Re-imagining Local Care Networks: *Neighbourhood Based Care and Wellbeing*

This case sets out the vision for local care networks over the next 7 – 10 years and outlines the key steps in achieving this.

November 2018
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1.0 Executive Summary

To BE FINALISED

This proposal sets out our future vision for Local Care Networks. A delivery alliance of partners, one budget, a shared outcome set, and reorientation of partnerships and services to Neighbourhoods, and a fundamental change in how we work together to achieve common goals.

The drivers for change are compelling, as we see marked inequalities in the borough, changing needs of our Lambeth population, continued fragmentation and variable experience despite our attempts to collaborate. We now need step change in our integration efforts with a fundamental change in how we

This proposal sets out recommendations to reboot our borough wide integration of services, and align integration of health, care and community services and focus in approx 9-12 Neighbourhoods across Lambeth.

Neighbourhoods are an important principle of this new model, as a natural place where community assets, services and people partner to improve peoples health and wellbeing. They build on what is already in place, with a more integrated community based approach that makes the most of our community assets. We do not recommend structural or organisational change, but on a change in partnerships, culture, behaviours and ways of working, underpinned by an alliance contract based on outcomes.

To add:
- Borough services-alignment and features of a new model
- Note one contract, one integrated model, not two
- Health and wellbeing networks/living well network/community assets-proposed approach to scoping- 6 months
- Prevention, ways of working, culture- specify what we mean
- Financial envelope and scope of services £125m-175m
- 19/20 shadow year- timescales and process
- 19/20 maintaining momentum on service improvements and service developments- shared programme
- Proposed governance arrangements
2.0 Introduction

2.1 Purpose of this Business Case

This business case sets out the vision, aims, scope and timetable to deliver our refreshed ambition of Local Care Networks, (LCNs) Neighbourhoods and Community Based Care Services in Lambeth. This will be achieved through a 7 - 10 year partnership contract, based on alliance principles, with an estimated financial envelope of between £125million and £175million. This will bring health, care, voluntary and community organisations together in partnership with one budget to deliver a set of shared outcomes for our adult population of Lambeth.

This case sets out the framework of a proposed future model for LCN and outlines a plan for change including:

- The case for change – why we need a new model for care in Lambeth
- The emerging model – its vision, aims and benefits for people delivering and using services
- The benefits and economic principles required to meet the forecast funding envelope
- The next phase of governance and plans operating framework

2.2 The Broader Context

National policy is driving integration of services throughout England and has set out a range of priorities and directives which services in Lambeth must meet. Key drivers pertinent to this business case include:

- Integrated care systems and Sustainability and Transformation Plans
- The National Institute for Health and Care Excellence (NICE)

The health and care system in England is currently making a concerted push to break down barriers and integrate services and systems. NHS organisations and local councils have come together to form Sustainability and Transformation Partnerships. Many areas are now on the journey to form integrated care systems, where they will work in partnership with local councils and others, taking collective responsibility for managing resources to improve the health of their local population. Across England, there are efforts to move from fragmented services to local partnerships. The scale and form of integration for each economy is multiple, with each partner needing to play an instrumental role in a range of integration endeavours.

Set within the national context, the London Health and Care Devolution act enables London to have greater autonomy in making decisions about its health and care service. This includes a focus on joining up health and care services and aligning
decisions about where and how these services are provided; as well as making better use of NHS buildings and land, with NHS trusts incentivised to see unused land and buildings and reinvesting this money into building better GP surgeries, community services and hospitals; and helping Londoners to be as healthy as possible.

Our Local Care Network Delivery Alliance is part of the boroughs integrated system known as Lambeth Together, which is fully aligned to the the integration ambitions of South East London STP as illustrated in Figure X. This proposal focuses on Lambeth’s community and neighbourhood based delivery model.

Figure X A system of systems

2.3 Local Context

The integration and innovation articulated in the NHS Five Year Forward View and has strong resonance in Lambeth. Lambeth has a long history of innovation, partnership working and collaboration. ‘Lambeth Together’ is Lambeth’s integrated care system, bringing together care providers, the local council, community and voluntary sector organisations and others to work together to address the health and care needs of the local community through delivery alliances.

Within Lambeth Together, the Living Well Alliance is already on the journey of supporting adults with mental health problems in a fundamentally different way, with partners collaborating under one alliance contract. This demonstrates that the commitment to integrated commissioning between health and social care, collaborative commissioner-provider working and a co-productive approach.
Integrated community-based care is at the heart of Lambeth LCNs. LCNs are now a well-established concept and sit comfortably within the overarching framework of the borough-wide Lambeth Together Strategic Alliance. LCNs have successfully brought together different care providers and community stakeholders. More recently a specific focus has been to develop an improved care co-ordination pathway for people with multiple long term conditions. Initially the LCNs’ remit was broad – to improve population health.

In addition, local services, communities and staff continue to pioneer new ideas, innovations and projects year on year, including Timebanking, Project Smith, SAIL. These contribute to making improvements in health and care, for example despite national trends of rising emergency admissions; these have been contained in Lambeth for specific populations such as older people.

The proposed future model for LCNs outlines a delivery model for realising the aspirations of integrated care to better meet the health and needs of the local community in Lambeth, with better integrated community-based care, the shift of resources towards prevention and early action, and better use of community assets.
3.0 Case for change

3.1 Health Needs in Lambeth

Lambeth is an inner London borough situated south of the River Thames. It is densely populated with 12,020 residents per square kilometre – more than double the London average. There is a high annual population turnover, with the sum of people leaving and those arriving equating to nearly 20% of the population in any one year.

327,600 people are resident in Lambeth, evenly split between men and women. Compared to London and England, Lambeth has smaller populations of people aged 65 or over, and children aged 0-19. Lambeth has a relatively large population of young adults: 44% of the population is aged 20-39 compared to 35% in London and 27% in England.

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Lambeth’s population is highly diverse with 60% (3 in 5) describing their ethnicity as other than white British. 24% describe themselves as Black, although this varies by age group, with nearly 80% of 10-19 year olds describing their ethnicity as other than white British.  

