Appendix 1

Forward View into Action: expression of interest in the National Vanguard Programme

Q1. Who is making the application?
(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)

Solent NHS Trust are leading the bid submission with the full support and engagement of ***Southampton City Council,*** a number of additional independent ***GP practices in the city, Southampton Voluntary Services***, ***University Hospitals Southampton NHS Foundation Trust, Southern Health NHS Foundation Trust,*** and ***Southampton City CCG.***

The bid underpins Southampton's model of integrated care as set out in Southampton Better Care and described through the eyes of Joan, a fictional character developed to illustrate our ambition for integrated care in Southampton. Joan and her family represent each and every unique person in our city, needing our care. We all share a vision and aspiration to ***join up care for Joan, her children and grandchildren.***

Additional stakeholders who have encouraged the creation of an MCP in Southampton include:

- ***The Southampton City Health and Wellbeing Board.*** The chair, Dave Shields asked us to include this quote , *"As chair of Southampton's Health & Wellbeing Board I am delighted to support this Vanguard bid for a Southampton MCP as it embraces our bold ambitions for the city as set out in our Better Care Fund programme. Local Councillors - from across political groupings - are really enthusiastic about Better Care Southampton and the approach being promoted in this bid will really help to address many of our challenges."*

- ***NHS England***
- ***The Local Medical Committee*** "The LMC would be happy to support a Vanguard bid in Southampton."
- ***The Trust Development Authority*** support Solent NHS Trust leading a submission to the Vanguard Programme.
- ***Southampton Healthwatch***

The team who have developed this bid consist of a number of influential clinicians and professionals in the city including but not limited to:

- Dr Cliff Howells, GP and Clinical Director of Solent NHS Trust Primary Care service line.

- Dr David Paynton, GP and National Clinical Lead for the RCGP's Centre for Commissioning.
- Dr Hayden Kirk, Consultant Physiotherapist and Clinical Director of Solent NHS Trust Adults Services Southampton service line.
- Alex Whitfield, Chief Operating Officer, Solent NHS Trust
- Alison Elliott, Director of People, Southampton City Council
- Jo Ash, Chief Executive of Southampton Voluntary Services
- Dr Steve Townsend, GP and Clinical Chair, Southampton City CCG
- John Richards, Chief Officer, Southampton City CCG
- And many other partners.

The single senior person best able to field queries about the application is Sue Harriman, Chief Executive of Solent NHS Trust.

Q2. What are you trying to do?
(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)

Joining it up for Joan, her children and grandchildren.

Our overriding vision is to join up care for each and every unique person in our city needing our care, as represented by Joan, her children and her grandchildren

One team will meet the ***community health and social care needs*** of people living in ***geographically defined communities*** within the city of Southampton.

The MCP will deliver cradle to grave, integrated community health and social care to ***all 250,000 people in Southampton city***, managed in clusters centred around GP practices, accelerating and expanding on the vision of Southampton Better Care.

The challenge is to develop systems of care, which ***improve the health, and wellbeing of a population*** and are sensitive to clinical and social demand rather than supply led. To achieve this we will create a governance framework, which ***incentivises innovation and integration of community services*** and supports the local population to optimise ***their health and well being***.

For Joan, her children and grandchildren the MCP will be a ***single team who provide all their integrated community health and social care needs.***

For children, we will provide health visiting, public health nursing, CAMHS services, community paediatrics, community nursing, children's social care services, children's centres and Early Help, and our innovative children's admission avoidance service (COAST); all through integrated teams.

For adults, the MCP will be the single team to provide community nursing, adult social care, community rehabilitation inpatient facilities, reablement, rapid response services to prevent unnecessary hospital admissions and rapid discharge services to support people to return home quickly from an acute episode. Adult and older people's mental health expertise will be within the community networks integrated with physical health teams, social care teams and voluntary services. ***The MCP will include community geriatricians, psychiatrists and rehabilitation consultants***.

