South London and Maudsley NHS
NHS Foundation Trust

Lewisham and Greenwich NHS
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Lewisham's Adult Integrated Care Programme

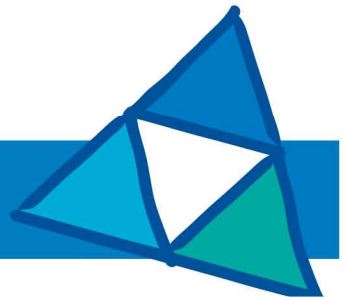
Presentation to the Healthier Communities Select Committee

14 October 2015

Better health, best care
for Lewisham people

Overview

- Lewisham's Vision
- Lewisham's whole system model of care
- Public engagement
- Lewisham's Neighbourhood Care Networks
- Delivering the new model
- Progress to date – scheme and enabling projects
- Immediate priorities



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Lewisham's vision

Lewisham Health & Care Partners (Lewisham Clinical Commissioning Group, Lewisham Council, Primary Care and local GPs, Lewisham and Greenwich NHS Trust, and South London and Maudsley Foundation Trust) have the following shared vision:

To achieve a viable and sustainable 'One Lewisham Health and Social Care System' that will enable the local population to maintain and improve their physical and mental wellbeing, enable independent living, and have access to person-centred, evidence-informed, high quality, yet cost-effective pro-active care, when it is needed.

A new system and model of care which...

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- Is co-produced with all stakeholders; by listening and engaging with everyone
- Gives people access to information and advice to help them to remain healthy and independent
- Places the user at the heart of the system - designing person centred, co-ordinated care which enables the user to direct their own care and support
- Creates effective neighbourhood care networks which are more efficient and reduce duplication
- Delivers more care and support closer to home - which avoids people having to enter hospital unnecessarily and, if admitted, gets them home safely as soon as possible
- Focuses on the strategic priorities identified for the borough, including those set out in *Lewisham's Health and Wellbeing Strategy* and those set out in *Our Healthier South East London strategy*

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Public Engagement

- Effective communication and engagement with the public is vital. Users are keen to be involved in the transformation of services and in developing neighbourhood care networks

- Users told us:
  - The concept of a 'Neighbourhood care network'* is new to most of them
  - They want better access to information, advice and services, improvements in appointments and waiting times and to receive high quality, co-ordinated care and support
  - Where appropriate, services should be available at a local or neighbourhood level
  - Information sharing is important across the whole system, both between patients/users/carers and services, and between the services themselves
  - There should be a focus on prevention, through proactive care and by building strong communities

- *The neighbourhood care network concept was introduced at the 'Your Voice Counts' event was held on 4th July 2015. Attendance was around 100 people.

Neighbourhood Care Networks

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- Four Neighbourhood Care Networks (NCNs) will be established in Lewisham to bring together the different organisations, individuals and agencies involved in a person's care

- No single blueprint but the foundations of NCNs will be:

  – improved access to preventative and early intervention support
  – transformed general practice and primary care rooted in the community
  – integrated physical and mental health and social care
  – full involvement and engagement with patients, service users, carers and other voluntary and community organisations in the co-design and delivery

- Work on building the NCNs must be done at the same time as the required transformation in secondary care

- There will be a continued focus on improving quality and maintaining safety

- Staff will be expected and supported to work differently across the system

- Investment will be required to move to the new model and ways of working

Delivering the new model

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- A reconstituted Adult Integrated Care Programme Board provides system wide leadership and accountability for the delivery of the new model to improve the health and wellbeing of the local population

- Board members are accountable for the following schemes and enablers:
  - Matthew Patrick (SLaM) - Prevention & Early Intervention
  - Marc Rowland (CCG and GP)- General Practice
  - Aileen Buckton (LBL) - Neighbourhood Community Teams
  - Martin Wilkinson (CCG) - Enhanced Care & Support
  - Tim Higginson (LGHT) - Estates, ICT and workforce

- The Board is supported by an operational group and programme lead who have responsibility for the development of the programme's annual plan and critical path

- Dedicated scheme managers and capacity to support financial modelling and communications and engagement are being put in place to increase scale and pace

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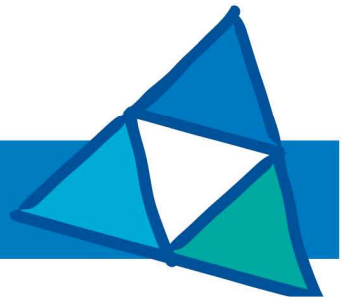
Progress to date

Schemes and enabling projects



Prevention & early intervention

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- A new Social Care and Health website went live in August. The website provides a comprehensive up to date resource which can be used by users, carers and service providers alike

- A Social Care and Health Directory of Services is also available

- Work continues to develop the Single Point of Access, building on Phase I which brought together Social Care and Advice Team (SCAIT) and district nurses.

- Screening tools have been introduced to improve prevention and to facilitate referrals to other services such as the Handyperson Service. The screening tool is initially being used with people who have fallen and are known to Linkline (Community Alarm Service).

- Housing Adaptations and Disabled Facilities Grant staff will be co-located to improve co-ordination of their work.