Some health issues related to long term conditions are worse for the Lambeth population than for the England population, and others are better. Compared to England, the Lambeth resident population has significantly higher rates of new sexually transmitted infections (the highest rate of all England local areas in 2017), and of new cases of tuberculosis. Error! Bookmark not defined. Lambeth has a significantly lower rate of diabetes diagnoses in adults aged over 17 compared to England, suggestive of poorer rates of diabetes detection. The <75 mortality rate for cardiovascular disease is significantly higher in Lambeth than England (94.3 compared to 73.5 per 100,000). The <75 mortality rate from cardiovascular disease considered preventable is also significantly higher in Lambeth than England (56.7 compared to 46.7 per 1000,000).

An estimated 18.1% of the Lambeth registered population aged 16-74 has a common mental health disorder. This is higher than the London average of 16.4% and the England average of 15.6%. However, the recorded prevalence of depression by general practice is lower than the England average, at 7.4% of the practice register aged 18+, compared to 9.1% for England. This may reflect a relatively lower detection rate by primary care services.

Risk factors for mental ill health and substance misuse include socioeconomic deprivation, children living in poverty, long-term unemployment, homelessness, violent crime and domestic abuse. For each of these measures (except domestic abuse where the comparison is not made) Lambeth has higher rates than the England averages.
Screening rates for breast, cervical and bowel cancers are all significantly lower in Lambeth than in England overall.\textsuperscript{10}

Health issues which are relatively better in Lambeth than England include excess weight in adults (although within Lambeth, there is a relationship between adult obesity and deprivation\textsuperscript{8}), percentage of physically active adults, smoking prevalence among those in routine and manual occupations, hip fractures in older people, alcohol-related harm hospital stays, and self-harm hospital stays.\textsuperscript{Error! Bookmark not defined.}

Smoking is a risk factor for a number of health issues including cardiovascular disease and cancers. Smoking prevalence in adults in Lambeth is similar to that of England and London.

A study into multiple long term conditions (MLTCs) in Lambeth in 2017 estimated the crude prevalence of two or more long term conditions (LTCs) to be 5.2%, i.e. 5.2% of the population of adults aged over 18 were known to have more than one LTC. It is known that the presence of MLTCs has a negative impact on patients: increasing mortality, functional decline and healthcare interventions, and reducing wellbeing. It also increases risk of mental and physical health issues among caregivers; is associated with increased use of health services; and has economic consequences to health and social care services and individuals.

The Lambeth study figures are likely to be an underestimate for reasons including lower than expected reported prevalence rates of conditions, higher mortality rates, and fewer long term conditions eligible for inclusion in the study compared to other published studies. The relatively young age profile of Lambeth (see section earlier) may also partly explain this low prevalence of MLTCs.

The prevalence of MTLCs in Lambeth was found to increase with age, ranging from 1 per 100 among adults aged 30-39 to 49 per 100 among adults aged 90+. Other characteristics which increased the likelihood of developing MLTCs (in addition to being older) are living in a less affluent area, being a smoker, and being obese.

3.2 Inequalities and Outcomes in Lambeth

Nearly one third of the population of Lambeth live in areas which are among the most deprived fifth of areas in the country \textsuperscript{2} and about 23% of children (12,400) live in low income families.\textsuperscript{9}

\textsuperscript{9} PHE, Lambeth Local Authority Health Profile 2018.
Over the last decade life expectancy has increased in both men and women – people are living longer in Lambeth – with the gap in life expectancy between England & Lambeth also narrowing. However life expectancy for men remains significantly lower in Lambeth compared to England (78.6 years in Lambeth compared to 79.5 years in England). The London average life expectancy for males is 80.4 years. Female life expectancy in Lambeth is similar to the national average (83.2 years compared to 83.1 years respectively). Within Lambeth, life expectancy for men living in the most deprived areas is 5.9 years lower than for men living in the least deprived areas. The equivalent gap for women is 4.0 years. **Error! Bookmark not defined.**

The mortality rate from diseases considered preventable is significantly higher in Lambeth than England (205.1 per 100,000 compared to 182.8 per 100,000). The figure below shows the disease groups that drive the life expectancy gap in men and women within Lambeth (comparing the most and least deprived areas. The biggest drivers for this gap within Lambeth is cancer (38%) and circulatory diseases

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(21%) for men and circulatory disease (31%) and respiratory disease (19%) for women.

Overall Healthy Life Expectancy (HLE) in Lambeth is significantly lower for men at 58.4 (compared to 63.3 for England) and similar for women at 63.4 (compared to 63.9 in England). HLE within Lambeth varies between 56.9 in the ward with the lowest HLE to 64.3 in the ward with the highest: a gap of 7.4 years. However this is much lower than some areas in England which have a HLE of 69.9 for men and 71.1 for women. This would suggest that people get long term limiting illnesses at an earlier age in overall and in even earlier in some wards in Lambeth compared to others. There are also significant differences between wards with the highest and lowest proportions of people with limiting long term illness or disability; and between wards with the highest and lowest proportions of people rating their health as bad or very bad.11

3.3 Fragmentation and experience of care in Lambeth

Local people have told us:

- Listen to Us
- Make it Easier for Us
- Give Us Quality Care
- Give Us Choice and Control
- Help Us to Thrive
- Help Us to Feel Safe, Secure and Protected from Harm

However, evidence shows that the health and care system in Lambeth, like many other parts of England, is still fragmented. Our system is complex and confusing. This is not only frustrating and difficult for patients, their carers and families, but also for staff operating within the system. Set amongst many other examples, Lambeth Healthwatch has done a huge amount of work looking at patient experience, including its ‘Going Home’ work on discharge from hospital and subsequent on-going care and support. ‘Going Home’ provided many examples of fragmented working

across different parts of the NHS and social care leading to poor patient experience and outcomes. Alongside fragmentation, there is duplication within the system, for example, multiple services carrying out their own assessments of individuals to determine eligibility. Evidence demonstrates how distressing fragmented care can be, its impact on health outcomes, and the waste of valuable resources.

Alongside this, Lambeth currently operates a series of bilateral contracts with providers, with each having its own performance frameworks and measures. This means providers are not expressly working to achieve the same goals and there is little incentive for them to focus on overall outcomes and the whole care pathway for an individual; instead they are able to focus solely on their own area of responsibility.

