Partnership Southwark

Working together to improve health and wellbeing for the people of Southwark

Partnership Southwark Strategic Board

Agenda

Thursday 7 March 2024 13:30 – 14:50 Part 1

Venue: Garden Room, Appleby Blue Almshouse, 94-116 Southwark Park Road

Chair: Cllr Evelyn Akoto

Time	Item	Lead
13:30	**Welcome and Introductions** **Apologies** **Declarations of Interest** **Minutes of the last meeting** **Action Log**	Chair **Enc 1 – Declarations** **Enc 1i – Minutes** **Enc 1ii – Action Log**
13:35	**Community/VCSE Spotlight: COPSINS – Link Age Southwark**	Saira Quli **Enc 2**
14.00-14:30	**Health and Care Plan Update - Frailty Priority deep dive**	Wendy McDermott Emily Gibbs Tania Kalsi **Enc 3**
14:30-14:40	**Place Executive Report**	Martin Wilkinson **Enc 4**
14:40-14:45	**Public Questions**	Chair
14:45-14:50	**AOB**	All
14:50	**Close Meeting**	Chair

Next in-public meeting date: 2 May 2024 – to be held virtually

Partnership Southwark

Declaration of Interests

Name of the meeting: Partnership Southwark Strategic Board

Meeting Date: 07/03/2024

Name	Position Held	Declaration of Interest
Amanda Coyle	Associate Director of Transformation	No interests to declare
Ami Kanabar	GP, Co-chair LMC	No interests to declare
Anood Al- Samerai	Director, Community Southwark	No interests to declare
Cedric Whilby	VCSE representative	1. Producer of 'Talking Saves Lives' public information film on black men and cancer 2. Trustee for Community Southwark 3. Trustee for Pen People CIC 4. On Black Asian Minority Ethnic (BAME) panel that challenges the causes of health inequalities for the BAME community in Southwark
Cllr Evelyn Akoto	Partnership Southwark Co-Chair & Cabinet Member for Health & Wellbeing	No interests to declare
Emily Finch	Clinical Lead, South London & Maudsley	No interests to declare
David Quirke-Thornton	Strategic Director of Children's and Adult's Services	No interests to declare
Julie Lowe	Site Chief Executive for Denmark Hill	No interests to declare
Gavin McColl	PCN Clinical Director, South Southwark	1. GP Partner Hurley Group: Holds a number of primary care contracts including urgent care contracts. Also runs the National Practitioner Health Service. As a partner of HG has a share allocation of Econsult Ltd 2. Trustee of Doctors in Distress: Works to prevent suicide of healthcare professionals 3. Trustee 'On Call Africa' Medical charity that works to address rural healthcare in Southern Zambia
Graham Head	Healthwatch	No interests to declare
Katy Porter	Independent Lay Member	1. Trustee, & Vice Chair, Depaul UK which is a national charity, working in the homelessness sector, and it's head office is based in Southwark. The organisation holds a contract with Southwark.

		2. CEO for The Loop Drug Checking Service. The Loop is a national charity developing services across the UK, including London. It operates in the substance use and health sector.
Martin Wilkinson	Acting Place Executive Lead	No interests to declare
Nancy Küchemann	Co-Chair Partnership Southwark and Co Chair of Clinical and Care Professional Leads	1. GP Partner at Villa Street Medical Centre. Practice is a member of SELDOC, the North Southwark GP Federation Quay Health Solutions and the North Southwark Primary Care Network. 2. Villa Street Medical Centre works with staff from Care Grow Live (CGL) to provide shared care clinics for people with drugs misuse, which is funded through the local enhanced service scheme. 3. Mrs Tilly Wright, Practice Manager at the practice and one of the Partners is a director of QHS. Mrs Wright is also the practice manager representative on the Local Medical Committee. 4. Mr Shaun Heath, Nurse Practitioner and Partner at the practice is a Senior lecturer at University of Greenwich. 5. Dr Joanna Cooper, GP and Partner at the practice is employed by Kings College Hospital as a GP with specialist interest in dermatology. 6. Husband Richard Leeming is councillor for Village Ward in south Southwark.
Nigel Smith	Director, IHL	No interests to declare
Olufemi Osonuga	PCN Clinical Director, North Southwark	1. GP Partner Nexus Health Group Director Quay Health Solutions Director PCN, North Southwark
Rebecca Dallmeyer	Director, QHS	1. Executive director of QHS CIC GP federation
Sangeeta Leahy	Director of Public Health	No interests to declare
Sarah Austin	Chief Executive Integrated & Specialist Medicine	No interests to declare
Sumeeta Dhir	Co-Chair of Clinical and Care Professional Leads	No interests to declare
Winnie Baffoe	VCSE representative	1. Director of Engagement and Influence at the South London Mission, which works closely with Impact on Urban Health. The South London Mission leases part of its building to Decima Street medical practice. 2. Board Member Community Southwark. 3. Married to the Executive Director of South London Mission 4. School Governor

PARTNERSHIP SOUTHWARK STRATEGIC BOARD – PART 1
MINUTES

Thursday 11 January 2024 at 13:30
Venue: 160 Tooley Street
Chair: Cllr Evelyn Akoto

Attendees

MEMBERS	
Cllr Evelyn Akoto (EA) (Chair)	Co-Chair, Cabinet Member of Health & Wellbeing
Dr Nancy Küchemann (NK)	Co-Chair, GP and Joint Chair of Clinical & Care Professional Leads
Winnie Baffoe (WB)	Director of Engagement & Influence, South London Mission, VCS
Martin Wilkinson (MW)	Acting Place Executive Lead, Partnership Southwark
Olufemi Osonuga (OO)	GP, Clinical Director North Southwark PCN
Anood Al-Sameria (AAS)	CEO, Community Southwark
Katy Porter (KP)	Independent Lay Member
Emily Finch (EF)	Clinical Lead, South London & Maudsley NHS Foundation Trust
Ami Kanabar (AK)	GP, Co- Chair LMC
Sarah Austin (SA)	Chief Executive Integrated & Specialist Medicine, GSTT
Sangeeta Leahy (SL)	Director of Public Health, Southwark Council
Sumeeta Dhir (SD)	GP and Joint CCPL Chair
Gavin McColl (GM)	GP, Clinical Director South Southwark PCN
Cedric Whilby (CW)	VCS Representative
ATTENDEES	
Amanda Coyle (AC)	Associate Director of Transformation
Sabera Ebrahim (SE)	Associate Director of Finance, Southwark, SEL ICB
Graham Head (GH)	Healthwatch Southwark
Barbara Reichwein (BR)	Programme Director, Impact on Urban Health
Peter Babudu (PB)	Executive Director, Impact on Urban Health
Simon Beard (SB)	Associate Director of Corporate Operations, SEL ICB
Catherine Worsfold (CW1)	Corporate Governance Lead, Southwark, SEL ICB
Adrian Ward (AW)	Head of Place PMO, SEL ICB
APOLOGIES	
Julie Lowe (JL)	Site Chief Executive, Kings College Hospital NHS FT
David Quirke-Thornton (DQT)	Strategic Director of Children's and Adult's Services, Southwark Council
Nigel Smith (NS)	Director, IHL
Rebecca Dallmeyer (RD)	Executive Director, Quay Health Solutions

1.	**Welcome & Introductions**
1.1	The Chair welcomed attendees to the Partnership Southwark Strategic Board held in public. EA in particular welcomed Councillor Jim Dickson from Lambeth who was attending to observe.

1.2	Apologies were noted.
1.3	**Declarations of Interest** The Chair **noted** inclusion of declarations within papers and asked if there were any conflicts to highlight with agenda items. No additional declarations were made.
1.4	**Minutes of last meeting** The minutes of the previous meeting were **agreed** with no amendments.
1.5	**Action Log** Two items were noted to be closed: 1. Details of the Patient Experience Team to be circulated to members. 2. Review of the 1001 days deep dive outcomes framework had been completed.
2.	**Community Spotlight – Impact on Urban Health**
2.1	The Chair introduced BR and PB to the meeting and thanked them for their attendance.
2.2	PB and BR delivered a presentation on the work of Impact on Urban Health (IUH), describing the purpose of IUH as existing to ensure everyone had a fair and just chance of living a healthy life, recognising the importance of equality in achieving this. The current focus of IUH activities in south east London was Lambeth and Southwark boroughs. Key highlights of the work carried out by IUH in the borough included: • Working with Guys and St Thomas's NHS Foundation Trust (GSTT) to support the financial health of their workforce. • Support to prevent evictions of residents from the private rented sector. • Support to Southwark for the free school meals rollout and providing evidence to a London wide evaluation. • Supporting the work of the ICS to improve access to appropriate healthcare support. BR provided some further case study details to illustrate the highlights described, and the benefits derived from the schemes, such as c.200 people benefitting from being linked via GPs to professional debt management advisors, and enabling 80% of those referred to the Kineara partnership to avoid losing their home by supporting renegotiation of terms with landlords. The next phase of the projects was to look at how the solutions developed from these projects could be absorbed into business as usual activity.
2.3	The floor was opened to questions: • GM asked how IUH had established funding and achieved stability – this was from funding returns from endowments, with partnering with other organisations to pool resources and expand access to resources by working with other funder organisations.

