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

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

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• Outcome development timescales adapted  
• Initiation and Shadow Phase redefined |
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This proposal sets out the vision, aims, scope and timetable to deliver our refreshed ambition for Local Care Networks (LCNs) in Lambeth, through Neighbourhood Based Care and Wellbeing.

It is intended that 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 per annum. It will bring health, care, and voluntary and community organisations together in partnership with one budget to deliver a set of shared outcomes for the adult population of Lambeth. Initially, ‘Neighbourhood Based Care’ and ‘Health and Wellbeing’ were proposed as two separate delivery alliances in Lambeth Together. We now recommend one delivery alliance, one integrated model and one contract through a Neighbourhood Based Care and Wellbeing Delivery Alliance.

Three locality-based Local Care Networks are well-established partnerships in Lambeth focussed on improving the health and wellbeing of local people by services and communities working together. Key achievements have been connecting people, community organisations with health and care staff, breaking down boundaries and building trust. We now need a big step change in our community based integration efforts. It is clear a new delivery model is needed to better manage demand, shift investment into prevention and early intervention, and mitigate demand for high cost care such as hospital admissions and high cost packages of care.

The drivers for change are compelling, as we see marked inequalities in the borough, changing needs of our Lambeth population, variable experience despite our attempts to collaborate and integrate, and significant pressure on many of our services and our workforce.

Reimagining Local Care Networks sets out the framework of the proposed future Neighbourhood Based Care and Wellbeing model and recommendations to transform our borough wide integration of services, align integration of health, care and community services, with a focus in 9 to 12 neighbourhoods across Lambeth.

Neighbourhoods are an important principle of this new model, as a natural place where community assets, services and local people partner to improve people’s 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 propose structural or organisational change, and thus big changes are needed in partnerships, culture, behaviours and ways of working to achieve the vision.

We propose significant development of borough wide services to support neighbourhoods that include further streamlined points of access; effective multi-disciplinary working; a continued shift towards holistic, and multi-morbidity services and interventions; increasing connections to community assets; bringing together of urgent, 24 hour and Rapid Response services to prevent admissions, and a population health orientation and preventative interventions.

Change will be phased so there is a collective focus on common 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.
The funding envelope for a **contract from 2020 will fall within an estimated range of £125million to £175million**. This is an indicative value which will be subject to change over the coming months 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. A wide range of service areas across the health and care system in Lambeth fall within the scope of the Delivery Alliance and which we anticipate will come under new contracting arrangements from 2020.

Pending approval, **January 2019 to April 2020 will be a preparatory shadow phase** to the delivery alliance, and a critical phase of delivery. The current time-limited Local Care Network Leadership Group will end in December 2018 as previously agreed by partners, and refreshed governance will be put in place for this important phase of preparation and delivery.

Subject to CCG and Council approvals, **procurement will be undertaken to secure a partner from April 2020**, and a provisional timeline is summarised within this document, alongside the gateway and check points required of the Integrated Support and Assurance Process. Contractual and integration options will be fully considered prior to these timescales to ensure the optimal vehicle and approach is being taken.

We are seeking **endorsement of the organising and delivery principles** set out in this proposal and **support to proceed with further development** of the delivery alliance. This requires:

- Partner and stakeholder organisations to endorse this approach, to discuss within their organisations, and to test with local people and frontline staff, so we can co-produce the delivery of change.
- Support for the CCG and council to work 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 to work together to agree the next stage governance from Jan 2019 – April 2020.
2.0 Introduction

2.1 Purpose
This proposal sets out the vision, aims, scope and timetable to deliver our refreshed ambition of Local Care Networks (LCNs) in Lambeth, through Neighbourhood Based Care and Wellbeing.

It is intended that 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 per annum. It will bring health, care, and voluntary and community organisations together in partnership with one budget to deliver a set of shared outcomes for the adult population of Lambeth.