For citizens of any age, the MCP will provide primary care services, long term condition management and public health promotion through GPs, specialist sexual health teams, health promotion teams and public health nursing teams. ***There will be a focus on prevention, early intervention and creative solutions.***

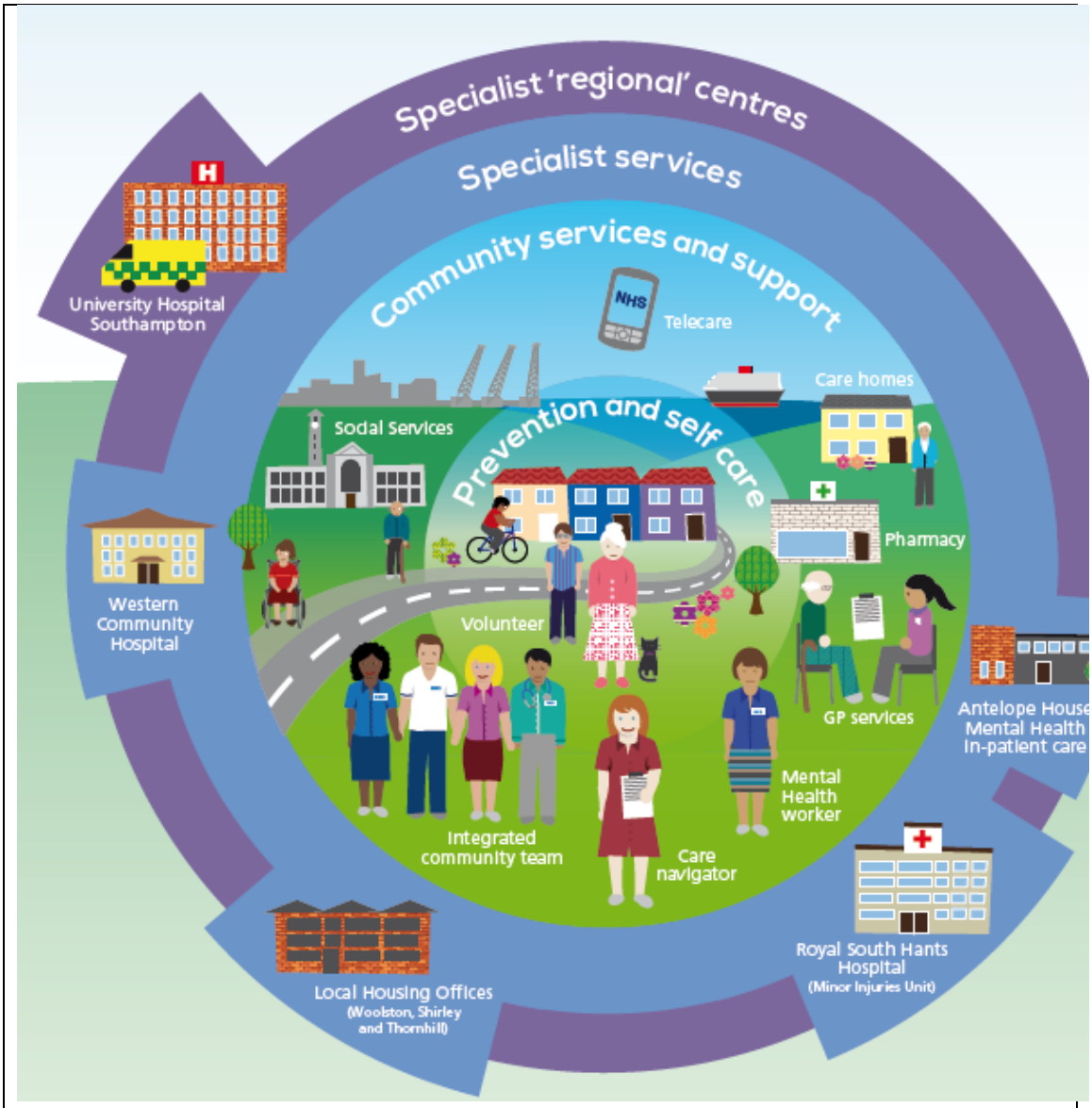
The vision is that there are ***no gaps*** between services or organisations, and ***no duplication*** for services or for individuals. Individuals are ***risk stratified*** using appropriate tools which will include ***ACG and frailty index tools as well as risk based assessments of children and families at risk.*** These are then clinically validated and personalised care plans developed, based on need. There will be a ***single shared care plan*** for an individual rather than numerous plans held by different agencies.