	• SA thanked IUH for their work in supporting GSTT colleagues with financial advice, noting that a lot of GSTT staff were also local residents. • AA expressed thanks to IUH for their two year project to bring together ethnic minority groups and decision makers to address inequality and develop partnership working, and asked how IUH chose their priorities. PB advised these were focused on where IUH felt they could most uniquely add value, where big gaps existed or there was the ability to shift how an issue was looked at. There was an increasing focus on identifying what was driving health inequalities and making a commitment to expand the range of partnerships. • EA commented that there was a wealth of data available to IUH from JSNAs that could be used to recognize emerging priorities. • FO asked about access to the services on offer. For those having rental challenges, BR advised this would be via a referral from the Council housing department. For access to professionals, FO asked if IUH were linked into the use of social prescribing link workers – IUH had funded an additional link worker to increase capacity for the financial advice services available. • FO also highlighted the benefits that could be obtained through a focus on access to dietary and culturally appropriate foods for ethnic minority groups. PB confirmed one of the IUH projects was around healthy food and supporting people with provision of food vouchers and access to affordable food of the appropriate food type. CW highlighted a new initiative to award grants to projects linked with poverty. • WB thanked IUH on behalf of South London Mission as a beneficiary. WB asked how to overcome the difficulty of fitting everyone into the four priorities for IUH. There was also an ask that where a pilot project is funded in a particular geographic area, some of the future planning looked at how to expand into other parts of the borough. PB advised that IUH are seeking to partner more organisations to get more funders on board to enable application thresholds to be reduced, and to look at how to scale up projects. • Linked to the IUH work on housing, CW highlighted the disparity in private sector housing provision for black African and Afro-Caribbean people, but also noted that Southwark has 3,000 young people living in temporary accommodation and therefore issues also existed in the statutory housing sector. AA proposed that a future PSSB meeting had a presentation from housing. • EA highlighted the issue of financial sustainability – how do we ensure longevity of projects once funding has finished – a conversation to take forward with partners.
2.4	EA thanked PB and BR for their time on behalf of the Board.

3.	**Health & Care Plan**
3.1	AC presented a video which was aimed at explaining to the public the purpose and aims of the Plan. This was accompanied by a draft information pack which was proposed as the format for future update reports. PSSB members were asked to comment.
3.2	Comments noted were: • Ensure the VCSE contribution is recognised – there was a lot of emphasis on health only. • Concern some groups were missed from the Start Well group. • Use of case studies may be beneficial to bring the theory to life. • Outcome metrics needed more development to ensure they were all SMART. • Governance looked complex – would be good to understand who is on the oversight group, how this was decided, and would minutes be shared. • AA asked about the Governance of the Oversight Group and if the VCSE representatives on the Wells groups were being funded for their time, and how they had been involved. AC confirmed next year's budget included VCSE payment. • In some places the language was difficult to engage with and needed looking at. • Need to consider a communications strategy for this Plan. This would help residents engage. A straightforward, clear public facing summary document would also be beneficial. AC advised an accessible "look back on the last year" document was under development.
3.3	The Board **NOTED** the update.
4.	**Green Plan Update**
4.1	NK introduced this item, reminding the members that a policy statement was agreed 12 months ago. Sustainability was inextricably linked to everything else the borough partners wanted to deliver for residents.
4.2	AW presented the case for delivery and reminded the group of the national NHS Net Zero plan, targets, and the current carbon footprint of the NHS. Two specific actions had been identified to be launched this year, being 1) development of a Green Champions network, and 2) implementation of an environmental sustainability impact assessment tool. The group were asked for comments.
4.3	SL felt it was important to consider how to tackle indoor air quality as this wasn't something often focussed on. This included looking as a system at how buildings were heated and how space was used.
4.4	WB highlighted the challenges for VCSE organisations around their estate and the lack of funds available to support green plans. AA advised an eco audit pilot had been started which could be rolled out across the borough. AW commented the ICB had an estates forum that could share

	learning that VCSE organisations could benefit from. The Council was also setting up a climate change partner delivery group. **ACTION: AW to check if VCSE representatives were part of the climate change partner delivery group.**
4.5	KP highlighted the need to think about a broad food strategy linked to food poverty. EA advised that Southwark Council have a strategy which could be brought to the PSSB for awareness.
4.6	The Board **NOTED** the update.
5.	**Place Executive Report**
5.1	Martin Wilkinson (MW), Place Executive Lead, offered the report for comment, taking contents as read.
5.2	EA asked for an update on the ICBs Management Cost Reduction programme. MW advised the management response to the staff consultation had been published, and work had started on the implementation process with job matching and HR processes underway. Implementation was expected in February and March. There were some joint Council/ ICB posts that MW would link in with Council colleagues on.
5.3	GM asked about use of PSSB space as an enabler. MW advised the estates forum had been charged with thinking about how use of space could be maximised. This was a good opportunity which should seek to maximise benefit across partners.
5.4	GH asked for an update on the Change of Control request for AT Medics. MW advised that patients at all affected practices had been written to, inviting them to a webinar, with practices leading on engagement.
5.5	The Board **NOTED** the report.
6.	**Forward Plan**
6.1	AC asked for comments on the PSSB forward plan, noting a minor change to the April development session where the time would now be used for the new PEL to hold 1-2-1 meetings with members rather than holding a workshop.
6.2	SA proposed for the forward plan that Kings and GSTT jointly presented to the Board on plans for management elective recovery, recognising that residents waiting for appointments was an increasing concern.
6.3	AA proposed that a housing representative be invited to join the PSSB.
6.4	AA also supported the plan to use a variety of venues across the borough, using new rather than previously used venues to ensure funding from spot hires was fairly spread.

6.5	**NK and EO encouraged members to feed back on the plan to AC.**
7.	**Public Questions**
7.1	Three questions were raised by members of the public. 1. Patient appointment processes – there was concern that increasing reliance on electronic methods of booking appointments was unfairly discriminating against people who could not use keyboards, read or write or were unable to use the relevant apps. This was creating anxiety for patients who were unable to respond in the 10 minute time limit set for sending a reply. **SA acknowledged the concern and had shared contact details to look at this further.** 2. Results of blood tests – concerns were raised about delays in GPs receiving blood test results. This was not only an issue for patient health but also increased cost from tests being repeated where results were not received. SA acknowledged this was associated with the roll out of a single patient record system (called EPIC) across Guys and St Thomas's and Kings Hospital trusts. This had been a significant piece of work, drawing circa 2,000 systems into one. This had been complicated in some areas, of which pathology was one. Work was ongoing to resolve teething issues and apologies were given for the impact. **ACTION: SA to obtain a timescale for resolution.** 3. Patient Participation Groups (PPGs) – concern was raised about the diminishing profile of PPGs in recent years – people wanted to be involved but there was no apparent support for PPGs. FO acknowledged this had happened but confirmed one of the targets in this year's access plan was to re-establish PPGs, with metrics set to measure achievement. AA also highlighted that a Community Southwark manager had been appointed in the last year and was working with Healthwatch to go out into the community and increase engagement.
8.	**AOB**
8.1	EA highlighted to the audience that a webinar was taking place on 16 January on the Southwark Maternity Commission and encouraged people to sign up.
8.2	The next held in public meeting is scheduled for 7 March 2024 at 13:30. Further details will be available on the website (SEL ICS Events) in due course.

The meeting closed at 14.55 with the Chair thanking everyone for their time.

PARTNERSHIP SOUTHWARK STRATEGIC BOARD ACTION LOG

No.	MEETING DATE	ACTION	STATUS	ACTION FOR / UPDATE
1	11/01/2024	Green Plan update - AW to check if VCSE representatives were part of the climate change partner delivery group.	Closed	AW
2	11/01/2024	PSSB Forward Plan - NK and EO encouraged members to feed back on the plan to AC	Closed	Board members
3	11/01/2024	Public questions (concern over increasing reliance on electronic methods to book appointments) - SA acknowledged the concern and had shared contact details to look at this further	Ongoing	SA
4	11/01/2024	Public questions (delays in GPs receiving blood test results) - SA to obtain a timescale for resolution of the pathology EPIC (single patient record system) teething issue	Ongoing	SA

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 2
Enclosure: 2

Title:	**Link Age Southwark**
Meeting Date:	**7 March 2024**
Author:	Saira Quli – Dementia Services Manager
Executive Lead:	

Summary of main points
Presentation about the work of Link Age Southwark

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
		X	

Action requested of PSSB
Consider the work of the voluntary sector and Link Age Southwark and how it aligns with the work of Partnership Southwark and how we can increase collaborative and inclusive working practices with voluntary sector providers.

Anticipated follow up

Links to Partnership Southwark Health and Care Plan priorities	
1001 Days	
Children and Young People's Mental Health	
Vital 5	
Community Mental Health Transformation	
Frailty	X
Lower Limb Wound Care	

Item Impact	
Equality Impact	n/a
Quality Impact	n/a
Financial Impact	n/a
Medicines & Prescribing Impact	n/a

Safeguarding Impact	Safeguarding is embedded into practice due to the vulnerability of service users		
Environmental Sustainability Impact (See guidance)	**Neutral**	**Positive**	**Negative**
	x		

Describe the engagement has been carried out in relation to this item

Link Age Southwark

Link Age Southwark
Communities supporting older people

Our Vision and Mission

Our **vision** is for ‘friendly local communities where older people thrive’.

Our **mission** is to keep older people and those living with a diagnosis of dementia connected to their local community, alleviating loneliness and social isolation, improving health and wellbeing and making communities stronger through volunteering.

Operating in the borough since 1993

Link Age Southwark
Communities supporting older people

Link Age Southwark
Communities supporting older people

Our Services

Befriending including dementia befriending – 1:1 volunteer support for those who are restricted in leaving their homes

Befriending Plus – 1:1 support for those whose needs are too complex to be matched with a volunteer

Social, exercise and activity groups – 20 groups including specialist dementia groups delivered in a range of community settings including sheltered housing.