There is strong international evidence that effective integration of care provides better patient experience\textsuperscript{12}. Neighbourhood-level integrated care models are starting to show a positive effect on patient experience and patient outcomes as well as more traditional finance and capacity process measures. We also know that the national vanguards are underpinned by the commitment to commission on the basis of improving outcomes, not on the basis of activity or services undertaken. This outcome improvement is only effectively delivered when providers of care work together in fundamentally new ways.

Local people and staff consistently tell us what matters to them: reducing inequalities, fairness, supporting the vulnerable and making sure no one is disadvantaged remain consistent themes.

<table>
<thead>
<tr>
<th>Theme</th>
<th>What matters to local people</th>
<th>What matters to staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery of high quality care</strong></td>
<td>• Build the skills to self-manage and live independently as much as possible.</td>
<td>• Treat each other equally, with respect, across sectors, disciplines and grades of staff (break down the barriers across sectors, professional groups and seniority).</td>
</tr>
<tr>
<td></td>
<td>• Make things simple, join them up, reduce the duplication and fragmentation, have greater ease.</td>
<td>• To have time and capacity to share and learn across teams, services and the system.</td>
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<tr>
<td></td>
<td>• To know what is available, how to access services, urgent and routine.</td>
<td>• To create an environment and system where we learn from mistakes together.</td>
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<tr>
<td></td>
<td>• Remove barriers (eg physical and mental health services, single conditions, different waiting lists or queues, multiple</td>
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</table>
3.4 System affordability: The Financial Gap

The health and care system in Lambeth is financially challenged in the face of public sector austerity since 2008 and growing demand for health and care. This means we face difficult choices with people in Lambeth about how we improve their health and wellbeing within the resources that are available.

This dilemma is not unique to Lambeth and we are part of wider public services where key support such as social security, housing provision and the police have been subject to funding pressure and increased demand for services.

Lambeth council has experienced reduced funding since 2008 which has impacted on adult social care which has meant the overall funding has reduced. This has been partly offset by funding through the NHS via the Better Care Fund and the current Social Care Grant which has enabled the council to maintain services and support the growth in demand.

NHS Lambeth CCG has seen financial growth since 2008 (between 2-3% on average) but this has not kept pace with growing demand linked to the increase in older people, improved life expectancy of people with disabilities and development of new treatments, drugs and technologies. These costs are growing at 4-5% a year. The gap between financial and demand growth is what creates a savings requirement.

The local NHS context is similarly difficult; both local NHS acute trusts face huge financial challenges, with King’s one of the 5 worst financially performing Trusts in the country. Lambeth CCG also faces significant financial challenge, with local acute trust demand having outstripped CCG funding since 2014/15 as shown in Figure X.
Emergency inpatient demand is broadly stable in Lambeth, due to local admission avoidance services. However, the complexity and acuity of patients who do have an unplanned admission is increasing, as are the associated costs and acute planned care has also seen very significant growth, particularly via GP referrals.

New models of care are needed to manage demand and shift investment into prevention and early intervention and mitigate demand for high cost care such as hospital admissions and high cost packages of care. Some good progress has been made already in Lambeth around shifting interventions ‘downstream’, outlined below, but this represents only the start of our efforts.

The proposed model is designed as an integrated community support and preventative care model, with services working with each other in a community asset based approach to maximise on the resources available across Lambeth.

- The number of emergency admissions of Lambeth residents are broadly flat – this unplanned care growth containment must be continued and new care approaches be designed for those people who are admitted (and who are therefore sicker, more complex and require more expensive care while in hospital)
- Many people are now supported at home – very few older people placed in residential and nursing care mostly associated with advancing dementia. However we are now seeing many more home based packages of care exceeding the cost of bed based care in the community, which place challenges on how we can continue to offer choice of types of care to people in Lambeth. Many people go home from hospital with intensive support when required; a key challenge now is supporting people who need night time care.
- Bringing together health and care services through the GSTT led reablement service has shown we can impact on rising demand for care.
• The local Kings Health Partners (KHP) Mind & Body Programme is showing early positive impact on improving outcomes for individuals and reducing usage of health services but there is significant scope for increasing its coverage and extending into community based care.
• Evidence from Living Well Network hubs for mental health has shown an increase in people accessing support early, higher use of low cost community alternatives (paid and unpaid), saved unnecessary referrals to specialist teams and reduced waiting times for specialist teams. This learning needs to be applied to other relevant areas.

3.5 What this means for Reimagining Local Care Networks

We need to build on the partnerships, relationships and collaborations developed in our neighbourhoods and prioritise focus on integrated community-based care and an explicit focus on prevention and realising the full potential of Lambeth’s community assets.

Given the current demand and capacity issues, combined with financial pressures, preventative out of hospital pathways and interventions are needed to mitigate demand and flex capacity in innovative ways. The proposed model of LCNs does this, with an emphasis on collaboration, across the system, a change in culture and ways of working, and recognising and using community assets more fully, with a shift in investment over time into prevention and early intervention

There is a correlation between deprivation and poor health outcomes with higher incidence of long term conditions and earlier onset of disease and lifestyle related health diseases. Some ethnic groups also experience a range of health challenges (e.g. low birth weight, higher prevalence and early onset of some long term conditions such as high blood pressure and diabetes. Integrated services need to take into account these differences in need and provide care in an equitable way to meet these differential needs. There also needs to be a refocus on early interventions and prevention. They also need to influence the social-economic factors that impact on health through a consideration of health in all policies.
4.0 Re-imaging Local Care Networks: Health and Well-Being and Neighbourhoods

4.1 Local Care Networks: The journey so far

Three locality based Local Care Networks (LCNs) in Lambeth were established to improve the health and wellbeing of local people by services and communities working together. Each LCN has developed local initiatives identified and progressed by stakeholders and connected local people and voluntary community sector organisations with health and care staff. All LCNs have supported the development of a care coordination pathway to improve the patient experience, care and outcomes for people with complex multiple long term conditions.