A key objective is to be able to improve the care that the public sector is able to provide, despite the ever increasing pressures on public sector finances. We will meet the needs of the city population ***making the best use of the city pound.***

For staff, their predominant team will be their ***geographical local team*** who they work with to care for their local population. They will continue to receive professional support and expertise through a matrix structure, but they will work for a locality.

For some specialist services, such as epilepsy specialist nursing or specialist neuro rehab therapists – the resource will be managed on a city wide basis with named contacts or sessions in each locality.

For the city there will be sufficient resource to support ***capacity building such that voluntary organisations*** can help to deliver integrated services through a range of community development models. We will also harness the role and contribution of ***individual volunteers*** including linking them to the geographical clusters.



Q3. Which model(s) are you pursuing? *(of the four described)*

Southampton city is pursing the ***Multi-Speciality Community Provider (MCP)*** model.

The Five Year Forward View and the Dalton Review both describe a visionary plan for transforming the provision of integrated care. All the partners in Southampton city see this as a way of strengthening integrated community care, accelerating Better Care Southampton and ensuring sustainability of primary and community providers to ***continue to support the out of hospital models and choice for patients and citizens***. Solent NHS Trust was one of the first community and mental health trusts to receive a new style CQC inspection, having been supported by the TDA to move to FT status. The CQC commended the trust for the high quality, compassionate care provided and the trust was supported to continue on the FT journey. However, the vision of an MCP has encouraged the trust to explore other organisational forms, including a social enterprise model, embedded in the community. Supporting the vanguard bid for Southampton city would enable national bodies to explore alternative options for trusts which are delayed within the FT

pipeline.

Solent NHS Trust is unusual in that it ***directly provides primary care***. The current list size is 14,000, spread across the West, Central and East areas of the city. One of the practices provides care for the homeless population in the city through the Homeless Healthcare Practice. There are plans in progress to directly support GMS practices in the city which will increase this to 30,000 in 2015 and likely to be ***over 50,000 by April 2016***. This growth will come by partnering and supporting practices to stay sustainable through an innovative sub contracting commercial model.

The Trust also provides ***community care, community inpatient wards, consultant paediatricians and geriatricians, CAMHS services and public health services***. Combining this with ***additional primary care practices working in partnership***, with ***social care and with adult and older people's mental health*** services, as well as ***voluntary and community organisations*** will allow the creation of a strong and innovative MCP for the city.

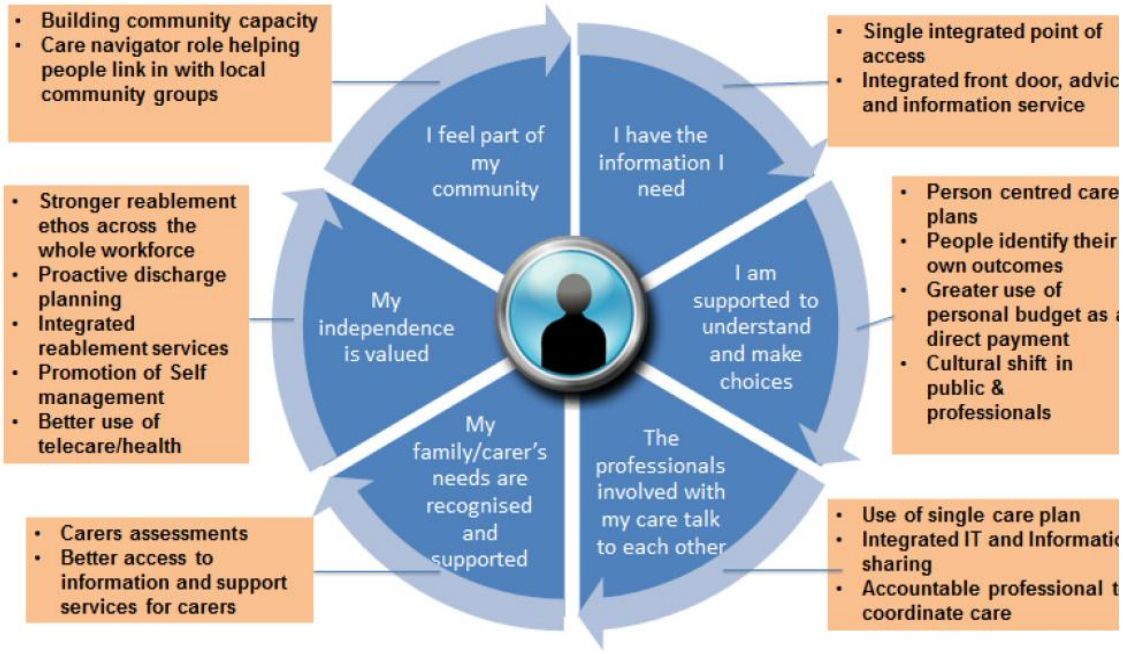
Southern Health NHS FT provides ***adult and older people's mental health*** services in the city and is fully signed up to bringing these into the MCP through partnership models. University Hospitals Southampton, who provide secondary and tertiary acute care in the city will support the MCP through the ongoing development of ***joined up pathways for long term conditions***. Southampton city council brings ***social care, housing*** and young people's ***education and training services*** into the MCP model.