Warm spaces – free lunch and social session

Newsletter – containing topical information as well as information about our activities and local activities

Information and Support – supporting with form filling and navigating through systems. Specialist dementia advice and guidance

Link Age Southwark
Communities supporting older people

Our Services

Telephone, Hospital and Digital Buddies – volunteers providing specialist 1:1 support

Celebrations – large social events, birthday and Christmas cards, goody bag delivery

Ageing Well Southwark – hub-based provision for seniors and carers delivered by the COPSINS partners in partnership with Adult Social Care

Gardening and Shopping – to support people to live independently in their own homes

Intergenerational activity – groups, parties and events with local schools

Transport – to support people to attend groups and events

All service provision is free of charge

Our Numbers

- 160 active befriending matches
- 350 volunteers supporting our work
- 40% of our service users are from UK minority ethnic communities
- 250 group members
- Average age of our service users is 81
- One third of the people we support have a diagnosis of dementia
- Contact with over 800 service users each year
- Information and support services provided to 200 older people

Link Age Southwark
Communities supporting older people

Our Impact

- Service User Survey
- Case Studies
- Volunteer Survey
- Group Evaluations
- I statements
- Annual Impact Report

Link Age Southwark
Communities supporting older people

Our Impact

I like the gentle exercise group. I am no longer lonely and have made new friends

I enjoy life more now I have a befriender

I am always by myself so once a week it is lovely to be in the company of others

I love the safe and friendly activities they provide for people with dementia

Link Age Southwark
Communities supporting older people

Our Impact

Really helpful in giving contacts and solutions to every day problems

Link Age Southwark provides support in an atomised world dominated by social media. It makes me less isolated and deprived

Thank you for helping me as I have no one

Having fun and exercise gives me confidence and hope

Link Age Southwark
Communities supporting older people

Partnership Southwark Strategic Board
Cover Sheet

Partnership Southwark
Working together to improve health and wellbeing for the people of Southwark

Item: 3
Enclosure: 3

Title:	**Frailty Priority deep dive**
Meeting Date:	**7 March 2024**
Author:	**Wendy McDermott**
Executive Lead:	**Martin Wilkinson**

Summary of main points
Partnership Southwark are exploring a system wide approach to Frailty. We are building on what we already know from national guidance, research, local data, feedback from Southwark residents their carers and the local workforce.

Item presented for (place an **X** in relevant box)	**Update**	**Discussion**	**Decision**
		X	

Action requested of PSSB
The Board is asked to: 1. Note the four focus areas for delivery aligned to Frailty 2. Note the approach to this programme is guided by the national approach to frailty and aligns with our neighbourhood principles and emphasis on working in partnership with staff, residents and wider stakeholders 3. Note that year 2 planning (January 2025 – December 2025) will build on the work from Year 1 and begin in Q3 4. Make suggestions and facilitate links with any further contacts or networks to drive and deliver the programme 5. Offer suggestions and a view as to how we ensure the momentum of the programme is maintained with reduced resources, or consideration as to any elements of the programme we could pause

Anticipated follow up
Ongoing updates to be presented to the Partnership Southwark Delivery Executive and Strategic Board.

Links to Partnership Southwark Health and Care Plan priorities	
1001 Days	
Children and Young People's Mental Health	
Vital 5	
Community Mental Health Transformation	
Frailty	x
Lower Limb Wound Care	

Item Impact

Equality Impact	This item seeks to address the health inequalities faced by Southwark residents aged 65+ taken from data compiled from Public Health, local hospital trusts, SEL Business Intelligence and primary care networks.
Quality Impact	To be developed as part of the programme design
Financial Impact	To be developed in line with the ambitions of the programme Start-up phase: Partnership Southwark programme team (BaU); CCPL resources
Medicines & Prescribing Impact	To be worked through – focus on de - prescribing
Safeguarding Impact	SEL Designated Safeguarding Adults Nurse is part of the team

Environmental Sustainability Impact (SIA) (See guidance)	Neutral	Positive	Negative
		This has been assessed as positive in line with SIA guidance: • The frailty model if successful will prevent or delay the deterioration of health and reduce the need for more intensive health and care services which have a high carbon footprint. • The development of a neighbourhood model using community assets will bring care closer to home, and reduce patient journeys. • We will ensure a lean model of care reducing inefficiencies and their associated carbon footprint, with digital opportunities exploited etc • Likely to reduce need for high carbon footprint medicines, as ill-health avoided, and also by tackling over-prescribing and poly-pharmacy.	

Describe the engagement that has been carried out in relation to this item
Engagement has been carried out with stakeholders across the local health and care system, including primary care networks, voluntary organisations, local hospital trusts, Southwark Council Adult Social Care & Public Health teams, HACT, Health Innovation Network and SEL ICB teams including Medicines Optimisation and Commissioning. Learning from existing engagement with service users and carers across the system has been included, e.g. Age Friendly Borough consultation and Southwark 2030.

The presentation offers an overview of the Frailty work so far, including 4 areas of focus for delivery

- **The Board is asked to:**

1. Note the four focus areas for delivery aligned to Frailty – one of the 6 Partnership Southwark Health & Care Plan priorities

2. Note the approach to this programme is guided by the national approach to frailty and aligns with our neighbourhood principles and emphasis on working in partnership with staff, residents and wider stakeholders

3. Note that year 2 planning (January 2025 – December 2025) will build on the work from Year 1 and begin in Q3.

4. Make suggestions and facilitate links with any further contacts or networks to drive and deliver the programme

5. Offer suggestions and a view as to how we ensure the momentum of the programme is maintained with reduced resources, or consideration as to any elements of the programme we could pause.

Contents

Health and Care Plan – Age and Caring Well

Working together on shared priorities will produce better outcomes for Southwark communities throughout people's lives

Support Southwark residents to **Start Well:**

- Families receive the right care that works for them, including during pregnancy and the 1001 days of a child's life
- Children get the best start in life and can reach their full potential
- Fewer children and young people are affected by poor mental health

Support Southwark residents to **Live Well:**

- For adults to access the support they need around the Vital 5 areas to promote good health and wellbeing on an equitable footing
  - hyper-tension
  - mental health
  - smoking cessation
  - alcohol intake
  - healthy weight
- People have access to and positive experiences of health and care services that they trust and meet their needs holistically - with fewer adults affected by poor Mental Health (MH)

Support Southwark residents to **Age Well & Being Cared for Well:**

- Integrated health and care services support people to live fulfilling and independent lives, where carers are also supported
- **A coordinated and integrated Frailty pathway to maximise mobility and function, reduce crisis and avoidable and unnecessary hospital admission and support timely discharge from Acute care to community**
- A holistic model of practice for lower limb wound care

Key Enablers

Workforce - Quality - Data - Digital - Buildings - Finance - Sustainability - Medicines optimisation - Safeguarding - Communication & Engagement - Communities - Cllrs/Elected Officials - Leadership & Governance

Age Well - Frailty Programme

Frailty is **not an inevitable** part of ageing, and putting in place **proactive personalised and preventative measures incorporating a biopsychosocial approach** to slow its onset or progression enables people to live independently for longer and helps to reduce demand for emergency care and long-term support.

(British Geriatrics Society, 2023)

Our Starting Point for a Vision for Frailty:

Older People of Southwark Living Happier, Healthier and longer lives – Live Longer Better

A Group of Working Age Adults

We will understand the needs of younger people and other groups at risk of Frailty and ensure these are identified and met

- ✓ **We are aware of what frailty is and are already taking steps in our daily life to keep health and strong and build our resilience**
- ✓ **We are aware of what is available in the community to proactively support our health and wellbeing hobbies, leisure and interests**
- ✓ **We use digital technology (Apps) to support our health and wellbeing**
- ✓ **We go to work and participate in a range of activities**
- ✓ **We are independent and function in an enabling environment**

Mr Osmanski

Mr Osmanski is 80. He has recently had a fall. He mentions this to the pharmacist when he pops in to collect his routine prescription. The pharmacist takes some time and talks to Mr Osmanski about the fall. She makes some suggestions as to steps he might take to reduce the risk of further falls. She records her conversation and actions on a shared care record. When Mr Osmanski visits the practice nurse for routine health screening and blood test she is able to check with him what steps he has taken and whether he needs further information, support or referral.

We will do this through health education, risk stratification and anticipatory care interventions. We will undertake a baseline assessment of frailty services. We will gain involvement and feedback from experts by experience and their carers. We will support the delivery and development of anticipatory care services that reduce frailty
risks and build resilience through education and health promotion.

- ✓ **I understand my medication.**
- ✓ **I don't feel so isolated or lonely.**
- ✓ **I know where to go to get help.**

The Vision and Programme Aims

What are the programme aims?

