NHS Lewisham Clinical Commissioning Group

Lewisham

ANNEX 1

Programme Initiation Document

Integrated Adult Care

Programme

Location	Lewisham
Programme:	Integrated adult care programme
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PID Version Number: 1	Date: 19 November 2013

Contents

1. Programme Summary & Background

In May 2013, the Government announced its ambition to make joined up and co-ordinated health and social care the norm by 2018.

In response to the Government's stated direction of travel, and in the context of rising demands and budgetary pressures across sectors, Lewisham's Health and Wellbeing Board has recognised that the pace and scale of integration across health and social care has to increase in order to improve the user experience and outcomes for all adults, to maximise the use of resources (reducing duplication and streamlining processes) and to achieve the significant savings that are required across the partnership.

This programme builds on the work undertaken to date. Health and social care partners in Lewisham have already taken steps to integrate services in a number of areas:

a) bringing district nurses into the Advice and Information Team (the first point of contact for most callers enquiring about health and social care support);

b) integrating the Council's reablement and Lewisham Healthcare Trust's intermediate care team to create a single enablement service to support people to maintain or regain their health and independence. This service is designed to help people avoid unnecessary hospital admissions or readmissions and reduce the need for costly high level health and care services. It is particularly focused at present on people who are new to social care and those being discharged from hospital;

c) bringing together a number of different disciplines into a single team working within the four GP neighbourhood clusters. These teams have undertaken a risk stratification of the GP's adult population to identify those who would benefit from early intervention work. The teams also include a community development worker who will link users to networks and opportunities within their local areas to support and improve their health and wellbeing.

This programme will add value by bringing together:

- various strands of activity that are underway or that are planned;
- data, research and information;
- knowledge of good practice and innovation;
- knowledge of common barriers to integration;
- common enablers that support the delivery of coherent integrated services
- monitoring of outcomes e.g. on quality and patient experience
- evaluation;
- financial information, modelling and monitoring.

This Programme Initiation Document sets out the high level aims and deliverables for the programme. It also outlines the proposed workstreams that will be established to undertake more detailed work on, amongst other things, identifying the existing use of resources and where future efficiencies can be made, establishing and monitoring success measures and developing the required enablers. More detail on the proposed workstreams is set out at section 4.

Although this programme's focus is on the integration of adult services, it will align with the ongoing integration of children's health, care and other services as set out in Lewisham's Children and Young People's Plan.

2. Programme Definition

Programme Objectives

The primary aims of this programme are to improve health and care and reduce health inequalities by increasing self help and independence, creating a culture of self responsibility, prevention and early intervention and providing affordable high quality advice, care and support close to, or in, people's own homes.

The specific desired outcomes for the programme are:

A positive experience within a health and wellbeing context for all adults in Lewisham – by enabling people to be connected to their communities and through the promotion of self help, to be in control of their health and wellbeing.

Better health and wellbeing outcomes and reduced health inequalities – seeing significant improvements in the outcomes as set out in national frameworks for public health, CCG and ASC.

High quality and safe services provided to Lewisham residents – provided by a professional and flexible workforce, robust joint contract monitoring and improved recording and sharing of information.

Sustainable, high quality and cost effective health and care systems - by reducing and shifting demand for complex health and care services to existing and new preventative and early intervention opportunities, by innovative commissioning which can respond flexibility to meet people's individual requirements and circumstances.

The delivery of financial efficiencies to enable partners to reflect reducing resource allocations.

The provision of 7 day services; better data sharing and joint approaches to case management as set out by the national conditions for the Integration Transformation Fund.