Southampton has a diverse population both in terms of age, ethnicity and wealth. It is a multicultural city which is small enough to be able to run city wide services and diverse enough to benefit from locality specific teams. It has the huge benefit of being ***a unitary authority with a co-terminus local authority, CCG and community healthcare provider. Southampton Voluntary Services*** is a well-established co-ordinator of voluntary and community organisations. The city has its challenges with higher levels of worklessness, teenage pregnancy, mental health issues, domestic violence and isolation, than many of its statistical neighbours. The Health and Well Being Board are entirely supportive of an integrated health, social and community model in the city, as evidenced by the very ambitious Better Care Programme. ***It is an ideal city to trial the Multi-Speciality Community Provider model.***

Q4. Where have you got to?
(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

Southampton city has already committed £62m to Better Care Southampton and has a stated aim to put ***over £130m of health and social care spend*** into a pooled fund be managed on behalf of the Council and CCG by the integrated commissioning unit. This puts the city into one of the ***top 10***

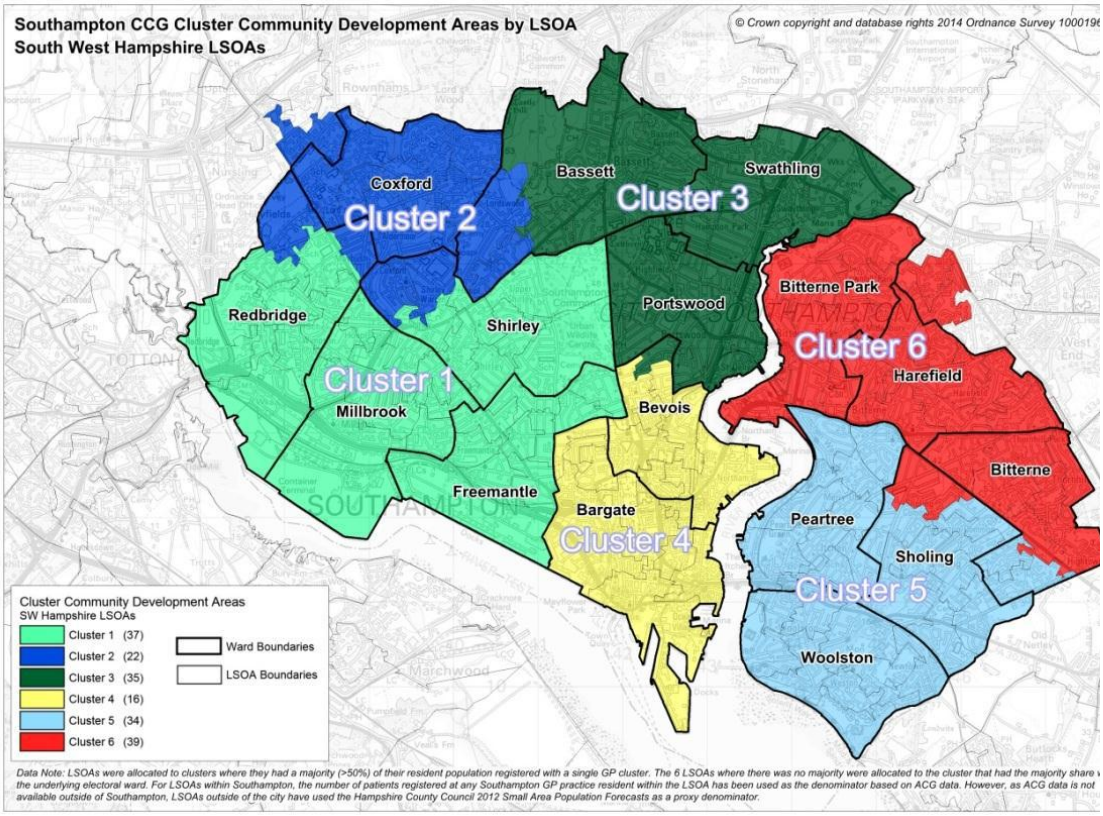
communities in the country and is significantly beyond the minimum required. The integrated commissioning unit was established in 2014 and is already commissioning pathways across health and social care. Southampton has been recognised nationally as having one of the most ambitious Better Care plans which has been created from a well-developed consensus in the city to deliver integrated health and social care services on a locality basis. This is the central plank of the CCG's 5 year plan.