Figure X: The journey so far (TRANSFER INTO A DIAGRAM/INSTEAD OF PHOTO)

LCN Forums has provided local spaces to connect voluntary and community sector (VSC) organisations with statutory health and care service providers. This has had benefits for the VCS organisations themselves, in an increase in activity and has also lead to integrated working that has delivered opportunities and benefits for local people, such as the following examples:
**Luiz’ story**

Starting as an idea that was supported by North Lambeth LCN, since December 2017, the Lambeth Portuguese Wellbeing Programme (LPWP) has been bringing together medical professionals and community experts to do joint care coordination person centred assessments with Portuguese-speaking Lambeth residents, to understand what support, medical and beyond, people need to improve their wellbeing.

Local resident Luiz, originally from Brazil, took part in the pilot. Luiz suffers from a heart condition, type 2 diabetes and anaemia. He lives on his own and he doesn’t speak much English. During the joint assessment, Luiz explained he felt stressed by debt and having to rely on family for help. He felt very isolated and talked about how his only social interactions were seeing his family infrequently, going to medical appointments and talking with his landlord in very basic English when he comes to collect the rent once a month. Luiz explained he spent his days between the TV and the computer. He also felt that he had not been eating enough because he doesn’t like eating alone. He believed all these things have affected his health.

The community liaison officer, was able to speak with Luiz in his native language, build up a relationship and help work through some of these issues. The community liaison officer helped Luiz review his finances and gain access to £400 a month additional benefits that Luiz was entitled to. Luiz was helped to contact his landlord to request an entrance ramp for his home, rearrange medical appointments and respond to letters. He has also been invited to attend Stockwell Partnership’s ‘Hug’ group of older Portuguese people, a group that meets regularly for social activities.

"I am very happy with the service and would recommend it to everyone I could".

**INSERT MORE EXAMPLES HERE**

LD/BLACK PRINCE TRUST

TEA PARTIES

WALK MAP LEARN
4.2 Reimagining Local Care networks; our vision and aims for Neighbourhoods

It is time to refresh the ambition and pace of integration in our local Neighbourhoods, and further our commitment to achieve the vision, developed by local partners and community stakeholders, for health and well-being in neighbourhoods to:

*Improve health and wellbeing of local people by services and communities working together with our shared resources.*

The shared aims are:

- Maximising wellbeing
- Working together
- Achieving value and quality

We will know we have achieved this when:

- People live independently as they want and can
- People live the life they want
- People are part of their community
- People are as healthy as possible
- People are at the center of their care and support: where care is organised around them
- When crisis happens, people experience the smallest possible disruption to their lives
- People manage their own conditions and get support to do this if they need
- People feel safe and respected, their dignity is maintained and they do not experience any discrimination or harassment

This requires us focusing on population health as a borough and in our Neighbourhoods in Lambeth, as shown below:

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13 Engagement themes from over 40 local initiatives
Originally, two delivery alliances were proposed inked to Local Care Networks, one for place or ‘Neighbourhood Based Care’ and one for Health and Wellbeing Networks. This proposal recommends one integrated delivery alliance, as an integrated Neighbourhood approach, and that health and wellbeing is ‘hardwired’ further into this delivery alliance model.

Furthermore, we recommend that the ‘health and wellbeing network’ is co-produced more widely in collaboration with communities, local people, the Living Well Network, and Lambeth Made colleagues, and over a longer period of time.

We will work to create the following conditions for success\textsuperscript{14}, key factors that need to be in place to enable this vision to be realised:

- **Joined up services**: care providers (hospitals, care homes, GPs, nurses and allied health professionals), the local council and the voluntary and community sector work together, with local people, to ensure that people receive the care they need, with a seamless experience across the range of services provided.

- **Quality and person centred care**: care provided should be of high quality with health professionals, carers and patients making decisions together.

- **Shared outcomes**: a high level set of outcomes, agreed across all the partner involved, that sit beyond individual organisation objectives, with each of the partners committed to achieving these and understanding progress.

- **A happy and motivated workforce**: those working in the health and care system, including services and support provided by the voluntary sector, are given appropriate training, learning is valued and they feel supported to do their best.

\textsuperscript{14} Carla Hobart – find deck – check these marry up & no gaps
• **A focus on keeping people well**: services focus on prevention and supporting healthy lifestyles, drawing on the range of community services and assets available.

• **Using shared resources**: the best use is made of pooled resources available across care providers, the local council and the voluntary and community sector, aligned to the shared outcomes of LCNs.

• **Leadership and governance framework**: leaders working beyond their organisations, set within a system level governance structure, who able to work with each other to resolve conflicts and manage tensions between LCN shared outcomes and the priorities of their individual organisations.

Changing culture, ways of working and behaviours underpins the success of a Neighbourhood model. Our future model is described at three main levels:
- As a partner in our STP, a **system** within a system (see section XX)
- Integration across the **borough**
- How we will work in **Neighbourhoods**

Figure x: An Neighbourhood alliance at an STP, borough and neighbourhood level

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<thead>
<tr>
<th><strong>STP INTEGRATION</strong></th>
<th><strong>STP objectives</strong></th>
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<tbody>
<tr>
<td>▪ Alignment required</td>
<td></td>
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<tr>
<td>▪ Out of scope for detailed discussion in this business case</td>
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<tr>
<th><strong>BOROUGH WIDE INTEGRATION</strong></th>
<th><strong>Shared objectives across all partners</strong></th>
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<tbody>
<tr>
<td>▪ Further progression of our Local Care Record and integrated care records for health and social care (including secondary and community care)</td>
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<td>▪ Integrated dataset bringing together data from primary, secondary and social care, plus wider determinants of health and wellbeing.</td>
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<td>▪ Integrated teams for specific conditions</td>
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<td>▪ Further streamlined points of access- integrated fro health and social care.</td>
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<td>▪ Public health support, population health orientation and borough-wide preventative interventions.</td>
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<tr>
<td>▪ Further bringing together of urgent, 24 hour and rapid response services to prevent admissions</td>
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<tr>
<th><strong>NEIGHBOURHOOD TEAMS</strong></th>
<th><strong>Neighbourhood specific objectives based on local need</strong></th>
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<tbody>
<tr>
<td>▪ Neighbourhood responsibility to work towards borough wide integration, but with freedom to determine a local approach to this.</td>
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<tr>
<td>▪ Neighbourhood service offer working in conjunction with local people, voluntary sector, community groups and grass roots initiatives to promote healthy and included communities, including nursing and primary care.</td>
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<td>▪ Care navigators/connectors/wellbeing advisors</td>
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<tr>
<td>▪ Enhanced effective MDTs for time limited interventions for complex patients</td>
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<td>▪ Use of community spaces for wellbeing activities, e.g. Alzheimer’s café</td>
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<tr>
<td>▪ Wider range of professionals in primary care e.g. physiotherapy, pharmacists</td>
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<tr>
<td>▪ Public health support, population health orientation and <strong>neighbourhood priority</strong> preventative interventions.</td>
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<tr>
<td>▪ Shift towards holistic, multimorbidity services</td>
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<tr>
<td>▪ Locally determined and developed <strong>Quality Improvement Initiatives</strong></td>
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<tr>
<td>▪ <strong>Co-working space</strong></td>
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4.3 Borough wide integration