To develop success measures for the programme we will establish baseline data which will include:

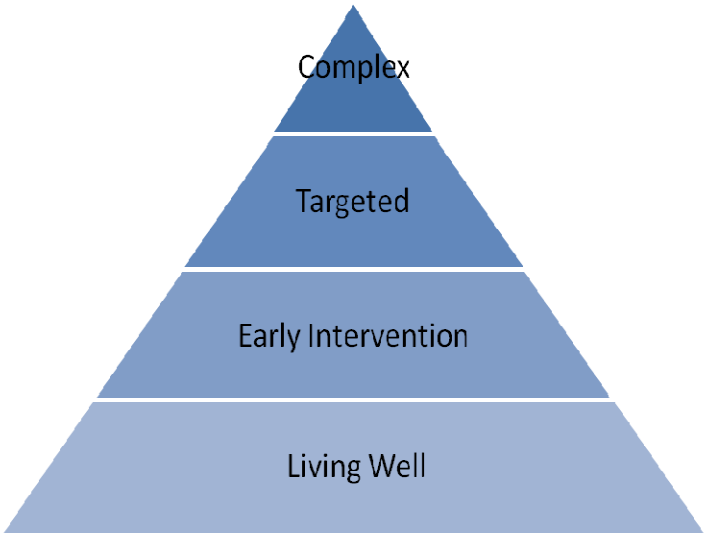
Impact indicators: non elective admissions, urgent care attendance, length of stay in acute and MH hospitals, readmission rates, entries into residential/nursing care, number and packages of domiciliary care, personal budgets, direct payments.

Operational metrics:, number of assessments and reviews, reablement cases.

Financial metrics: total system cost, unit cost, cost per user, benchmarking.

Programme Deliverables

The programme has identified a triangle of need shown below:



Across the four levels , the programme will deliver:

Living Well – active and engaged communities (Level 1)

- Easy and clear access to high quality, personalised information
- Clear communication using consistent messages and integrated campaigns raise awareness and encourage people to take action themselves
- Activities and opportunities available locally to promote and support health and well being
- Effective advice and support (including advice on benefits entitlement) to promote living well
- Stronger community networks working effectively to support people to live well and stay healthy

Early Intervention – Level 2

- Professionals and voluntary sector workers have knowledge and confidence to empower and signpost effectively
- Shared tool for risk stratification to identify those most at risk
- Systems and processes in place to enable safe sharing of information on individuals - individuals tell their story only once
- Rapid delivery and installation of equipment, housing adaptations and other assistive technology
- Proactive and consistent management of health and wellbeing by professionals and voluntary sector workers
- Effective self management of long term conditions
- Strong community networks working effectively to identify and support individuals and carers that require additional help.

Recovery and Regaining Independence – Levels 2 & 3

- Co-ordinated services that are able to respond quickly to unexpected deterioration and other health or care emergencies or crises
- Rapid delivery and installation of equipment, technology and housing adaptions
- Effective support within appropriate settings to enable people to recover
- Effective links to community and neighbourhood support e.g. social network to maintain recovery and independence
- Ongoing effective support to maintain independence
- Professionals provide support to individuals and carers to enable them to exercise

choice and control in relation to their health and wellbeing.

Positive Experience of More Complex Care and Support – Levels 3 & 4

- A co-produced and jointly agreed single assessment
- A jointly produced, agreed and fully implemented care plan
- A single co-produced health and social care record
- Key pathways are coordinated across health and social care e.g. dementia, falls
- Single reviews undertaken by trusted reviewer on behalf of health and social care whenever possible
- Effective allocation of statutory resources to meet needs.

Programme Scope

The programme is ambitious and builds on earlier integration work, increasing the scale and pace.

It is a **population-based approach**, covering all adults in Lewisham. It includes the frail and vulnerable, older people, people with long term conditions and /or mental health problems, people with learning disabilities, carers, as well as the wider adult community. It does not include the under 18 population of Lewisham.

It is a **whole system approach** covering most services and activities across the health and care sector, including public health. It will embrace opportunities and flexibility that can be delivered through the voluntary, community and private sectors. It will be aligned with universal services such as Supporting People, housing, employment, adult education, culture and leisure.