- Raise awareness, knowledge and understanding of frailty
- Data informed approach - increase our understanding of inequity and inequalities for older people and use this to improve access and support to all sectors of the community
- Explore co-produced solutions with older residents, carers, families and the wider community and build compassionate, supportive local communities and neighbourhoods to support frail residents
- Drive a collaborative and integrated approach to identifying and managing frailty, explore opportunities with commissioning, aligning funding, external funding and innovation
- Drive the delivery of personalised care and ensure there is a suitably skilled and competent workforce
- Provide a range of health and wellbeing support that meets individuals' physical, social and psychological needs
- Optimise community assets, work with VCSE providers
- Explore intergenerational opportunities
- Proactively manage frailty, reduce, delay and prevent the reliance on urgent and emergency care services and the burden on ASC and expedite discharge
- Seek opportunities for collaboration across SEL

The Picture in Southwark

- Data
- Core20 PLUS5
- Faraday Ward
- Some insights into what our communities are telling us

There are 307,600 people living in Southwark, with **26,000** people aged 65 and over
Southwark's over 65 population is expected to grow to **45,200** residents by 2033, a 74% rise

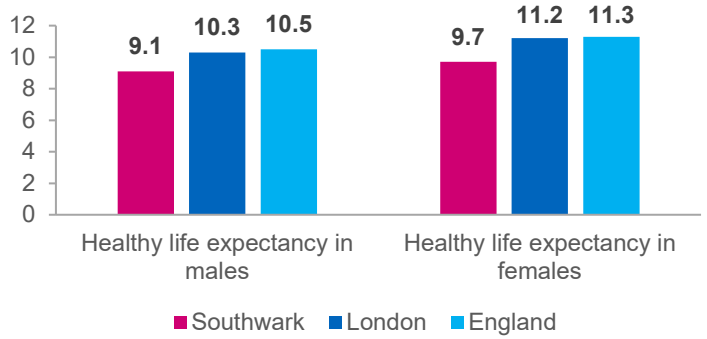
Healthy life expectancy of Southwark's older population is lower than regional and national average:

- Southwark's healthy life expectancy at age 65 in males is 9.1 years, compared with 10.3 years in London and 10.5 years in England
- Southwark's healthy life expectancy at age 65 in females is 9.7 years, compared with 11.2 years in London and 11.3 years in England.
- These figures highlight that although residents are living longer, these years may not be spent in good health

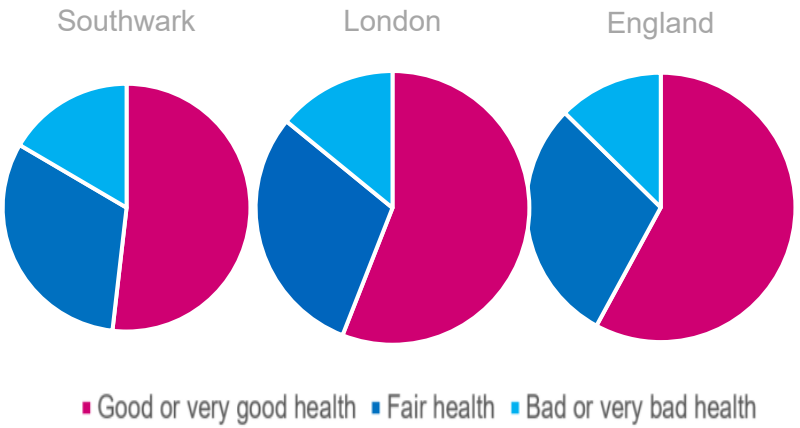
General Health Census outcome of aged 65 and over population in Southwark, London and England, 2021.

51% of Southwark residents report Good or very good health

Figure 1: Healthy life expectancy at age 65 by gender in Southwark, London and England, 2018-2020.



Figures 2: self reporting



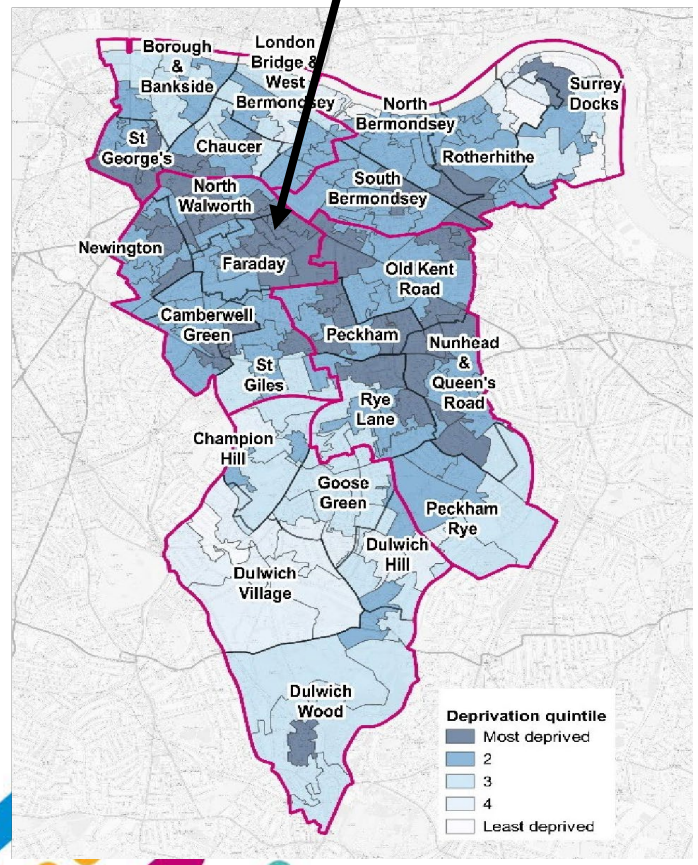
References

1. Office for Health & Improvement Disparities, Productive Healthy Ageing Profile, 2018-2020
2. Southwark Council Public Health, Joint Strategic Needs Assessment 2023
3. ONS, Census 2021

Why we have chosen Faraday Neighbourhood/Ward as our starting point

Out of 23 wards in Southwark, Faraday is ranked as the most deprived ward.

Faraday is a Core20 neighbourhood as identified by the index of multiple deprivation.



Tables 1&2 show which GP practices in Southwark have the highest number of patients living in Core 20 areas. Four of the GP practices (in green) in Faraday are in the top 8 for both the over 65 and the over 80. populations.

1. East Street Surgery
2. Villa Street Medical Centre
3. Old Kent Road Surgery
4. Nexus

GP practice tables showing % and numbers of patients over 65 and over 80 living in Core20 areas

Table 1 Over 65 population

Practice Name	% Core20 Population	Over 65 Population	Actual Core20 Pop
301 East Street Surgery	61.75%	570	352
The Acorn & Gaumont House Surgery	56.48%	857	484
Queens Road Surgery	52.53%	790	415
Villa Street Medical Centre	51.49%	569	293
Park Medical Centre	49.93%	711	355
The Trafalgar Surgery	46.91%	324	152
Silverlock Medical Centre	44.12%	825	364
Old Kent Road Surgery	39.78%	553	220
Nexus Health Group	31.99%	6,899	2,207

Table 2 Over 80 population

Practice Name	% Core20 Population	Over 80 Population	Core20 Pop
301 East Street Surgery	**74.29%**	**105**	**78**
The Acorn & Gaumont House Surgery	53.54%	198	106
Queens Road Surgery	53.37%	193	103
Villa Street Medical Centre	50.91%	110	56
Silverlock Medical Centre	50.00%	152	76
Park Medical Centre	49.15%	177	87
The Trafalgar Surgery	45.31%	64	29
Old Kent Road Surgery	43.37%	83	36
Nexus Health Group	34.33%	1,410	484

Data (example slide – work in progress to develop Southwark version)

Frailty: Who is at risk?

Frailty index by gender and age 65+, Islington 2018 [5]

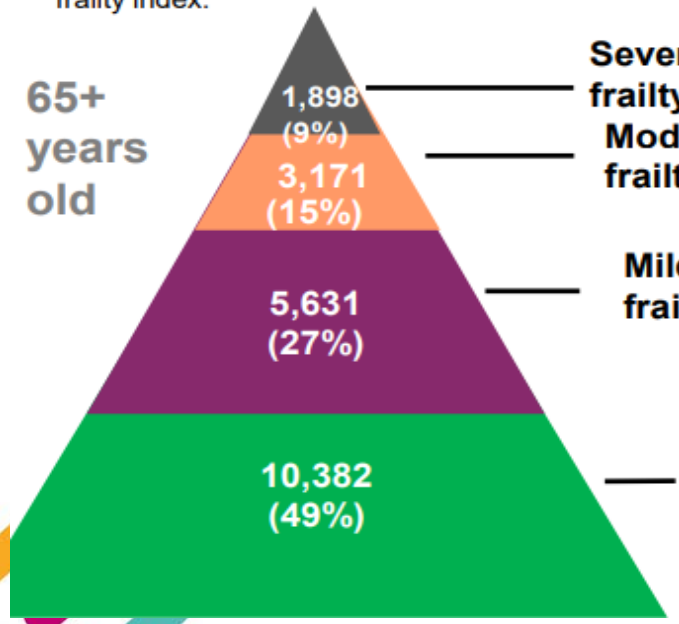
Both men and women (65+) are **similarly likely** to have **mild frailty** (both 27%). **Women (65+) are** more likely to have **moderate frailty** (16%) than older men (14%), and to have a **severe frailty** then older men (10% vs 7%).