Within neighbourhood based care, it is important to acknowledge that there are services that work across a borough, and for many reasons, it would not be appropriate to break these up into neighbourhoods. The key is that such services would network effectively with a range of neighbourhoods. Borough wide and specialist health and social care services will work into neighbourhood teams. Devising mechanisms and pathways that champion joined up decision making, putting the person at the heart of care planning, streaming care delivery and reducing duplication.

We expect the following features in our future integrated community based model developed by partners in LCN Delivery Alliance model of care, based on international best practice:

- Further streamlined points of access - integrated for health and social care including more signposting to 3rd sector\(^\text{15}\)

- Enhanced effective MDTs for time limited interventions for complex patients resulting in lower bed utilisation and fewer delayed discharges.

- Continued shift of towards holistic, and multi-morbidity services and interventions with a demonstrable reduction in specialist secondary care costs\(^\text{16}\)

- Use of care navigators/connectors/well-being advisors to support access to community assets

- Use of community spaces for wellbeing activities, Alzheimer’s café, Cafe clinic (access to a range of professionals and advice for patients and carers)

- Further bringing together of urgent, 24 hour and Rapid Response services to prevent admissions

- Wider range of professionals in primary care, and in neighbourhoods e.g. pharmacists, physiotherapists etc.\(^\text{17}\)

- Creation of an integrated dataset bringing together data from primary, secondary and social care

- Further progression of our Local care Record and integrated care records for health and social care (including secondary and community care)

\(^\text{15}\) https://moderngov.denbighshire.gov.uk/documents/s18921/App%201%20SPOA%20Report.pdf?LLL=0


\(^\text{17}\) https://www.england.nhs.uk/gp/case-studies/wallingbrook-health-group/
- Public health support, population health orientation and preventative interventions
- Integrated teams for specific conditions avoiding complex pathway service navigation and fragmentation

4.4 Health and Well-Being in Neighbourhoods: Realising the Vision

Originally, two delivery alliances were proposed linked to Local Care Networks, one for place or “Neighbourhood Based Care” and one for Health and Wellbeing Networks. We recommend that one delivery alliance is progressed, as an integrated Neighbourhood approach, and that health and wellbeing is ‘hardwired’ further into the delivery alliance model. Furthermore, we recommend that the ‘health and wellbeing network’ is scoped more widely.

We recommend an integrated model and one alliance contract organised around Neighbourhoods

The core components of Health and Well-Being Neighbourhoods are health and well-being networks (HWBN) and neighbourhood based care (NBC).

4.4.1 Health and Wellbeing in our communities

There is widespread recognition and evidence of the importance of addressing the wider social determinants of health and a large proportion of our health outcomes and needs derive from social and economic inequalities outside our existing health
and care system. This ranges from isolation and loneliness to housing and benefit issues. There is a desire to move from a medical model of care to a whole system that embraces a holistic, preventative and social approach to supporting people with all aspects of their wellbeing.

The value of community assets in Lambeth is well known, there are still much that is untapped in the potential of the voluntary and community sector\(^\text{18}\) and the skills and expertise they bring in improving health and wellbeing of local communities through direct treatment and support, supported self-management and also through system re-design.

There needs to be a means of engaging and building long-term trusted relationships between individuals and organisations with an interest in health and wellbeing in Lambeth outside and alongside the traditional health system.

There is a wide range of local community assets that can help support and improve health and wellbeing that are not fully utilised, is fragmented and not connected to the health and care system. There is consensus that "health and wellbeing networks" would need to:

- Support community assets to develop, grow and thrive
- Facilitate connections between community assets so that they can function as a network
- Facilitate connections of people to the assets, so that people are informed and able to choose the activity/support they want to pursue
- Build trust and relationships, challenging existing ways of working and instigating culture-change
- Improve working relationships between staff in different provider organisations e.g. training (eg MDT), staff forums, networking.

From engagement work performed to date, we recognise that we need to more time to develop our thinking in this area and to engage a wider range of stakeholders in determining what HWBN’s will look like in Lambeth. We propose a 6 month process of co-production and co-design with local stakeholders and apply:

- A “co-productive” approach where all participating have equal voice and value in the process.
- Engage with a wide-range of stakeholder groups to provide diverse perspectives. This includes patients and their families as well as those who sit outside of the traditional health and care system such as, the Voluntary and Community Sector and the wider-community at large (including businesses, schools, housing, arts, sports and culture providers).

\(^\text{18}\) Untapped Potential: Bringing the voluntary sector’s strengths to health and care transformation (April 2016). The Richmond Group.
- Recognising, appreciating and building on what already exists – there are many fantastic initiatives and assets in Lambeth and a huge amount of work that has taken place.

Our plans for this proposed process can be found in Appendix X.

### 4.4.2 Neighbourhood based care in an integrated community model

Most of the collaborations progressed through our locality structured Local Care Networks have happened in more local Neighbourhoods (e.g. Minet Green, Stockwell, Kennington, Clapham Park)

We propose to organize around Neighbourhoods that reflect the natural geography of the borough and mirror the places where local people live their lives. These should not be artificially designed and should not have ‘hard’ boundaries. Given the evidence on the optimal size of a neighbourhood, we would expect to see 9 – 12 in Lambeth. Boundaries between neighbourhoods will be intelligent and permeable, offering a seamless service to residents with capacity for collaborative service delivery and sharing of resources across boundaries.