A range of services such as housing fall outside of the scope of the integrated care programme. These services will form critical interdependences to the programme It is a strategic programme that seeks a step change in the way services are delivered, in patient and service user experience and in performance and outcomes.

Programme Constraints

(a) Legislative Changes

The Care Bill requires the promotion of integration of care and support with local authorities, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. The Bill introduces a number of statutory requirements in relation to the provision of health and care. The timetable is attached at Appendix A.

(b) Commissioning

The constraints are those which apply nationally and limit the flexibility in relation to local commissioning arrangements. Ideally the programme would seek to move away from the national payment by results tariff and towards local risk sharing and incentive agreements so enabling more effective joint management of integration at the local level.

(c) Financial

Development and implemention of detailed proposals will need to be completed within existing resources; these are reducing overall. Further, the complexity of disaggregating budgets to establish pooled budgets may constrain the speed and scale of the integration programme. Estimates of the financial benefits of integration are constrained by the limited nature of the current evidence base.

(d) Accommodation

The co-location of services will inevitably be constrained by the limitations of the existing building stock.

Programme Assumptions

1. Operational Assumptions

The early development of Lewisham's integrated adult care programme has been informed by the evidence and learning from international, national and local research and evaluations including:

The King's Fund Reports:
•'Transforming our Health Care System' highlights ten priorities for CCG commissioners to transform health care (2013)
•Exploring the system wide costs of falls in older people in Torbay (August 2013)
•Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust - Integrated care for patients and populations: Improving outcomes by working together (2012)
•Where next for the NHS reforms – The case for Integrated care (2011)
•Integrated Care – What is it? Does it Work ? What does it mean for the NHS ?(2011)
•Integrating Health and Social care in Torbay (March 2011)
•Avoiding hospital Admissions: What does the research evidence say? (December 2010)

Nuffield Trust
•Commissioning Integrated Care in a Liberated NHS (September 2011)
•Evaluation of the first year of the Inner North West London Integrated Care Pilot (May 2013)

McKinsey & Company
•Understanding patient's needs and risk – a key to a better NHS (June 2013)
•What it takes to make integrated care work (May 2013)
•Local modelling of the Lewisham health and social care system

The overall conclusion of the current available evidence is that there is no single 'best practice' model of integrated care. What matters most is that the delivery model is focused on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations.

The research has highlighted, however, that there are organisational barriers to successful integration. Lewisham's approach to integrated delivery attempts to address proactively the most frequently cited barriers by having:

- Clear joint governance arrangements and sufficient project management support – the PID sets out the proposed governance arrangements and the role of the Health and Wellbeing Board;
- Involvement of front line staff - a 'bottom-up' approach – the PID describes how the project's proposals are already well grounded in the current and future operational work with provider organisations at a neighbourhood level;
- Engagement of the local communities - the health and social care Joint Public Engagement Group, which includes representation from the voluntary sector, will oversee this work.
- Development of the workforce - it is recognised in the PID that both the provider and commissioning workforce need to develop a common language and culture change which promotes a person centred approach and enables independence, choice and self

help;
- Effective way of sharing information across agencies to implement shared approach to risk stratification, care planning and a single care record;
- Robust commissioning supported by a clear contractual framework which aligns incentives to sustaining and supporting the integrated approach.

2. Financial Assumptions

Reviews by The King's Fund and the Nuffield Trust conclude that significant benefits can arise from the integration of health and social care services where these are targeted at those client groups for whom care is currently poorly co-ordinated. High level modelling of the current costs of Lewisham's health and social care systems information indicates potential net savings of between £7.5millon and £15 million which could be achieved as a result of applying the evidence from best practice in Integrated care, assuming a re-investment of 10% of savings (McKinsey & Company - May 2013).

Also local evaluation of the North Lewisham Health Improvement Programme demonstrated that by raising awareness and changing behaviour about smoking, healthy eating and exercise in a community had 'a return of investment of a ratio of 1.8:1 to 3.0:1'.