The Better Care Southampton vision has three main aims which will be accelerated and broadened, through this programme.

i) cluster based teams, embedded in communities, of integrated primary, community, social and mental health care;

The clusters have been identified and widely consulted on. The map below shows the Southampton city clusters for Better Care Southampton. ***The team development activities*** have started within these clusters and ***governance processes are being established.*** The clusters, as shown, will be the smallest geographical entity with a dedicated team. For some services, care will be managed across two clusters, in larger localities, and for other, more specialist services, care will be managed across the city as a whole. By building up from a smaller cluster, services will be able to wrap around Joan, her children and grandchildren, while not losing the benefit of scale on a city wide basis, where that is beneficial.



ii) ***integrated discharge, rehab and reablement***

This brings together health and social care community and inpatient rehab and reablement alongside rapid response and crisis services. The implementation has started and will be further accelerated if we are successful in achieving vanguard status.

iii) building community capacity

Pilots are underway to demonstrate the effectiveness of ***community navigators*** and ***building community capital and resilience.*** All of our services recognise the importance of enabling and supporting the community to deliver services with us.

Primary Care: Solent NHS Trust are in a unique position of already directly running four APMS GP practices in the city, and providing highly skilled staff into two other practices. We provide ***8-8, 7 day a week*** services involving multi-disciplinary teams where advanced nurse practitioners and mental health nurses support GPs and practice nurses. We are also in the advanced stages of delivering ***an innovative model to ensure the sustainability of a large GMS practice*** by using the NHS trust to underpin and support the primary care services. This has the support of NHS England and the Local Medical Committee who see it as a way of delivering sustainable primary care in the future. We have won NHSE Innovation funding to deliver a new service delivery model for all our patients, and separately for ***GP and practice nurse workforce development***. Our vision is to further develop this existing primary care provision by using this model to support other practices and by working in partnership with independent partnerships. As the MCP develops a variety

of primary care models will be included, from direct provision, through integrated support and networked partnership working. This will be supported by the CCG who are moving to ***co-commissioning of primary care in April 2015*** and full delegation by April 2016. The Solent primary care practices are already moving to the concept of ***Care Planning embedded in your practice***, as described through the RCGP's Rose's story

Community Healthcare and Social Services: These teams have worked closely together for a number of years and have recently explored the Plymouth model of community healthcare. As part of the BCF, ***the crisis response, rehabilitation and reablement teams within Solent NHS Trust and Southampton City Council are in the process of fully integrating*** under a single management team. Southampton City Council and the CCG have just been through a procurement process to transform the ***domiciliary care market in the city*** which will ensure sustainable domiciliary care providers are ***commissioned on a cluster basis*** and able to support the implementation of the MCP. Solent community nursing and rehabilitation teams are already organised around the geographical localities. A number of integrated models are already delivered between Solent NHS Trust and Southampton City Council for children's services including children with special educational needs and disabilities and children aged under 5 years, through children's centres.

