 recognise and promote the importance of a whole-family approach which is built on the principles of 'Reaching out – think family' to help 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 whilst also safeguarding children and young people 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.