Research has indicated also that there are wider financial benefits of investing in specialist housing for vulnerable and older people. The research by Frontier Economic (September 2010) examined the annual benefit from the provision of specialist housing to the different sectors and estimated that for an older person the savings in health were about £1,500 per person and a similar level of savings for social care. This would indicate a further saving of about £5 million per annum with the effective provision of specialist housing vulnerable and older people (assuming a frail older population of 1500 people in Lewisham).

As part of the resource workstream, officers will consider what resources will be necessary to undertake more detailed financial modelling to assess the potential total financial efficiencies overall, by different organisation, the time frame and the level of investment required.

Programme Interfaces

A number of areas, organisations and strategies will need to align with the work of the integration programme. These include:

- NHS England – primary care commisoning including GPs, pharmacies and opticians
- Housing –to ensure that the Integration Care Programme is underpinned by an effective housing strategy, particularly in relation to specialist housing for vulnerable and older people. The programme will align with Supporting People to ensure the best use of housing related support resources
- Pathways redesign and implementation - such as GP referral pathways.
- Healthwatch/public engagement – to engage fully with individuals and local communities on all aspects of the programme.
- Community and Cultural Development – to contribute to the development of flexible opportunities, activities and support which gives people choice and control in maintaining/regaining their health and wellbeing.
- Other key groups e.g. Urgent Care Board which includes the LAS and NHS 111.

Each project board will identify the specific interfaces that are required to ensure achievement of the deliverables assigned to that workstream..

3. Business Case

There is a strong driver for integration nationally. In May 2013, the Government and other key national players launched 'Integrated Care and Support: our shared commitment'. This document stated that major change was needed by "…building a system of integrated care for every person in England. It means care and support built around the needs of the individual, their carers and family and that gets the most out of every penny we spend.' The announcement included:

- An ambition to make joined up and coordinated health and social care the norm by 2018.
- The development of the first ever agreed definition of good integrated care and support – developed by the National Voices.
- The identification of ten new 'pioneer' areas around the country which will be looking for the innovative practical approaches needed to achieve changes as quickly as possible.
- The development of new measures of peoples' experience of joined up care and support so change can be evaluated.

In response to the Government's invite, at the end of June, Lewisham submitted an expression of interest in becoming a Pioneer in health and social care integration. Both the Council and the CCG face challenging financial targets to achieve over the coming years combined with increased demand from a population with increased and specific needs. Both had already taken action to integrate in some areas, recognising the benefits in integrating services by reducing duplication in management and functions, improving outcomes for service users and improving performance.

In the expression of interest, Lewisham highlighted the commitment of the Health and Wellbeing Board to increase the scale and pace of integrating working, building on

- a basis of knowledge of what has worked to date and what has not;
- a local understanding of the cultural and organisational changes that are needed to bring different disciplines together; and
- Our experience of the action required to resolve issues and break down barriers

The submission set out in detail the work that has taken place to date in redeveloping the "intermediate tier" of care, and the establishment of multi-disciplinary teams around the GP neighbourhood clusters.

Although the Pioneer bid was unsuccessful, the Health and Wellbeing Board has already demonstrated its commitment to a more ambitious model based on the four different levels of advice, support and care any individual may receive during their life time:

1. **Living Well** – empowering and supporting individuals, families and communities to take action to make healthy lifestyle choices and to engage in activities that maintain and improve their physical and mental well-being and to maintain their independence, by providing relevant advice and assistance on issues such as not smoking, eating healthy, drinking less alcohol and exercising more.