**Figure X Neighbourhoods**

Neighbourhoods will work to a single common purpose, promoting continuity of care, improving communication between professionals and teams and championing culture change. Providing space for professionals to co-work and come together will increase communication between offers and service lines, this will work to erode perceived care boundaries and promote liaison across primary, secondary and acute
care pathways, wrapping care around individuals. Multi-professional teams will enhance value by reducing duplication. Sharing learning and expertise through joint working, sharing practice will extend the reach of precious resources and shared recording systems will ensure seamless care. Working alongside people in their context with a diverse range of resources at their fingertips will increase holistic care. Integration of voluntary sector colleagues, care navigator and connecting roles into team’s key to championing ways of working that utilize the resources of the voluntary sector and the community assets^{19}.

Quality Improvement initiatives that champion co-production as a methodology will transform working practices and improve customer experience. Neighbourhoods will become the places that service providers, together with local people, voluntary sector, community groups and grass roots initiatives will coproduce healthy and included communities.

Whilst an overarching set of health and wellbeing priorities for all neighbourhoods in Lambeth prevails, there is not a single ‘recipe’^{20} or answer to achieving goals. Care delivery, service roles and local provision are co-designed for what ‘is best’ for individual neighbourhoods. This will provide scope for health and prevention outcomes to be locally decided, based on the needs and preferences of local people. In turn reducing inequalities and targeting health and wellbeing needs of the local population.

Drawing from examples in Morecambe Bay and North Manchester, there are core principles to neighbourhood based care.
4.5 What outcomes do we want to achieve?

LCNs, Neighbourhoods and Community Based Care Services Alliance will require a set of **granular outcomes** to underpin it, just like the LWN Alliance. These outcomes will need to be co-produced with local people and local staff over the next 18 months, but we can already articulate a number of key principles which will guide their design:

- Whilst the final scope of the LCN Alliance is not yet known, we do know two (overlapping) ‘populations’ that will be in scope:
  - An older, frail cohort in need of home-based support and possibly at risk of social isolation
  - People with complex multimorbidity (i.e. 3 or more LTCs – the Care Coordination cohort)
- These populations should be the start point of outcomes development work, but in the explicit understanding that when final scope is known, all relevant ‘populations’ will need to be covered by outcomes
- The most effective outcomes (that support outcomes-based commissioning) are granular and co-produced with specific populations with similar needs, rather than more generic outcomes that relate to a ‘whole population’
- The granular LCN outcome set should map to the overarching Lambeth Together Outcomes areas – Better Population Outcomes, Better Experience (including experience of care and better quality of life), Better Experience of Providing Care and Better Value
- Where possible, existing outcome indicators (where they are relevant and robust) should be used and an understanding of existing indicator sets should be gained; but where no existing outcome exists for an identified issue, commitment should be given to develop an appropriate outcome metric

4.6 Benefits case

**INSERT BENEFIT EXAMPLES FROM THE EVIDENCE BASE AS ILLUSTRATIVE OF THE IMPACT ELEMENTS OF THE PROPOSED MODEL CAN HAVE**

4.7 Service Scope and Funding Envelope

There are a wide range of service areas across the health and care system in Lambeth which fall within the scope of these Neighbourhood Based Care and Health and Wellbeing Network proposals and which we anticipate will come under new contracting arrangements from 2020. A list of these services has been set out below; however, this is not exhaustive and may change over the development phase:

- Adult community services, such as:
o Admission avoidance services
o Supported discharge and reablement services
o Community nursing services
o Specialist and long term conditions community services e.g. heart failure, diabetes, COPD
o Adult continuing care services
o Care co-ordination service

- Proportion of acute care, specifically in relation to:
  o People with multiple long term conditions
  o People with ambulatory sensitive care conditions

- Primary care services, such as:
  o Extended access services
  o Some specialist care offers

- Range of voluntary and community sector services

- Adult social care for older people and physical disabilities, including community and domiciliary support

- Staying healthy services

Given the services in scope, the funding envelope for a contract from 2020 will fall within an estimated range of £125million to £175m. This is an indicative value which will be subject to change over the development phase due to a number of variables, such as final confirmation of service scope, future financial allocations for commissioners and the application of inflation, uplifts and efficiencies.

This is an indicative value based on 2018/19 budgets and activity. The financial envelope will be set using latest activity and growth assumptions set against the underlying cost pressures and the efficiencies required to live within the available resources. This will be determined by the five year allocations for CCG, and Council settlements, and the requirements set out in the NHS Planning Guidance and Ten Year NHS Plan. We expect these to be issued in December 2018.
5.0 Making things happen

5.1 Implementation and phases

The big changes proposed will be phased to make sure partners focus on priorities and developments together and a strong grip is maintained on ambitious benefits realisation plans. These phases will need to align with a variety of enablers such as One Public Estate, digital and One London, workforce and culture change, and technical preparedness as part of Lambeth Together, South East London STP, and London Devolution initiatives. This will require careful planning of key developments to turbo-charge or rate limit change, such as a new integrated healthcare record, new buildings and fixed assets in the borough, mandatory priorities or pathway changes as part of wider collaborations.

We propose a series of phases pre and post contract phases as illustrated in Figure X.

Figure X: Phases of implementation and benefits realisation. (WORK UP BENEFITS MORE)
Much service and pathway development is underway in Lambeth community services (health and care) and this will continue at pace during 2019 with incumbent providers. Service change is often led by individual provider organisations in parallel, involving stakeholders as needed in specific aspects of change. In 2019, these improvements will need to be much more closely aligned to build the foundations of the Neighbourhood model, and much service improvement be approached actively as a joint endeavour amongst providers and partners, whilst retaining the organisational oversight of progress required.

5.2 2019/20 Shadow Year

January 2019 to April 2020 will be a shadow year

The current time-limited Local Care Network Leadership Group will end in December 2018 as previously agreed by partners, and governance will be refreshed for this important preparatory phase.