Frailty index by ethnicity in people aged 65, Islington, 2018 [5]

Women from Other/Mixed ethnic groups (35%) and men from Other /Mixed and Black ethnic groups (41% and 40% respectively) are more likely to have a **mild frailty** compared to the Islington average (27%).
White women and Asian men are more likely to have a **severe frailty (24% and 31% respectively)** than the Islington average (9%)

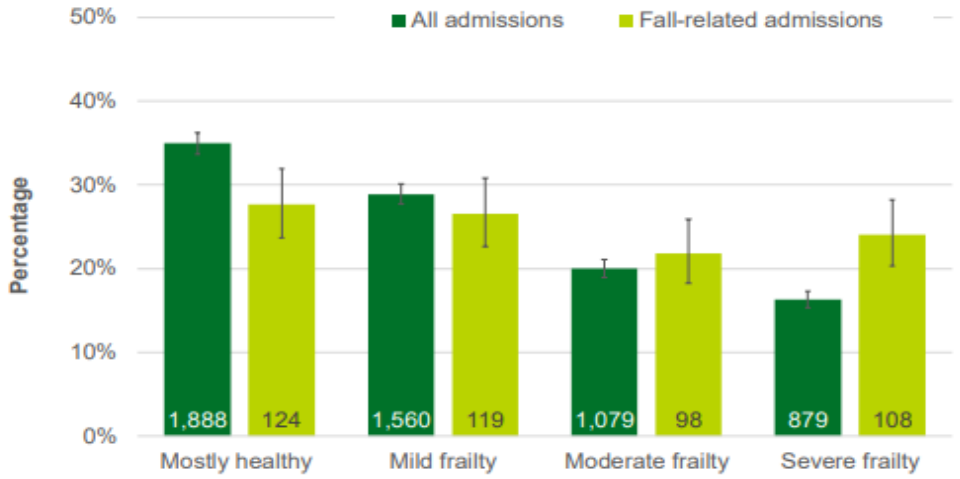
Frailty index, age 65+, Islington 2018 [5]

The population (65+) has been segmented to identify elderly people living health lives, and those with severe, moderate and mild frailty based on the frailty index.



Based on the local review of the frailty index about **one third (5,631)** of older people aged 65 and over in Islington are classified with a mild frailty.

Frailty index: overall and fall-related admissions, age 65+, Islington 2017/18 [5]



In Islington, local data shows that older people (65+) with severe frailty have a significantly higher proportion of admissions related to falls than overall admissions (24% vs 16%).

Source: GP PH linked dataset (2018), hospital admission data (2017/18) [3]

What are people telling us?

Accessible physical activity has such a strong role in terms of keeping the heart well (including dementia prevention and **living in the community for longer**).

We need to start working with people earlier to help them plan for their old age

We should take the community to people who are housebound

Remaining independent is important to me

More practical support needed for older people to live safely and independently in their homes

We need transport that is available for safe door to door journeys

Respect older people in council housing who choose to live alone

There's no-where for us people from the Caribbean to go. It's a cultural thing to sit together outside, and talk, drink, play games – Dominos/Ludi - but we have nowhere so we sit here [Peckham Sq.]. People think we're being anti-social but where else should we be? If you are young and white, there's a million places for you to go, but if you are older and black, where should we go?

Age Friendly Borough Research, 2023

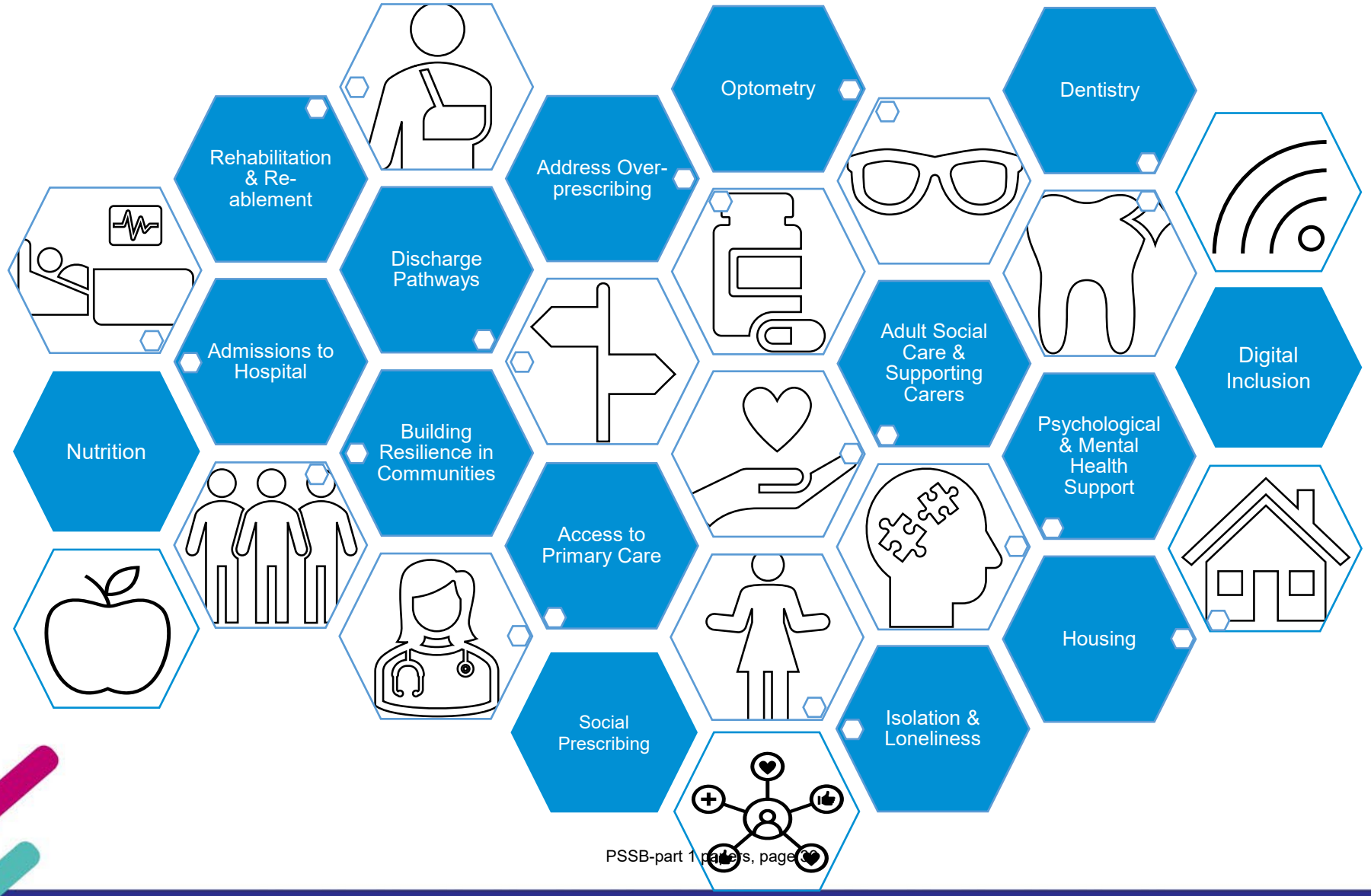
Frameworks, Models & Principles

- National Frailty Approach
- The Southwark Neighbourhood Playbook
- Proactive Care and Enhanced Health in Care Homes
- Prototyping

Local Care Partnership

- Whole System Lens
- Joining the dots

Whole System Lens



Age Well - The "solution" is not about a new service but better connections with what is wanted and needed by those with frailty and their carers and how to connect across services.

From this

To this

Our Delivery Plan

- 4 Key workstreams
- Timeline
- Governance
- Risks, Issues, Opportunities log

4 Areas of Focus and Delivery

1.Identify all existing reference groups/relevant Networks Interviews/questionnaires/ discussions with older people and carers. Plan stakeholder workshops

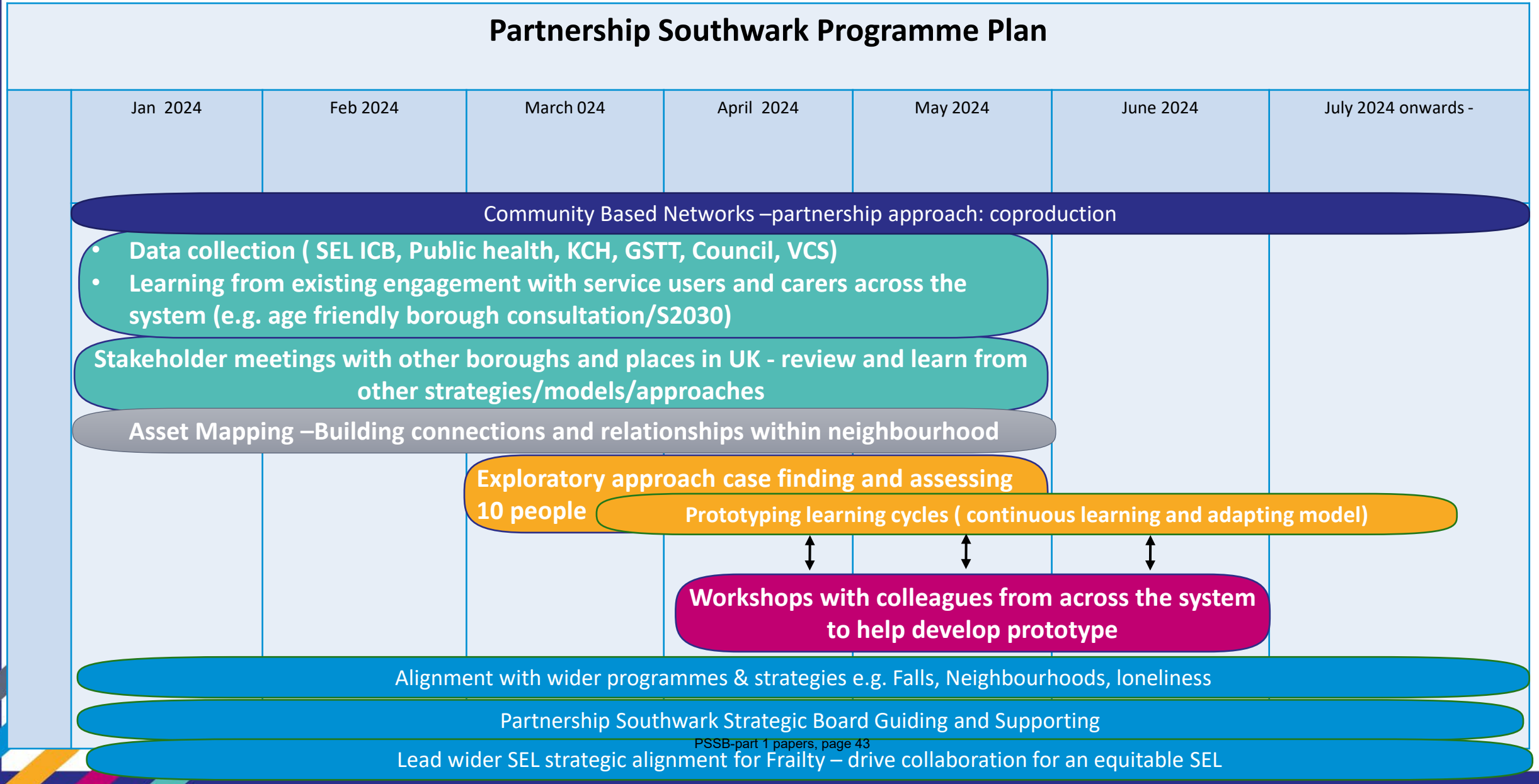
2. Mapping and building knowledge of all local assets in Faraday– people/place/environment/ Services/teams/community offers