   It is estimated that this cohort is about 80% of the total population and accounts for less than 30% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

2. **Early Intervention** - identifying at an early stage when more support is required and providing fast and convenient access to high quality support and advice. For example,

when an individual or family is finding it less easy to manage alone without additional assistance, such that a little bit of help now will prevent more work later. In health this means systematically detecting and intervening earlier on health issues – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure. It is estimated that this cohort is about 15% of the total population and accounts for over 30% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

3. **Targeted Intervention** – identifying those specific high risk individuals who would benefit from active intervention to avoid a potential crisis such as an inappropriate admission and re-admissions to hospital. The aim is to mitigate risk through proactive intervention. It is estimated that this cohort is about 4.5% of the total population and accounts for 29% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

4. **Complex Care** – coordinating and managing a complex health and social care package in a single care plan which is tailored around the needs of the individual, carer and the family with them at the heart and still in control - 'nothing about me, without me'. For example, the care package to support a person choosing to die at home. Often it is these complex cases that fall through the cracks of a non-integrated care system. It is estimated that this cohort is about 0.5% of the total population and accounts for 11% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

In taking forward the programme, the focus will be on the co-ordination of services around the user and on the integration of care, not of organisations. This will require breaking down organisational boundaries, achieving culture change across the whole system, improving information sharing, and ensuring care is properly coordinated across all settings.

4. Project Organisation & Governance

Lewisham's adult integration programme will require the involvement of different commissioning and provider organisations, from both the statutory and non statutory sector, working together in new ways.

Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The following Boards will ensure effective governance of the programme:

- Health and Well Being Board
- Adults Integration Programme Board (AIPB)
- Individual Project Boards for each workstream

The Health and Wellbeing Board will be the overarching body that monitors the progress of the programme. To ensure that the progress of each individual workstream is more regularly assessed, the Health and Wellbeing Board has agreed to the establishment of an Adults Integration Programme Board (AIPB). This Board will ensure robust plans and delivery mechanisms are in place for each workstream) and that regular progress reports are presented to the Health and Wellbeing Board.

It is proposed that the AIPB sits alongside, and work closely with, the existing Health and Wellbeing Delivery Group, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group .

The AIPB will be accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme. It will have specific responsibility to:

- Oversee the implementation, monitoring and evaluation of the agreed work programme as outlined in the Programme Initiation Document (PID);
- Coordinate the plans for the use of the Integrated Transformational Funds
- Develop and recommend the local framework for commissioning of health care and social care;
- Identify further opportunities to develop a transformational agenda to improve the health and wellbeing of the population of Lewisham.

Initial members of the AIPB are:

- Marc Rowland, Chair NHS Lewisham Clinical Commissioning Group
- Martin Wilkinson, Chief Officer, NHS Lewisham Clinical Commissioning Group
- Aileen Buckton, Executive Director for Community Services, Lewisham Council
- Claire Champion, Director of Nursing and Clinical Services, Lewisham and Greenwich Healthcare Trust
- Peter Stachniewski, Head of Financial Services, Lewisham Council
- Danny Ruta, Director of Public Health Lewisham Council
- Genevieve Macklin, Head of Strategic Housing, Lewisham Council.

This membership will be reviewed regularly and additional members from Community Development and South London and Maudsley NHS Trust will be invited to join the board

when appropriate.

The board itself will be supported by a small operational group, led initially by Sarah Wainer (Head of Strategy, Improvement and Partnerships) and Susanna Masters (Corporate Director NHS Lewisham Clinical Commissioning Group) who will ensure progress is being made in all workstreams and that regular reports are provided to the programme board and to the Health and Wellbeing Board.

The governance for the programme will also include the Neighbourhood Connection Groups which provide direct involvement and engagement in the programme at a neighbourhood level.

Each of the agreed workstreams will have a project group which will report into the programme board. Each project group will develop its own workplan to achieve the stated outcomes. Part of this work will involve engaging service users and residents in the co-production of new approaches. The project leads will also ensure that where activity is also taking place and being taken forward by existing groups as part of the delivery of the Health and Wellbeing Strategy objectives this work is aligned to the appropriate workstream to avoid duplication. The initial workstreams to be set up are:

Workstream 1 –health and wellbeing campaigns; health and self help promotion; co-ordination and access to information and signposting for all including self funders; initial advice and support; links to community opportunities and activities.