Primary Care

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- Two GP networks (provider vehicles) have formally incorporated as companies, two more to follow
- On-going support is being provided to establish and develop all four GP networks, including CQC registration, to allow the formal delivery of services from 2016/17
- Development of formal CCG “commissioning offer” to GP networks for 2016/17
- A Protected Learning Time (PLT) session held in September was used to inform and engage GPs in the programme. The CCG is continuing to work with GPs through Neighbourhood forums/practices throughout October with the objective of increasing levels of understanding and engagement.

Neighbourhood Community Teams

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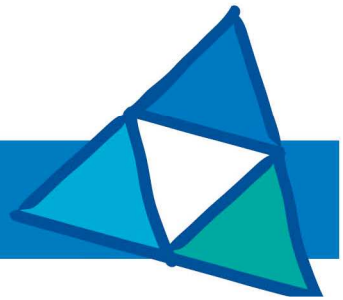
•A building block within the Neighbourhood Care Networks

•Work is taking place to develop joint approaches to care planning, case management and risk stratification

•Shadowing of key functions has taken place to gain a detailed understanding of how people move through the social care system. Links to key pathways such as dementia have also been established

•An engagement plan targeting GPs, practice managers, nurses and social care staff as well as wider stakeholders has been developed. The PLT event in September included a focus on NCTs and an initial e-bulletin has been circulated to social care and nursing staff

•The Waldron will be used as the first roll-out site for one of the Neighbourhood Community Teams



Enhanced care & support

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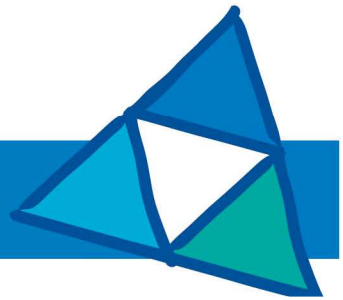
The scheme's scope includes the following services and provision:

- Rapid Response
- Admissions Avoidance
- Supported Discharge
- Discharge to Assess
- Enablement
- Brymore / Community Beds
- Ambulatory Care
- Appropriate Care pathways
- Palliative Care in Care Homes
- Developing Continuing Healthcare
- Lewisham Community Neuro-Rehab Team
- Crisis Concordat action plan
- Extra Care services and Older Adults Housing.

Work currently taking place includes:

- Consideration of the Admissions Avoidance Service audit report
- Audits of Supported discharge and Rapid Response and Recuperative beds
- Development of a business case for a Home Ward



Estates enabler

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- Representatives across health and care have been brought together to consider how better use could be made of the estates across the system to deliver new models of care.

- A longer term estates strategy is being developed to meet the requirements of Lewisham's Neighbourhood Care Networks

- The estate audit work already undertaken in Neighbourhood 4 (south east Lewisham) is to be rolled out across the whole borough.

- The Neighbourhood Community Team for Neighbourhood 1 (north Lewisham) will shortly be located in the Waldron Centre

IMT enabler

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•*Connect Care,* an integrated health and care dataset, has been launched to improve the sharing of health and care information between professionals

• Health information is available in Connect Care now and can be accessed by those licensed to use it

•Work to extend the Connect Care dataset continues and will include data from Lewisham's adult social care system

•More generally work is underway to use IMT as an enabler to support the provision and delivery of care, to facilitate mobile working and to help meet the challenge of becoming paperless organisations

Workforce enabler

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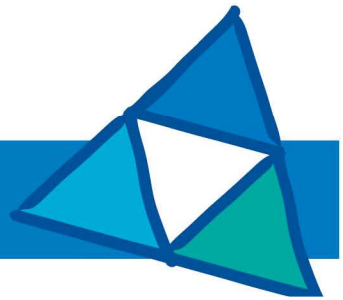
This year we have :

- Held 8 “Under One Roof” workshops to formally mark the inception of the neighbourhood community teams, attended by 143 staff
- Held 16 “Working Together Better” values and behaviours focused workshops to develop local approaches to working together, attended by 151 staff
- Undertaken a priority stocktake of provider workforce development activity in order to identify areas of overlap between different partner organisations and to identify shared or common priorities for further joint working
- The stocktake will identify those development activities that can support the integrated delivery of health and care services



Immediate priorities

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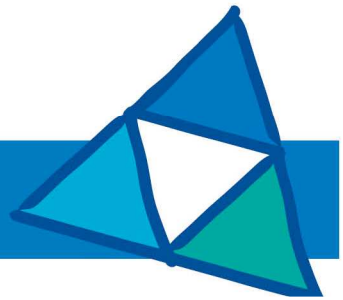
•Improving our communication and engagement with all stakeholders across Lewisham

•Co-designing the model for Lewisham's Neighbourhood Care Networks and for the transformation of services

•Getting the right capacity and capabilities at all levels and across all parts of the system to achieve the transformation at the pace and scale that is required.



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QUESTIONS?

Martin Wilkinson, Chief Officer, Lewisham Clinical Commissioning Group

Tim Higginson, Chief Executive, Lewisham and Greenwich NHS Trust

Aileen Buckton, Executive Director, Community Services, Lewisham Council