It is proposed that pathway and service developments relevant across primary care, community services (health and social care) and communities that are relevant to the refreshed Neighborhood Based Care and integration vision are aligned into a Lambeth Transformation Programme for 2019, and overseen by a Lambeth Transformation Board and Executive to ensure these critical service developments develop and evolve as one coherent

5.3 Procurement Process

The procurement timeline is illustrated below, subject to Council and CCG approval

Figure X: Procurement process and timeline (subject to approval)
5.5 Risks

Risk management will be overseen by refreshed governance (subject to approval) for Neighbourhood Based Care in 2019 during the Shadow phase

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Scale of the transformation</strong></td>
<td>Transformation programmes are underpinned by processes and methodologies that ensure effective design and delivery plans - particularly an ethos of co-production</td>
</tr>
<tr>
<td>Not achieving what we set out to do through ineffective design and mobilisation</td>
<td></td>
</tr>
<tr>
<td>Failure to manage business as usual and steady state during the phasing of the new model</td>
<td>Transition plans to be developed to ensure BAU and management of change and will be accompanied by resource where appropriate</td>
</tr>
<tr>
<td>Failure to manage transition</td>
<td>All service level changes will be underpinned by operational protocols that manage access, continuity of care and risk.</td>
</tr>
<tr>
<td>Failure to maintain engagement and interest of current LCN Forum members, particularly voluntary community sector during the transition/ shadow year</td>
<td>Incremental steps for transformation will be developed.</td>
</tr>
<tr>
<td>The ambition could be too big and not able to translate to organisational level</td>
<td>The LCN Leadership Group will scrutinise transformation plans on a monthly basis.</td>
</tr>
<tr>
<td>Failure to implement plans quick enough</td>
<td>A Senior Responsible Owner (SRO) will be accountable and responsible for specific transformational schemes.</td>
</tr>
<tr>
<td></td>
<td>Existing prototyping and work through the LCN Forums demonstrate the benefits of the voluntary sector, health and social care working together to deliver safe and effective care.</td>
</tr>
<tr>
<td></td>
<td>Incremental phasing of the transformation will be agreed and delivered.</td>
</tr>
<tr>
<td></td>
<td>Milestone planning will be robust and realistic with programme management and co-ordination to ensure delivery.</td>
</tr>
</tbody>
</table>
### 2. Coproduction, involving local people, workforce buy-in and cultural change

Lack of understanding of coproduction across the system, leading to tokenism and disengagement of local people and frontline staff

Coproduction seen as an ‘add on’ to the day job and not a culture change

Duplication of effort and inconsistency of approaches across Lambeth Together as Living Well Alliance, Local Care Networks and Lambeth Made (childrens strategy) all focus on coproduction/ codesign and engagement activities

Failure to effectively engage and include the workforce and local people with the proposed transformation

Workforce across the system are not sufficiently skilled to deliver the new ways of working

Failure to communicate the vision and change process to deliver the transformation

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| Coproduction partner working across Local Care Networks and living Well Alliance. To develop coproduction framework for Lambeth that aligns with Lambeth Made |
| Establishment of ‘communities of practice’, supported by training from the coproduction partner to build understanding and capability across the system around coproduction |
| Communications to the combined workforce will be supported by a plan and provided at regular intervals. Partner organisations will be supported to produce consistent but suitably frames communication messages |
| We will ensure redesign is described by what local people themselves have said about what works and what doesn’t work to ensure local people and people with lived experience are at the heart of the process. |
| A coproduction plan, alongside communications and engagement plans, will be developed that builds on front line staff/ local peoples involvement to date around the design of the neighbourhood based care/ health and wellbeing integrated model |
| The LCN Leadership Group will be visible and engage the combined workforce about the vision and how we are going to get there. This will be supported by the communication plan |
| A Senior Responsible Owner (SRO) will be accountable and responsible for specific transformational schemes |

### 3. Integration

Organisational silos continue despite working to delivery alliances principles in the shadow year

Failure to co-produce the new model across the system leading to lack of buy in and undermining of the LCN delivery alliance objectives

Provider organisations not developed in their system working to respond to the procurement of a delivery alliance

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| The LCN leadership Group will build on the trust and relationships developed through the LCNs |
| All system leaders will be signed up to working together through the Lambeth Together Strategic Alliance Leadership Team |
| Commissioning and contracts will support integrated working with shared objectives, shared risks/gains |
| There will be alignment of LCN delivery alliance aims with those of individual organisations to ensure success for LCNs mean success for each member |
| Funding for a comprehensive and tailored programme of Organisation, Team and Personal development programme will be sought to drive the required cultural change and build capability across partners to work together in an alliance |
| The leadership teams and workforce will be trained in Quality Improvement (QI) methodologies to support future change |
| QI driver diagrams will support the delivery and measurement of change |
| Evaluation and audit cycles will be embedded in all stages of the transformation and beyond |
| The development of internal Change teams will be encouraged-created and staffed by people from across organisations with appropriate external support and facilitation |
A Senior Responsible Owner (SRO) will be accountable and responsible for specific transformational schemes.

### 4. Shift to prevention and population health outcomes

Current system pressures and focus on managing immediate demand prevents sufficient focus on early intervention and prevention, thus failing to deliver the required changes in public behaviour and improvements in population health.

- Failure to invest in the community leading to continued over reliance on statutory services
- Failure to embed prevention/health and wellbeing offer into the neighbourhood based care delivery model

The draft outcomes framework is undeliverable, unmeasurable.

- The draft outcomes framework has been developed to reflect the ability of providers to impact on outcome measures
- A clear evidence base has been used to build the outcomes framework, ensuring deliverability
- Performance monitoring will reflect the achievement of outcomes, giving early indications of variance
- User feedback will be central to checking progress and success
- Analysis of population health needs and agreed system-wide plans for improving population health.