Workstream 2 –the development of effective systems and processes for early and targeted interventions, including enablement, telecare, equipment, enablement, respite, admission avoidance and hospital discharge.

Workstream 3 – the development of single assessments, including risk stratification, joint care plans, joint reviews, direct payments, personal budgets, personalised health budgets and the development of a single health and care record.

Workstream 4 – the review of key pathways across health and social care from initial contact to ongoing care –dementia, falls**,** COPD, Heart Failure and Diabetes.

Workstream 5 – workforce development, new delivery models and culture change covering brief interventions, knowledge and confidence to empower and signpost effectively; proactive management of health and wellbeing.

Workstream 6 – ICT including information sharing protocols, integrated systems, joint records; digital interface.

Workstream 7 – community development, the Communities That Care initiative, neighbourhood networks.

Workstream 8 – commissioning and market development, resource management including the achievement of savings, quality and safety assurance.

Workstream 9 – interface with housing and supported accommodation.

Workstream 10 – programme support covering sources of programme funding; financial modelling and forecasting; risk management, programme consultations and communications and governance.

5. Programme Communication Plan

The integration of health and care is a complex programme requiring action across many areas and adoption by key stakeholders of the programme's aims and objectives. As recognised by the Pioneer panel, Lewisham needs to consider how it will communicate its proposals for integration more widely. Any plan must ensure there is a wide understanding of the benefits of integration and of the desired outcomes for residents. Therefore a key element of the programme will be the development of an overarching communications plan. This will be undertaken by the project group responsible for Workstream 10.

The communication plan will also set out when reports will be presented to the Health and Wellbeing Board, other key partnership groups and relevant scrutiny committees.

6. Programme Finances

As part of the programme we will review the budgets supporting those services included in its scope enabling them to contribute to the required Council and QIPP savings.

For the Council, the 2013/14 budgets are: Adult Social Care £81m, Public Health £15.6m, Investment Fund £0.742m.

For the CCG, the 2013/14 budget of £336m includes the total budget for healthcare excluding budgets specifically for under 18 year olds. This includes all care settings and care categories. As integrated work is progressed further analysis of Council and NHS spend will take place in order to accurately assess the relevant baselines and future expenditure.

The Government is supporting the integration of Health and Social Care by transferring resources from the NHS to local authorities. These funds must be used to support adult social care services which also have a health benefit. Subject to agreement by the CCG and by the Health and Wellbeing Board, the Council will receive £4.9m in 2013/14 to promote integrated working. In 14/15, a further £1m is expected to be transferred which will increase the total additional resource to in the region of £6m.

In the spending round for 2015/16, the Government announced further funding of £3.8 billion for health and social care through the Integration Transformation Fund (ITF). This overall amount takes into account monies already announced for 13/14 and 14/15. Again, the specific amount to be transferred to Lewisham for 15/16 has not yet been announced. A detailed plan for the use of Lewisham's 14/15 and 15/16 allocations has to be submitted to NHS England by 15 February 2014. Detailed discussions are currently taking place between the CCG and the Council and proposed areas of spend will be presented to the Health and Wellbeing Board for approval in January.

<u>Programme Expenditure</u>

Currently, work on the integrated programme will be taken forward by existing staff across the CCG and the Council. Until the individual workstreams are fully established and the individual workplans drawn up it is not possible to say precisely what additional programme management resources are needed. Any requests for such resources will be considered by the Adult Integrated Programme Board.