This proposal sets out the framework for refreshed ambition for Local Care Networks and outlines a plan for change including:

- Case for change – why we need a new model of care in Lambeth
- Vision, aims and benefits for people delivering and using services
- Emerging model - neighbourhoods of person centred, coordinated services and health and wellbeing initiatives
- Strategic approach to make the change and deliver the benefits

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 proposal include:

- NHS Five Year Forward View (5YFV) and Next Steps (NHS England, 2015 & 2017)
- Integrated care systems and Sustainability and Transformation Plans (STPs)

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 this national context, the London Health and Care Devolution act enables London to have greater autonomy in making decisions about its health and care services. This includes a focus on joining up services and aligning decisions about where and how these services are provided; making better use of NHS buildings and land, with NHS trusts incentivised to sell 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.
2.3 Local Context
Lambeth has a long history of innovation, partnership working and collaboration akin to the integration ambition set out in the NHS Five Year Forward View; and aligned to the emerging themes of the NHS long term plan.

**Lambeth Together** is Lambeth’s integrated care partnership, bringing together care providers (acute, primary, mental health, social care and voluntary sector), the local council, and community and voluntary sector organisations to work together to address the health and care needs of the local community through delivery alliances. Lambeth Together is fully aligned to the integration ambitions of South East London’s STP and Aspirant Integrated Care Systems (ICS) and the Local Care Network/Neighbourhood Delivery Alliance sit within this, as illustrated below.

**SOUTH EAST LONDON INTEGRATED CARE SYSTEM – SYSTEM OF SYSTEMS (Care Partnerships)**

The South East London STP has an agreed overall ICS end state roadmap – set out below. This demonstrates the:
- Work the STP is doing with other STPs focussed on tertiary and highly specialised provision and mental health
- Work within the STP to support neighbourhood, borough, pan borough and pan South East London delivery models
- The underpinning clinical programmes that will drive the underpinning care pathway redesign
- The South East London enabling programmes that will ensure fit for purpose infrastructure
- The STP as the overarching governance, organising and strategic function

The proposed Neighbourhood Based Care and Wellbeing model plays an important function within the existing health and care system in Lambeth at three different levels as illustrated below in Figure 2:

- **At STP level:** as a partner in the STP and in London, a system within a system
  Neighbourhood Based Care and Wellbeing in the LCN Delivery Alliance supports high quality community based care as part of Lambeth Together and Our Healthier South East London. It brings key partners across the system and community together to address the health and care needs of the local community.

- **At a borough level:** integrating across the borough

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1 Source: South East London STP, 2018
Neighbourhood Based Care and Wellbeing will enable high quality borough wide integration, support primary care networks and build resilient communities. The progression of Local Care Records and borough level prevention and public health initiatives will continue, alongside other services that need to take place at borough level.

- **At a neighbourhood level:** based on Lambeth’s town centres / natural geographies
  Neighbourhood outcomes are aligned to those at borough and STP level, with flexibility to tailor offers, services, and delivery approaches to the needs of local residents, working closely with the voluntary and community sector.

![Diagram showing STP integration, Borough wide integration, and Neighbourhood based teams]

Within Lambeth Together, the Living Well Network 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 a commitment to integrated commissioning between health and social care, collaborative commissioner-provider working and a co-productive approach. The approach, which was piloted through our Integrated Personalised Support Alliance (IPSA), has already delivered significantly improved outcomes for people with mental illness, and generated cost savings.

### 2.4 Local Care Networks (LCNs): the journey so far

Local Care Networks are well-established locality-based partnerships focussed on improving the health and wellbeing of local people by services and communities working together. The journey summarised below shows the wide range of initiatives that have been championed, and case studies throughout this paper illustrate the potential impact of strengthening our neighbourhood partnerships further.
Figure 3: The journey so far

LCNs have supported the development of a care coordination pathway to improve patient experience, quality of care and outcomes for people with complex multiple long term conditions. Whilst retaining a local population health focus, LCNs have developed projects identified by local people and staff. Key achievements of LCNs have been connecting local people and voluntary community (VSC) sector organisations with health and care staff, establishing new partnerships, breaking down boundaries and building trust.

Within Lambeth, local services, communities and staff continue to pioneer new ideas, innovations and projects year on year. These initiatives contribute to making improvements in health and care. For example, despite national trends of rising emergency admissions, as a result of local initiatives, these have been contained in Lambeth for specific populations such as older people. Examples of community led initiatives include Time-banking, Project Smith, SAIL and Citizens Forum, and highlight the vast amount of community assets that sit within Lambeth.

In reimagining Local Care Networks, we build on these strengths, commitment and partnerships further.
3.0 Case for change

Fragmentation  Tackling inequalities  Culture change

Changing health needs  Financial gap  Variable outcomes

Figure 4: The case for change

3.1 Changing 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.

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.