The neighbourhood model draws on local knowledge, expertise and assets to ensure maximum impact

Integration will ensure staff learn from other sectors and are able to deliver an holistic, person centred approach which draws on the individual’s abilities, networks and ambitions

MDT’s will include voluntary sector representation ensuring close working and knowledge of what is available locally

Building on work already started through the LCN Forums, health and wellbeing initiatives and support will be delivered in an integrated neighbourhood based model. A new neighbourhood connections (social prescribing) model for Lambeth will be developed and implemented

Work across LCNs and Lambeth Council (around community development, Lambeth Forums and Voluntary Community Sector infrastructure support) will be aligned to improve efficiencies and effectiveness.

Foundation Trusts engagement with national prevention/health and wellbeing CQUIN, Making Every Contact Count (MECC) and local Vital 5 roll out.

### 5. Leadership and governance

Failure to implement a shared leadership approach across the shadow LCN delivery group.

- Unclear decision making across the partnership and delegated authority for decision making to LCN Leadership Group not realised
- The partnership cannot deliver what it has set out to do due the governance frameworks of the providers

The principles of alliance working will be incorporated at all levels of leadership and appraised.

Lambeth Together Strategic Alliance Leadership Team will be responsible for monitoring and addressing any failings in performance against agreed alliance principles

Transparent work programme that constituent organisations lead and implement will be developed.

Effective collective decision-making processes will be agreed across the partnership.

### 6. Enablers

Failure to deliver a realistic estates strategy that will meet the needs of the service offer. Its unclear whether adequate physical space exists to support the delivery of the neighbourhood model.

Failure to deliver a realistic digital strategy that supports

Implementation of an estates strategy that reflects the resources available and future estate requirements to deliver the service model.

The implementation of the model will be different in each neighbourhood, reflecting available resources. Co-location of frontline staff, enabling integration and collaboration will be considered
<table>
<thead>
<tr>
<th>Communication, continuity of care, digital “interventions” and access to services.</th>
<th>Estate will be considered across sectors rather than in silos (with commitment to avoiding variable and disproportionate pricing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational delivery of the new model will be inhibited due to an inability to effectively share data.</td>
<td>Where less than ideal estates solutions are available applications for new funding through national funding opportunities will be made as and when they arise.</td>
</tr>
<tr>
<td>Failure to increase out of hospital capability and capacity to deliver the quality care for people in the community by successfully recruiting a new type of workforce whilst retaining, developing and retraining existing teams.</td>
<td>New working patterns and enabling technology will allow greater flexibility and more efficient use of estate.</td>
</tr>
<tr>
<td>Information sharing agreements have been signed between all partners (including primary care through the GP Federations) for direct patient care. Further data sharing agreements will be progressed to support outcomes and evaluation.</td>
<td>Information sharing agreements have been signed between all partners (including primary care through the GP Federations) for direct patient care. Further data sharing agreements will be progressed to support outcomes and evaluation.</td>
</tr>
<tr>
<td>There will be a shared data set developed by the provider organisations under the shadow LCN delivery group.</td>
<td>New working patterns and enabling technology will allow greater flexibility and more efficient use of estate.</td>
</tr>
<tr>
<td>Local Care Record - care planning scoping and developments will ensure shared view and reduce duplication around the care plans.</td>
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</tr>
<tr>
<td>MDT’s and integrated working will ensure close practitioner to practitioner relationships, enabling sharing of knowledge in the best interests of patients.</td>
<td>MDT’s and integrated working will ensure close practitioner to practitioner relationships, enabling sharing of knowledge in the best interests of patients.</td>
</tr>
<tr>
<td>Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care.</td>
<td>Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care.</td>
</tr>
<tr>
<td>A Senior Responsible Owner (SRO) will be accountable and responsible for enablers.</td>
<td>A Senior Responsible Owner (SRO) will be accountable and responsible for enablers.</td>
</tr>
</tbody>
</table>

### 7. Financial and performance

Failure to successfully reduce the system-wide cost of delivering health and social care services to our population cohort against a background of a system with significant challenges in the key national performance targets (both planned and unplanned care) and current regulatory Intervention.

Significant financial challenges felt by key provider partners and uncertainty for commissioners in light of movement away from historic contracting approach (i.e. KCHFT)

Inadequate resourcing of the transformation/ change team to support the implementation of the delivery alliance.

**To be checked and added to by**

Providers will implement a shadow alliance supported by integration agreements setting out delegated authority powers. The LCN Leadership Group will have delegated authority for in scope LCN delivery alliance services and will performance manage the benefits realisation plan.

Financial saving/contribution to forecast deficit reduction - pooled budgets, shared approach to investment and expected efficiencies, agreement on how costs and savings will be shared.

Agreed performance improvement and sustainability commitment - shared commitments and deliverables.

Dedicated capacity and infrastructure to execute system wide plans will be agreed through the partnership.

Shared set of principles to manage finances collectively will be agreed and tested in the shadow year.

### 8. Contractual

Challenges associated with the movement away from historic contracting approach (i.e. KCHFT) and huge uncertainty facing commissioners as to contractual

[Christine/ Moira best placed to write mitigation here?]
and financial implications, not just within the acute contracting portfolio, but right across commissioning budgets

| Significant resource requirements to successfully implement Alliance contract process involving diverse group of provider partners |
| To be checked/added to |

Dedicated capacity and infrastructure to execute system wide plans will need to be agreed through the partnership

Shared commitment across providers and commissioners to Alliance contracting approach

6.0 Conclusions and Recommendations

This paper sets out the case for change and a consolidation of our proposed approach for Lambeth. This is based on the work of the past few years, experience and testing of different approaches to working with people in Lambeth and our local workforce and emerging evidence from elsewhere in the country.

We are asking partner organisations, stakeholder organisations to endorse this approach, discuss within their organisation and to work together to start to take out to test with more people in Lambeth and frontline staff so that we can co-produce the delivery of change.

The CCG and council will be working on the proposed procurement approach, co-producing the defined outcomes building on work already undertaken and developing the proposed financial model/envelope for a longer term agreement including growth and savings

Partners are asked to work together to agree the next stage governance from Jan 2019-March 2020.

7.0 Appendix to follow:

Alignment with STP
Proposals to developing the scope and purpose of Health and Wellbeing Networks
Changing Needs of Lambeth (detailed info)
Benefits case of propose interventions (illustrative)