7. Programme Plan – Key Milestones

KEY MILESTONES	Start	Finish
Development Stage:		
AIPB established	November 2013	November 2013
Health and Wellbeing Board agree Programme Initiation Document	19 November 2013	19 November 2013
Workstreams established:		
• Initial workstream meetings take place	December 2013	December 2013
• Workstream plans developed	December 2013	January 2014
• Workstream plans approved by AIPB	January 2014	January 2014
Evaluation framework developed	January 2014	January 2014
Health and Wellbeing Board agree plans for the Integration Transformation Fund 2014/15 and 2015/16.	21 January 2014	21 January 2014
Planning and Implementation Stage:		
Initial efficiencies identified	December 2013	January 2014
Approved plans phase 2 implemented	January 2014	March 2015
Detailed financial modelling	February 2014	September 2014
Approved plans phase 3 implemented	April 2015	March 2016

8. Programme Quality Assurance & Performance Indicators

Mechanisms will be established under Workstream 10 to ensure the programme delivers against agreed plans and milestones and to an agreed standard. The controls will include regular project lead reports to the AIPB, monthly updates and exception reports against workplans.

As mentioned earlier, baseline data will be collected in order to establish success measures and set performance indicators. This will include indicators for non elective admissions, urgent care attendance, length of stay in acute and MH hospitals; readmission rates; entries into residential/nursing care; number and packages of domiciliary care, personal budgets, direct payments. Financial impact indicators will also be established.

The programme will follow the principles and methodology set out in *Managing Successful Programmes.*

9. Programme Risks

A Risk Register will be produced for the overall programme and individual risk registers will be developed for each workstream. The Risk Register will be regularly monitored by the AIPB.

A number of areas have already been identified which present possible risks to the programme.

Achievement of financial efficiencies – the timetable to achieve the required efficiencies is challenging and needs to be aligned with the timetables and targets for the local government savings and the CCG's QIPP programmes. Research has indicated that it requires long term sustained multi-organisational focus to achieve maximum efficiencies. Also the levels of financial benefits stated within the PID are based on the best available evidence of good practice, but remain at this point theoretical to Lewisham.

Resources – ther may be insufficient resources to invest in new delivery models, new approaches or to build capacity or capability. In addition, the staffing resource may be inadequate to realise the full potential of the programme.

IT Systems, Processes and Governance - systems for effective information sharing across organisations may be difficult due to technical difficulties, governance/confidential issues and/or investment.

Workforce Capacity and Capability – a different culture and relationship with the users of services and a different way of working across organisations is required. This will require buy in from all organisations involved and commitment from staff. Also the programme will seek to develop generic workers working across health and social care.
Action Research – it may be difficult to evaluate the specific improvements in quality, patient experience, health outcomes and finance as a result of the programme, due to the interrelated nature of this programme which interfaces with wider health and social care changes eg Dilnott,

Cross Organisation commitment to the Integration agenda – is needed to maintain long term sustained multi-organisational focus to achieve maximum efficiencies, despite wider national policy changes and local acute configuration changes. The AIPB will need to mindful that a gap between the strategic direction of the programme and the operational delivery may emerge. Lewisham and the CCG officers will require the capacity and capability to plan and implement the programme effectively, ensuring it remains focussed on delivering improved outcomes. Strong relationships will be important to withstand the changes and to manage competing priorities. There is a risk that relationships are not currently sufficiently well developed to support this.

Approaches to risk – implementing the Integrated Care Programme will involve the development of new delivery models that will require new approaches to managing risk within and across organisations.

10. Equalities Impact Assessment

The equality impact for each workstream will be considered by each project board and where necessary equality impact assessments will be undertaken. This activity will be monitored by the AIPB.

11. Environmental Impact

The environmental impact for each workstream will be considered by each project board and reported to the AIPB.

12. Health & Safety

No Health and Safety issues have been identified in this initial start up phase of the programme.

13. Programme Evaluation

The AIPB will ensure that an appropriate evaluation framework is developed and implemented for each workstream. This will involve reviews at the end of each project, at the end of the programme and following the closure of the programme. The AIPB's oversight of the evaluation will enable the effective transfer of learning across workstreams

The challenges of evaluating specific improvements in quality, patient experience, health outcomes and finance as a result of the programme have been highlighted as a key risk.

The costs of evaluation will be met from within the total budgets described in paragraph 6 above.