Voluntary and Community Services. Southampton Voluntary Services is an umbrella organisation for nearly 500 voluntary and community organisations across the city. They are a well established part of ***integrated care programmes in the city***. The voluntary sector have a long history of success in community projects including the Thornhill Plus You Project, West Itchen Trust and Age Concern providing care navigation in GP practices. The ***city faith groups*** also provide support for individuals and communities and are involved in locality teams. A number of pathways deliver integrated care, provided by local and national voluntary organisations, and current sub-contracting of voluntary sector providers. There is scope to extend this through ***innovative contracting relationships and procurement strategies for the voluntary sector*** as part of the wider system development.

Mental Health Services: Solent NHS Trust provides CAMHS services in the city and has plans to bring these into more integrated and holistic children's services. Southern NHS Foundation Trust provides ***adult and older people's mental health*** services and is fully supported of bringing them into a city MCP in order to better integrate care around people. Solent and Southern have already started a project to bring older people's mental health services into ***jointly managed teams on a locality basis*** in the city using shared buildings.

Children's Services: Southampton will be one of the first systems to integrate the MARAC and MASH to more quickly identify children and families at risk of domestic abuse or safeguarding concerns. This is an example of integration of services for the benefit of families, and closer joint working with statutory partners like the police.

A single IT system. Solent has procured TPP Systm1 as the new clinical record system for all the community health services in the city. This is the same system that a large number of primary care practices in the city use. A significant number of other practices use EMIS which can interface with TPP Systm1. This IT platform will create ***a single care record*** across a significant number of primary care practices and all of community health care by October 2015. This will enable each patient to have a single care plan. In addition, ***the Hampshire Health record (HHR) provides a single record*** for patients across the acute hospital, primary, community, mental health and social care. The HHR is well established and is being expanded to include even more information. The information governance challenges surrounding shared data have been resolved within the city. The IT innovations also includes ongoing investment in ***telemedicine and telecare,*** and the joining up of health and social care maximises the benefit of recent investment in a city council ***single point of access*** to support telecare systems.

Urgent Care System and interface with the acute hospital. Southampton City has a well-established process for investing in support for urgent care. The community teams provide ***hospital in-reach teams*** who work in the acute hospital pulling patients out. Solent provides a ***Community Emergency Department Team*** (CEDT) who turn patients round at the front door. The acute and community geriatricians have established a collaborative locality working model which ensures that the acute geriatric beds mirror their community localities. This ensures that an individual geriatrician always looks after patients from the same city locality and as a result has developed very strong relationships with the patients, GPs and community health and social care teams in that locality. The experience from this model of cross organisational locality working will look to be replicated with further community and secondary care specialities across the MCP.

Long term condition pathways exist across the acute / community sector including for diabetic care, respiratory and COPD conditions and paediatrics.

Carers are a crucial part of the plans for integrated community based care in the city. The city council, voluntary sector and healthcare providers have committed plans to improve the support available for carers across the city. We also recognise that not all carers are living locally but some provide care at a distance and need different support mechanisms. ***Young carers are a particular area of focus*** and Southampton Voluntary Services have well established support services for this vulnerable group.

Workforce Development. Solent have been working with ***Health Education Wessex*** to plan for the workforce of the future. We know that we will need more staff capable of working in a multi-speciality way, working across the boundaries of traditional professional groups and comfortable with providing community based care as an alternative to acute hospital admissions. These staff will need to be less task based and more client focused, more proactive and less reactive and happy trusting assessments from their colleagues. This will need ***a shift in training programmes*** for clinicians where more time is spent in community settings than has historically been the case. Solent GP

practices are also developing models of ***career development for GPs***. This includes supporting GPSi's with specialisms in geriatrics and paediatrics as well as mental health and long term conditions. The MCP will give a strong foundation for these development opportunities. ***The integrated locality teams will provide training and development opportunities for the workforce of the future.***

Q5. Where do you think you could get to by April 2016?
(Please describe the changes, realistically, that could be achieved by then.)

A Southampton Task Force will programme manage the implementation of the MCP through 2015 and 2016. This will be governed by the ***Southampton City Accountable Officers*** who have a well-established relationship and meet regularly. An MCP Board will be established during 2015/16 with representation from the various providers involved and this will, in effect, be a shadow board for a full MCP launch in 2016/17. ***Established co-production groups*** will help validate and inform the implementation with representation from patients, community groups, employees and the voluntary sector. There is a group called the ***Can Do group*** which is the existing implementation forum for Better Care Southampton and this will be a key programme management group for the MCP.