There is a predicted 9% increase in residents predicted by 2025, and a significant increase in the over 85 population. Further detail can be found in Appendix A.

Figure 5 2016 Lambeth male/female pyramid

Figure 6 Lambeth demography

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There is a predicted 9% increase in residents by 2025, and a significant increase in the over 85 population. Further detail can be found in Appendix A.

3.2 Inequalities and Outcomes in Lambeth
Nearly one third of the population of Lambeth live in areas which are among the most deprived 20% of areas in the country and approximately 23% of children (12,400) live in low income families.\(^4\)

**Index of multiple deprivation (IMD) 2015**

- The Index of multiple deprivation (IMD) measures the level of deprivation in small areas of geography known as ‘lower-layer super output areas’ (LSOA) in England and ranks each LSOA (about 1,500) people according to how deprived it is compared to the others.

**Map of Lambeth LSOAs by quintile\(^*\) of deprivation**

- 83% of the population of Coldharbour ward live in LSOAs ranked among the most deprived 23% of LSOAs in England
- Only one LSOA in Lambeth, part of Thornton ward, is ranked among the least deprived 20% of LSOAs in England

\(\text{"*The use of lower-layer super output areas (LSOAs) is a standard way of dividing the country. They are designed to be of a similar population size with an average of 1,500 residents in each.\"}

\(\text{"*A quintile is one fifth (20%) of the population. It divides the population into five quintiles, we can compare them.\"}

Copies of this, and other public health profiles, are available from the Lambeth 1014 website: www.lambeth.gov.uk

Health inequalities are avoidable; they are unfair differences in health status between groups of people or communities. In Lambeth, health status differences include:

- Men in Lambeth on average have a shorter life span by 1 year compared to England. Within Lambeth there is a 4 year difference in life span between the most and least deprived areas of Lambeth.
- For women there is very little difference compared to England but within Lambeth there is a 6 year difference in life span between the most and least deprived areas.\(^5\)

\(^4\) PHE, Lambeth Local Authority Health Profile 2018.

\(^5\) PHE, Lambeth Local Authority Health Profile 2018.
• The differences are even greater for “healthy” life expectancy – on average men and women can expect to live in poor health for 17 (range 14-21) years and 21 (range 18-27) years respectively.
• Local analysis shows that after controlling for deprivation and sex differences, children from all ethnic groups are more likely to be obese and children from Black Caribbean and South Asian groups are twice as likely to be obese at age 10/11 compared to white British children in Lambeth. Obesity is an important risk factor for a range of long term conditions including diabetes, heart disease, stroke and musculoskeletal conditions.
• Lambeth multiple long term conditions study suggests that Black groups are likely to develop multiple long term conditions 10 years earlier.
• Local studies on blood pressure control also show that Black and minority ethnic groups are more likely to have a blood pressure measurement but less likely to have their blood pressure controlled compared to white British groups.
• National studies show that Black men are reported to have higher rates of psychotic disorders compared to other ethnic groups.

Differences are mainly due to avoidable deaths from cancers, cardiovascular and respiratory conditions which can be prevented (smoking, diet and blood pressure prevention programmes) and early identification and management of these conditions.

Lambeth has higher levels of social deprivation. Income and health are strongly associated particularly for children in low income families and deprived older people. Although working age employment levels are high the most vulnerable (people with learning disability and mental health issues) are less likely to be employed. Other factors that impact on health inequalities are the environment (including housing and homelessness), educational attainment, and levels of crime. At a national level Public Health England (PHE) has reported ethnic differences in the wider determinants of health as well as other factors that may impact on health & wellbeing outcomes.

**Case study 1: Holistic support for Portuguese speaking residents**

With a large Portuguese speaking community in North Lambeth, local staff noticed that outcomes were often worse and people tended to attend A&E more. The Lambeth Portuguese Wellbeing Programme has brought together medical professionals and community experts to do joint care coordination person centred assessments with Portuguese-speaking residents, to better understand support needs, medical and beyond.

### Luiz’ story

Local resident Luiz, originally from Brazil, suffers from a heart condition, type 2 diabetes and anaemia. He lives on his own and he doesn’t speak much English. During a care coordination assessment, Luiz explained he felt stressed by debt and having to rely on family for help. He felt isolated and talked about how his only social interactions were seeing his family infrequently, going to medical appointments and talking with his landlord in basic English when he comes to collect the rent once a month.