3. Scoping & Prototyping a neighbourhood approach: to proactively identify and address needs of at least 10 people

4. Strategic development: Exploring opportunities across SEL, including research National Institute for Health and Care Research (NIHR) to support programme

Key Activity (January – June)	Who
Programme management (ongoing)	Partnership Southwark
Coordinating stakeholder engagement & communication	Partnership Southwark, Southwark Council, Link Age Southwark, Community Southwark
Coordinating Data working group and outputs – baselining ambitions and measuring success	Partnership Southwark, Southwark Council, GSTT, KCH, SEL ICB
Agree Neighbourhood	Key stakeholder group (see appendices)
Identify people to work with – case finding	Quay Health Solutions (QHS), GSTT, ASC, Link Age Southwark
Design initial approach (tool, logistics, timeframe, resources) and begin assessment activity	Partnership Southwark, Southwark Council, GSTT, QHS, Link Age Southwark, SEL ICB
Capture outputs/set up fortnightly learning cycles to develop prototype/ways of working	Partnership Southwark
Workshops to share prototyping/learning and to seek further input. Link with Age friendly approach	Key stakeholder group (see appendices
Comms plan	Partnership Southwark
Discussions with wider SEL colleagues to share practice/learn/consider SEL Strategy and potential for provider collaboration for some heath elements of the programme.	Partnership Southwark, QHS, GSTT

Our Timeline



Draft Governance map

Planning and Oversight

Delivery workstreams

Partnership Southwark Strategic Board

Partnership Southwark Delivery Executive

Partnership Southwark Age Well and Care Well Collaborative *Bi-monthly*

Quality Oversight group Reporting/Advising

Frailty Steering Group

Falls Steering Group

1. Stakeholders/Reference groups/Networks

2. Connected community / Asset Mapping and building knowledge

3. Prototyping a neighbourhood approach

4. Strategic development exploring collaboration across SEL and NHIR to support

Data workstream Task and finish group with SEL BI team

Draft Frailty Programme - Risks, issues and opportunities log (1 of 2)

	Risks/Issues	Description	Opportunities and Mitigations
1	**Workforce**	Reduced ability to recruit, retain and support staff.	Continuing to work within governance structures and workforce development leads.
	Management Cost Reduction (MCR)	Reduced workforce as a result of the recent MCR process in the ICB, also vacant positions and time needed to recruit to these posts.	Ensure the impact is understood and recognised widely by all partners. Keep abreast of the HR process and implications for any changes and impact, to enable programme planning to respond. Acknowledge what we may need to pause, seek alternative resources for supporting delivery.
2	**Data & intelligence** **Epic has just launched, effecting access to some of the data**	The business intelligence unit are inundated with work relating to the transition of systems.	Keep abreast of the transition of the system. Use older data when appropriate
3	**Outcomes & Evaluation Need to agree a set of measures to understand the impact of the developing programme**	Outputs Milestones Population outcomes	to be developed as part of the programme and prototype development
4	**Managing the unintended consequences of creating inequalities whilst prototyping**	This could be access to services where there may be waiting lists e.g. OT assessment/Physiotherapy/dietetics – we would want to begin solving issues live as part of the programme	Build in these conversations in partnership with all provider organisations within the frailty steering group

Draft Frailty Programme - Risks, issues and opportunities (2 of 2)

	Risk	Description	Opportunities and Mitigations
5	**Resources and expertise to ensure co-production**	Adequate resources , skills and expertise to lead programmes that build trust through use of Asset Based Community Development or strength based approaches - focus on assets, opportunities and see people as citizens and co-producers rather than seeing them as clients.	The Board demonstrates the appetite for this approach, recognising the additional time implications. Invests in co-production and this sits at the centre of how the health and care system learns and embeds change in Southwark. All organisations agree to consider resources to support this approach, coordinated via steering group.
6	**Financial pressures**	Partnership Southwark partner organisations need to make financial savings and/or face significant budget pressures.	Partner organisations continue to provide a stable financial environment that supports improvement and investment in healthcare and outcomes. The commitment to financial sustainability will be vital to ensuring a robust and effective delivering of core responsibilities, secured through approaches that demonstrably improve productivity, efficiency, and value through making the best possible use of funding available.
7	**Learning**	Risk of learning from the prototyping not being distributed during and on completion to inform wider systemic change. Opportunities to amplify and influence change more widely lost.	Use the Frailty Steering, board engagement, strategic communications Actions: Development of a communication plan to provide intermittent learning publications (can be as simple as blog posts) to draw out key learning during the early phase and implications of this learning on the wider practice and approach to frailty across support systems. End of pprototying impact and learning report produced and distribution plan developed and rolled out widely to sector partners/feed into SEL development.

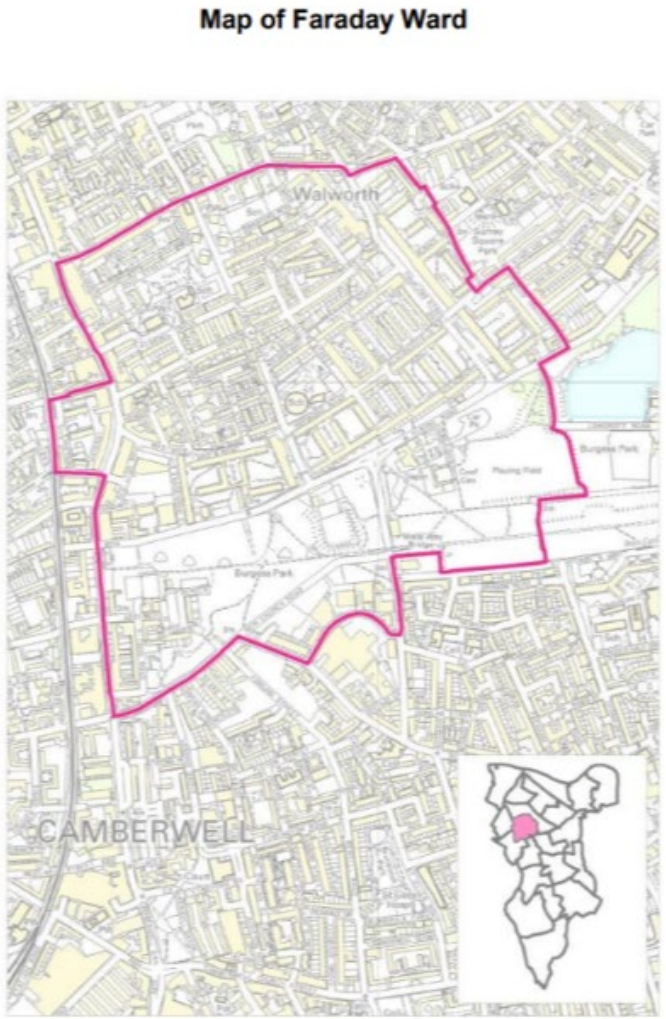
Thank you for listening

Any Questions?