By April 2016, our ambition is to have ***one team working in each identified community***. In every locality in the city, this team will include community health and social care teams for children and adults wrapped around clusters of GP practices. The teams will also include voluntary sector organisations and mental health services. Other local authority functions such as housing, homelessness, employment and training services may also be operating as part of the cluster teams or with strong links into those teams. Members of these teams will be ***co-located within their locality*** where possible and working to a ***single locality leader***. We will run a single induction process for staff in these teams and will have locality leadership in place in each cluster with all staff having either a full employment contract into the locality team, or else an honorary contract to the team. We will have in place a Capability Maturity Model to evaluate the maturity of each cluster team. This is ambitious and challenging but with support from the vanguard programme we are confident we could be achieving most of this by April 2016.

The locality teams will be using all the community resources available to deliver great joined up care to Joan, her children and grandchildren. This could include the postmen and refuse men alerting the local team if they are concerned about a resident; the domiciliary care worker who visits Joan referring to the mental health nurses if Joan's dementia seems to be deteriorating; the housing officer contacting the local church if a young mum seems to be struggling. ***It is about an interconnected network of statutory and community organisations working together to support great outcomes all underpinned by a strong multi-speciality community provider.***

Primary Care in the city will be on a more sustainable basis with more practices supported to work 8-8, 7 days a week with ***innovative workforce models***, using pharmacists, advanced nurse practitioners and mental health

nurses as part of the practice teams.

Care planning will be in place for everyone with one or more long term condition and these plans will empower individuals and promote health and wellbeing and support self-management. ***One care plan for one person.***

For patients with long term conditions, we will build on the existing strong community / acute relationships and put in place additional pathways, for example for chest pain and IV management. These will provide seamless care for patients with long term conditions. Ideas like a mobile medic will be piloted. Acute clinicians will come out of the hospital more often to deliver care in community settings, and community teams will continue their presence in the acute hospital ensuring that people are turned round quickly at the front door when they can be, and discharged home as soon as they are medically ready for discharge. ***The MCP will give us the right clinical and financial governance structures to deliver care in a different way***

A City Charter will be in place, which provides a framework for how the clusters operate and defines the core principles /strategy that each cluster must adopt. This will ensure that local autonomy is complemented by city wide consistency where that is beneficial.

The engagement process over 2015/16 allows ***organisational involvement to grow over time*** and allows any general practices not involved in April 2015, for example, to join over individually appropriately timescales. Organisational form change will follow the functional changes as appropriate.

Work will focus in each community on three key pathways.

- Urgent care
- Routine care
- Proactive care

Current model based on organisational provider

Future model based on key pathways

Urgent

Primary Care

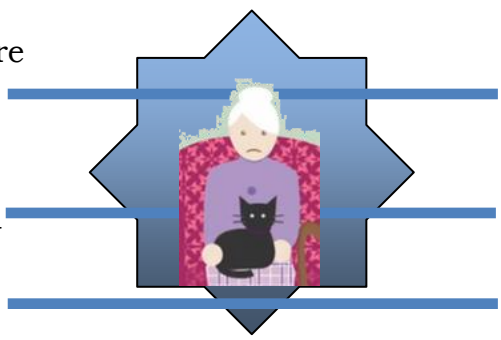
Social Care

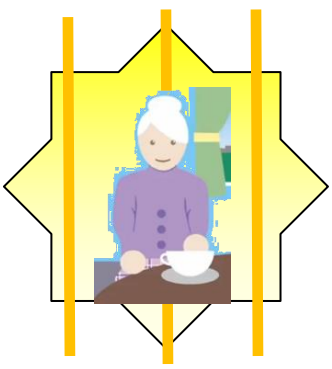
Community Health care

Community &

Proactive

Routine





Voluntary sector

By April 2016 we will expect to be in a position to ***operate to a capitated contract for 16/17*** whereby commissioners provide capitated funding using Person Based Resource Allocation (PBRA) or similar methodology and the MCP directly provides, sub contracts or partners with, other community based health and social care within Southampton. We would hope to shadow run some elements of capitated contracts in 15/16.