Supplementary information

- ✓Asset mapping Faraday Ward and Wider
- ✓Key stakeholder list

Asset Mapping: Faraday



Community Pharmacy

- Superdrug Pharmacy, Walworth Road
- Ridgway Pharmacy, Walworth Road
- Taplow Medipharmacy, Thurlow Road
- Tesco Pharmacy, Dunton Road
- Lenny Pharmacy, East Street
- A R Chemist, Old Kent Road
- Ling's Chemist Barn Twist, Old Kent Road

Community Group

- Golden Oldies
- Southwark Pensioners Centre
- Walworth Living Room
- Southwark Resource Centre
- St John's Centre
- Healthy Living Centre, Age UK

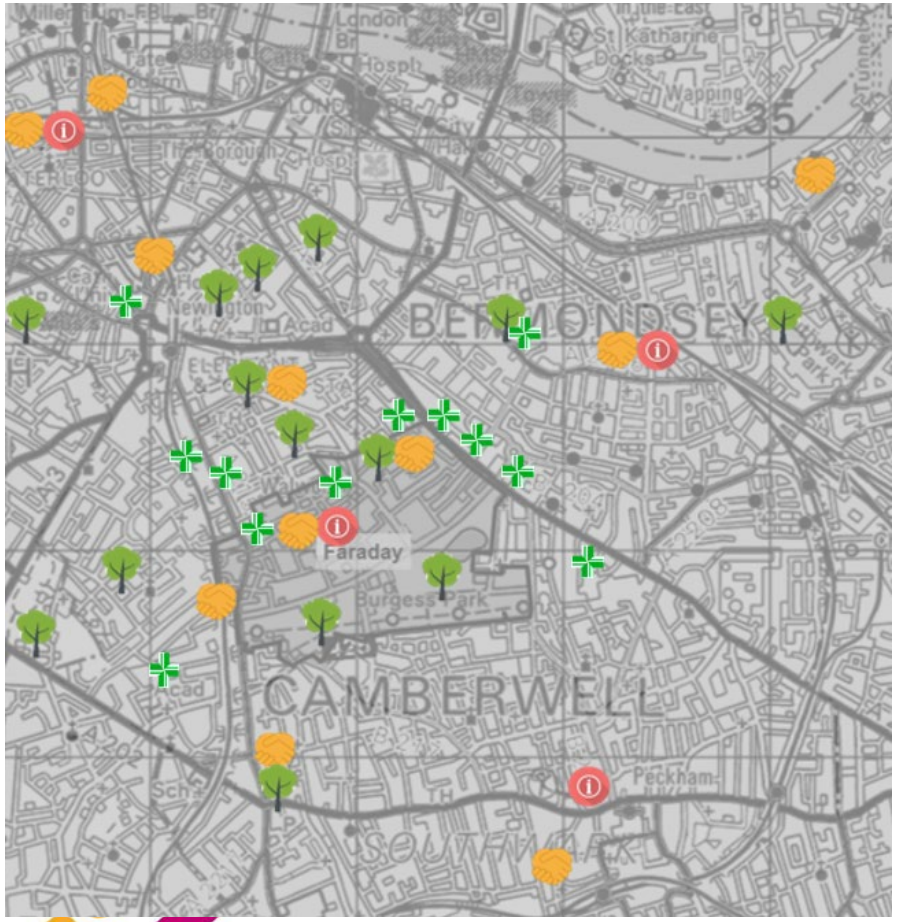
Information and Advice

- SDA Independent Living @ Southwark Resource Centre
- Southwark Pensioners Centre
- Health Living Centre, Age UK

Green Space

- Burgess Park
- Faraday Gardens
- Surrey Square Park
- Kennington Park

Asset Mapping: Wider



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- Tesco Pharmacy, Dunton Road
- Lenny Pharmacy, East Street
- A R Chemist, Old Kent Road
- Ling's Chemist Barn Twist, Old Kent Road
- St Georges Pharmacy
- Sheel Pharmacy Ltd
- Cambelle Pharmacy
- Asda pharmacy, Old Kent Road

Community Group

- Golden Oldies, Walworth Methodist Church
- Southwark Pensioners Centre
- Walworth Living Room
- St John's Centre
- Healthy Living Centre, Age UK
- Waterloo Action Centre
- Blackfriars Settlement
- Time and Talents
- Bienvenidos Latinos Adultos (Latin Age UK)
- Elimhouse Community Association Southwark

Green space

- Burgess Park
- Faraday Gardens
- Surrey Square Park
- Kennington Park
- Southwark Park
- Bermondsey Spa Gardens
- Tabard Gardens
- Newington Gardens
- Dickens Square Gardens
- Elephant Park
- Nursery Row Park
- Parsley Park
- Camberwell Green

Information and Advice

- SDA Independent Living @ Southwark Resource Centre
- Southwark Pensioners Centre
- Waterloo Action Centre
- Aging Well Southwark @ Age UK
- Citizens Advice Peckham

Key Stakeholder list

Wendy McDermott	Programme Manager, Partnership Southwark	SEL ICB
Sarah Bullman	Projects Manager, Partnership Southwark	SEL ICB
Rebecca Dallmeyer	Executive Director	Quay Health Solutions
Emily Gibbs	Southwark Borough Clinical Lead	SEL ICB
Sophie Wellings	Chief Executive	Link Age Southwark
Kathryn Simpson	Assistant Director, ASC	Southwark Council
Tania Kalsi	Consultant Geriatrician	GSTT
Brenda Donnelly	Clinical Director	Improving Health Ltd
Sadhna Murphy	Associate Director, Medicines Optimisation	SEL ICB
Amy Mauger	Social Prescribing Link Worker	Quay Health Solutions
Jar O'Brien	Operational Service Lead for Integrated Care	GSTT
Helen Baker	Senior Pharmaceutical Advisor, Medicines Optimisation	SEL ICB
Oenone Poole-Wilson	Geriatric & Internal Medicine Consultant	Kings College Hospital
Helen Gorton	Lead Frailty Practitioner & Frailty Team Lead	Kings College Hospital
Jessica Neece	Programme Lead, Joint Commissioning Team	SEL ICB & Southwark Council
Karen Crane	Service Delivery Manager, ASC	Southwark Council
Harprit Lally	South Southwark PCN Programme manager	SEL ICB
Katy Griffith	Age Friendly Borough lead	Southwark Council
Cathy Ingram	Programme Manager, Integrated Care Transformation Team	GSTT
Julian Walker	Head of Communications and Engagement, Partnership Southwark	SEL ICB
Alice Fletcher- Etherington	Public Health Policy Officer	Southwark Council
Isabel Rodrigues de Abreu	Senior Project Manager	Health Innovation Network
Rebecca Rieley	Head of Communities and Projects	HACT
Sheena Starrett	Age-friendly Coordinator (Southwark)	HACT
Julie Whitney	Consultant Practitioner Gerontology R&I Lead	Kings College Hospital

Enclosure: 4
Agenda item: 4

PLACE EXECUTIVE LEAD REPORT

This report is for discussion and noting; to update the board on key highlights on Partnership Southwark and the delegated functions.

Appointment of new Place Executive Lead/Strategic Director for Integrated Health & Care

Southwark Council and South East London ICB, on behalf of the partnership, were pleased to announce last week the appointment of Darren Summers as the new Southwark Place Executive Lead, thereby becoming a member of the ICB Board and the Council's Senior Management Team. Darren, who will be joining in early June, brings with him a wealth of experience and expertise to the leadership of the work to meet the health and care needs of the residents and communities of Southwark.

Darren's career journey reflects a profound commitment to serving others, starting from his early days in homeless services. Over the years, Darren has held several senior roles in mental health commissioning, strategic, and operational management within the NHS. Notably, as Deputy CEO and Executive Director for Partnerships in the North London Mental Health Partnership, Darren has played a pivotal role in fostering collaborative relationships with voluntary and community organisations, local authorities, and health institutions, ensuring that local people received comprehensive, high-quality care and support. The partners are particularly pleased to welcome Darren to this joint leadership role between the Council and the ICB. Darren's appointment marks a significant milestone in the ongoing efforts to work together to prioritise the needs of our communities. His dedication to collaboration and inclusivity connects strongly with our commitment to fostering a thriving and equitable Southwark for all.

The current acting arrangements will continue until Darren starts in early June.

Joint Forward Plan – 2024 refresh – Partnership Southwark section

The South East London Integrated Care Board (SEL ICB) published its first Joint Forward Plan (JFP) in July 2023, setting out a 5 year strategic plan for meeting population health needs, aligned to the priorities set out in the SEL Integrated Care Partnership strategy. It is a statutory requirement to produce the plan and to undertake an annual refresh of it, endorsed by Health and Wellbeing Boards within the ICB area.

The plan covers a wide range of planning requirements to ensure that services are being developed that make tangible progress in addressing the core purpose of our wider integrated care system:

- improving outcomes in health and healthcare,
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- the NHS support broader social and economic development

The plan covers a wide range of services including:

- South East London-wide care pathway programmes such as urgent and emergency care, planned care, primary care, mental health, cancer, children and young people.
- System-wide enabler programmes such as workforce, digital, estates, finance, sustainability, quality and medicines optimisation.
- Local Care Partnership summary plans for each borough

The Partnership Southwark section sets the five key objectives underpinning the local plan, which correspond to the Health and Wellbeing Strategy:

- 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

The plan also sets out 8 priority areas for Partnership Southwark for the term of plan which correspond closely to the Partnership Southwark Health and Care Plan:

- Strategic collaboration, with an initial focus on mental health
- The Start Well, Live Well, Age Well and Caring Well workstreams focusing on specific priorities for joint working across the partnership including 1001 days, mental health in Children and Young People, community mental health transformation, Vital 5, cancer screening and Age Well workstreams including frailty, lower limb wound care and workforce.

As part of the work underway by the ICB to refresh the plan the Southwark borough section has been fully reviewed by the management team. The refresh process did not identify the need for any significant changes from the 5 year strategy set out in the July 2023 plan. Changes to note are:

- The planning template contains one new page which sets out a summary of our key successes, challenges and learning from 2023/24.
- An increased emphasis on the need to tackle system-wide pressures arising from mental health complex care placements, including a reference to our plans to put in place shadow delegation arrangements within a framework agreed across partners, provided by South London Partnership, our local mental health provider collaborative.
- There have also been other minor updates and clarifications with regards to planned actions for 2024/25 and beyond, reflecting latest progress in the various programmes as reported to the board in January on the Partnership Southwark Health and Care Plan.

The draft Southwark section was circulated to the Partnership Southwark Delivery Executive on 23 February for review.

The full refreshed plan will be discussed at the Southwark Health and Wellbeing Board on 14th March 2024, and agreed at the SELICB Board on 23rd March 2024 before publication by 31st March.

Better Care Fund (BCF) Plan 2023 to 2025: update on 2024/25

The BCF is a pooled budget agreed between the ICB and council for the provision of integrated community based health and care services worth £54.2m in 2023/24 and £58.8m in 2024/25. It funds a wide range of core community health and social care budgets.

The plan describes the Southwark approach to delivering the twin BCF goals to:

- **Enable people to stay well, safe and independent at home for longer** (with a focus on admissions avoidance)
- **Provide the right care in the right place at the right time** (with a focus on transfers of care from hospital)

The current BCF Plan was agreed by the Health and Wellbeing Board in August 2023 and subsequently approved by NHSE. Although a 2 year plan, there is a requirement to update and refresh 2024/25 plans in line with NHSE planning requirements, with an expected focus on discharge funding, performance metrics and modelling demand and capacity for services that support discharge. Unfortunately, this planning guidance, originally scheduled for release in early January, had not been received at the time of writing this report.

BCF planning and delivery monitoring is overseen by a monthly meeting reporting to the Joint Commissioning Oversight Group. In the absence of guidance, the group has agreed to an "in principle" approach to 2024/25 which is closely in line with the existing 2 year plan. It is considered that the balance of investments and strategic approach set out in the plan is broadly correct, and subject to national guidance is unlikely to change significantly.

There has been no material slippage or under performance in the delivery of the BCF to report. However serious cost pressures relating to the BCF funded Integrated Community Equipment Service contract and associated operational issues are having to be managed, as are social care cost pressures in care home and home care placements.

Clearly intense pressures remain on the urgent and emergency care system and the BCF will continue to play a key role in addressing pressures on the acute system through admissions avoidance and discharge improvement. There will be increased focus on the impact of BCF funding on this issue.

When the planning guidance has been issued it will be necessary to complete the necessary templates and present to the Health and Wellbeing Board for agreement.

A further update will be provided to the board when the planning guidance has been issued and draft plans are in development.

Performance at Guy's and St Thomas' NHS Foundation Trust (GSTT)

As an example of the pressures affecting our local and SEL system, we asked GSTT to provide an update on their performance for this board meeting. They have provided feedback under the following categories, which are reported on by all Acute Trusts as part of their recovery plans.

Cancer Backlog: As of February, services have achieved a further reduction in the backlog and moves the Trust nearer to achieving the year end (fair share) target.

Urgent and Emergency Care (UEC): In January the Trust is ranked 12th out of 122 general hospitals for All-Type 4 Hour performance. The Trust's All-Type 4 Hour performance for January is 76.4% against an end of year commitment to achieve 76.0%.

Diagnostic Waiting Times and Activity: Diagnostic performance continues to be an area of significant risk for the Trust, validation of the PTL (waiting lists) remains challenging and weekly growth continues to be seen. Internal and partnership working is taking place in this area.

Long Waiters for elective care (operations): There is close monitoring of the current cohort of patients due to breach 78 weeks in March 2024. Further recent and upcoming industrial action is another risk to this trajectory.

We can look to develop further updates on performance from our main service providers over time if helpful to the Board.

Pharmacy First – Southwark and National Schemes

Southwark Pharmacy First Scheme (to be rebranded)
The Southwark Pharmacy First service (to be rebranded to avoid confusion with the national Pharmacy First scheme) was launched in 2015. The scheme provides free over the counter medication to patients with a minor ailment, who are registered with a Southwark GP practice and are exempt from prescription charges. These patients would otherwise have visited a GP or A&E department. The scheme aims to promote self-care through the pharmacy, improve access and choice for people with minor ailments, without the need for a prescription from their GP practice.

The scheme operates as a referral system into pharmacy services from local medical practice or other providers (e.g. 111) as well as self- referral by residents. Following the consultation, the pharmacist would offer self-care advice or may provide an over the counter (OTC) product (if appropriate) from the local pharmacy first formulary. The Medicines Optimisation Team has oversight of the pharmacy first formulary which was extended in January 2024, to include 'Over the Counter' medicines commonly used to manage winter ailments.

An analysis of data from participating pharmacies in October 2022 to September 2023 showed that the most common symptoms for which patients presented were headache, temperature, hayfever, and colds and flu-like symptoms.

Pharmacy First Scheme (National)
The national Pharmacy First scheme is a new advanced service, launched on the 31st January 2024. It includes seven new clinical pathways and will replace the Community Pharmacist Consultation Service (CPCS). The full service consists of three elements. Community Pharmacies will provide all three elements (only exception is otitis media pathway due to need to use otoscopes)

- Pharmacy First (**clinical pathways**) – new element
- Pharmacy First (**urgent repeat medicines supply**) – previously commissioned as the CPCS
- Pharmacy First (**NHS referrals for minor illness**) – previously commissioned as the CPCS

The clinical pathway allows for seven common infections (sinusitis; sore throat; infected insect bites; shingles; uncomplicated UTI in women; impetigo; acute otitis media) to be managed by community pharmacies. Patients can access the pathway directly from pharmacies or through referral from General Practice.

Community Pharmacy Consultation Service (CPCS)
There are no changes to the Community Pharmacy Consultation Service (CPCS) and General Practices will continue to refer patients with a minor illness to community pharmacies. This scheme is different to the local Pharmacy First scheme in that patients cannot self-refer to it. However, after referral by General Practice, patients not eligible for the local scheme will still be offered advice and will be asked to purchase the Over-the -Counter medicine if required.

To date, 91% of pharmacies in Southwark have registered to deliver the service.

ICB Finance Update

Southwark Place has a delegated budget of £264m for 2023/24. £164m is managed by Southwark place and NHS Contracts for Mental Health (£39m) and Physical Health (£60m) whilst delegated are managed by South East London Commissioning team on a South East London wide basis.

The table below shows the reporting position as at the end of January 24. The borough is reporting a surplus of £66k in month 10 and forecasting delivery of its control total which is a surplus of £75k for the year. This includes the release of reserves (£1.97m). Within this overall position there are underspends and overspends in budget areas.

	Year to Date Budget £'000s	Year to Date Actual £'000s	Year to Date Variance £'000s	Annual Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	461	89	372	553	107	447
Community Health Services	27,178	26,042	1,136	32,613	31,226	1,387
Mental Health Services	6,324	7,565	-1,241	7,589	9,064	-1,475
Continuing Care Services	16,406	15,655	750	19,687	18,853	834
Prescribing	26,775	29,777	-3,002	32,030	35,735	-3,705
Prescribing Reserves	335	0	335	503	0	503
Other Primary Care Services	795	750	45	955	901	54
Other Programme Services	1,362	170	1,192	1,635	205	1,430
Programme Wide Projects	250	250	0	300	260	40
Delegated Primary Care Services	53,426	53,426	0	64,113	64,113	0
Corporate Budgets	3,676	3,198	478	4,411	3,851	560
Total	136,989	136,923	66	164,389	164,313	76

Latest prescribing position is an overspend of £3. 7m. The current reported position is a deterioration from previous month. This reflects activity and cost pressures. The borough has seen an increase in costs in cardiovascular disease and management of other long-term conditions. Some of this increase is due to a quality improvement review. Prescribing position is currently very volatile and is not stable.

The position on mental health placements has deteriorated from previous month due to increased costs for adult mental health placements.

Underspend in Continuing Healthcare is due to a combination of things, including maximising the AQP provision and reflecting changes made where CHC is not eligible.

The community services underspend position includes many of the recovery actions. A key risk relates to the NRS contract (Community Equipment Service) which is reporting an overspend of £1,079k against a budget of £1.5m

Borough has efficiency target of 4.5% which amounts to £4.0m. As at month 10 borough is reporting a forecast under delivery of savings of £380k (9.28%) mainly due to the under delivery in both the Mental health and Prescribing savings plans.

The ICB is currently finalising its 2024/25 financial plan and place budgets will reflect agreed delegation arrangements, national planning guidance and local approaches. Draft high level budgets have been issued to place with final signed off budgets to be agreed by March 24. Further detail on 2024/25 delegated budgets to place will be provided once this process has concluded.

Decisions taken at Place

Mental Health Supported Accommodation Services Contact Award
Seven Mental Health Supported Accommodation Services in Southwark went out to procurement in September 2023. The contracts are commissioned by South East London ICB as NHS contracts, two of these are jointly commissioned between South East London ICB and Southwark Council. The contracts were grouped into three lots according to the profile of resident support needs. The contract duration is three years with the option to extend for an additional two years across all lots.

Seven evaluators scored each bid individually across all three lots, followed by moderation meetings to agree final scores. The top two bidding organisations for each lot were shortlisted and invited to an in-person interview. The interview panel scored each presentation/interview. The process was considered at the January Joint Commissioning and Oversight Group and agreed to align the joint contracts. The process and recommendation were then considered at the January Integrated Governance and Assurance Committee.

The Place Executive Lead approved the decision for contract award for the provision of Mental Health Supported Housing Services as follows:

- Lot 1 - medium to high support needs - was awarded to Southside Partnership (Certitude) for St James and Dunton Road services.
- Lot 2 - forensic and complex needs - was awarded to Turning Point for Milestone and Peckham Rye services.
- Lot 3 - high support through stepdown - was awarded to Southside Partnership (Certitude) for Landcroft, Kirkwood and Glengarry Roads services.

Martin Wilkinson
Acting Place Executive Lead