Personal budgets and direct commissioning of personal care packages for children and adults will have progressed significantly. Community capital will have increased so that local communities provide some of the personally commissioned support through voluntary and community organisations.

Information and data will be integrated between some of the partners by April 2016 so that data can drive predictive action planning to better prepare for operational and strategic challenges. Analysis of what works best will be simpler because of the shared data systems. ***Full integration of data and optimal use of Hampshire Health Record*** will continue into 2016/17.

Estates will be an enabler of integrated locality based care. The city has the usual mix of poor quality, old estate and newer, excellent quality estate. The MCP will support primary care practices with their estates challenges and create health hubs around practices, or in existing community assets.

Carers will be better supported. There will be a strong focus on recognising carers and their needs in their own right when delivering integrated health and social care to people. The MCP will support those with caring responsibilities to remain mentally and physically well by developing systems to identify carers earlier and signpost to local support services. Young carers and carers who are not local to their loved one will also be supported by the locality teams. Carers will be valued as important members of the community teams.

Metrics. By April 2016 we will be seeing real traction on key metrics which demonstrate improving patient centred care. These metrics will include the Southampton Better Care metrics: ***reducing non-elective admissions, reducing delayed transfers of care, reducing permanent admissions to care homes and reducing injuries due to falls.*** In addition there will be metrics supporting improved care for children, working age adults and families.

By 2016 all service specifications for services commissioned by the city council or the CCG will reflect the cluster model and ***every commissioning contract will be based around clusters.***

By April 2016, Southampton city will have a growing reputation for ***high quality, cost effective, seamlessly integrated health and social care*** – where Joan, her children and grandchildren do not have to repeat themselves, where they are empowered to live healthy and happy lives and the public and

community sector supports them to fulfil their potential whether they are 9 or 99.

As we move into 2016/17 and beyond, the ambition is for that the strong, effective, well governed MCP will be able to include more of the outpatient activity from the acute hospital, by working with acute colleagues to join up acute pathways with community teams. This might lead to a development into a PACS model over time. The range of services could also expand to include police, fire, education, local community pharmacies, employment and training services – all linked to the clusters.

Q6. What do you want from a structured national programme?

(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Southampton city is committed to implementation of an MCP and being part of a structured national programme will enable the implementation to happen faster by being ***part of a learning community***, where we can share ideas and solutions with others who are pursuing the same ambition. We are particularly interested in robust ***evaluation methods and models*** so that the outcomes of this programme can be rigorously measured. We want to develop a rigorous methodology which enables us to monitor our own progress and measure success so we know when we have made a real difference to care for Joan, her children and grandchildren.

Support to allow the innovations demonstrated in Southampton to be ***shared more widely through the UK*** and for Southampton to learn from other systems.

Support for the ***commercial models for capitated contracts*** and the data analysis required for successful management of these contracts.

Solent are already well progressed in implementing an innovative model ***to support a large GMS GP practice*** to be sustainable and support for the ***legal and commercial frameworks*** for this model would be useful. We would also appreciate facilitation support for bringing the remaining GP practices into the model. CCG co-commissioning will enable the CCG to design contracts aligned to the strategy but there are a handful of practices where there will still be work to do in getting hearts and minds entirely behind the vision.

A key requirement of a successful MCP will be the efficient use of estates in the community. Southampton MCP would appreciate support in implementing ***the estates strategy including for primary care premises*** especially in terms of developing cost effective financing options, to fully meet the health and wellbeing needs of the city.

IT development is well underway in the city with the Hampshire Health Record well established and TPP Systm1 used by a number of primary and community services. However, there is still much that could be done, and

national support in developing fully integrated care records across health and social care would go a long way to increasing integration of services.

The Southampton city model is brought in partnership with Southampton Voluntary Services and a structured national programme enables ***national charities to formulate an approach for integrating with models*** like this which could be replicated elsewhere.

Work has already started with Health Education Wessex on the workforce changes needed to support this model, but ***help on workforce design and development***, learning from innovative programmes elsewhere in the country, would enable the MCP to move faster.

National support will allow greater investment in management support to enhance and complement the existing system wide team enabling Southampton city to reach our goals more quickly – delivering ***truly joined up care for Joan by April 2016***.

Please send the completed form to the New Care Models Team (england.fiveyearview@nhs.net) by **9 February 2015**.