A community liaison officer was able to speak with Luiz in his native language, build 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".
3.3 Health Differences across neighbourhoods in Lambeth
We have selected three wards in Lambeth (Tulse Hill, Streatham South and Stockwell) to illustrate some of the health-related differences between neighbourhoods within Lambeth. In developing deeper understanding of needs in neighbourhoods, services can be tailored to local communities needs in innovative and localised ways.

Analysis highlights the different local needs and can be found in Appendix B.

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<tr>
<th>Streatham South</th>
<th>Stockwell</th>
<th>Tulse Hill</th>
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<td>Older population (12% &gt;65 years)</td>
<td>All cause emergency admissions and stroke admissions are higher than the England average</td>
<td>More pensioners living alone, and more older people in deprivation than England average</td>
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<tr>
<td>Contains some of the least and most deprived areas of England</td>
<td>All areas of Stockwell are within the 40% most deprived areas of England</td>
<td>More overcrowded than the England average</td>
</tr>
<tr>
<td>Admissions for stroke, COPD and myocardial infarction are lower than the England average</td>
<td>More pensioners living alone, but also more overcrowding than the England average</td>
<td>Higher incidence of prostate cancer than England average</td>
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Figure 9 Health difference in Tulse Hill, Streatham South and Stockwell

3.4 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

Like many other parts of country, our system is sometimes complex and confusing. This is not only frustrating and difficult for local people, but also for staff working within our system. Both staff and local people see duplication, repetition and waste alongside the gaps, fragmentation and hand offs. Following people’s journeys, such as Lambeth Healthwatch’s ‘Going Home’, bring to life how this can feel.

Many of our services are under extreme pressure with a challenged workforce and high vacancy rates in key parts of our system. We know that well intended strategies to manage demand and other pressures can lead to unintended consequences. We need to reset the system in neighbourhoods and borough wide community services to achieve a fundamentally different set of goals, and outcomes.

There is strong international evidence that effective integration of care provides better patient experience. 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. The national vanguards are underpinned by a commitment to commission on the basis of improving outcomes, not on the basis of activity or services undertaken. These improvements can only be effectively delivered when providers of care work together in fundamentally new ways.

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6 Source: Lambeth Public Health analysis, 2018 (icons courtesy of Freepik.com)
7 York University literature review supporting the Salford Together ICO Outline Business Case, November 2015
Lambeth currently operates a series of separate contracts with providers, each with 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.

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

<table>
<thead>
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<th>Theme</th>
<th>What matters to local people</th>
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| **Delivery of high quality care** | • Build the skills to self-manage and live independently as much as possible.  
• Make things simple, join them up, reduce the duplication and fragmentation, have greater ease.  
• Ensure we know what is available, how to access services, urgent and routine.  
• Remove barriers (eg physical and mental health services, single conditions, different waiting lists or queues, multiple complex criteria for a complex array of services).                                                                                                                                                                                                 |
| **Culture and ways of working** | • Staff and services treat each other equally, with respect, across sectors, disciplines and grades (break down the barriers across sectors, professional groups and seniority).  
• Staff have the time and capacity to share and learn across teams, services and the system.  
• Work in an environment and system where they can learn from mistakes.  
• Work more closely with others, including the voluntary and community sector, to provide better care.                                                                                                                                                                                                                                         |
| **Community engagement**       | • Create the conditions that encourage people to get involved in community activities.  
• Remove the barriers such as transport and affordability.                                                                                                                                                                                                                                                                                                                                                          |

Table 1: Engagement themes

3.5 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 the growing demand for health and care. This means we face challenging conversations with local people about how to improve their health and wellbeing within the resources available.

This dilemma is not unique to Lambeth, nor more broadly for other public services where key areas of support 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. 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 comparatively low financial growth since 2008 (between 2-3% on average) but this has not kept pace with growing demand linked to the increase in older

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8 Source: Engagement Review 2018, C. Hobart
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.

Locally NHS acute trusts face huge financial challenges and Kings College Foundation Trust is one of the 5 most financially challenged Trusts in the country. Lambeth CCG also faces significant financial challenge, with local demand for hospital care having outstripped CCG funding increases since 2014/15 as shown below.

![Figure 10: Cumulative allocation and secondary care activity 2014-2018](image)

Whilst emergency inpatient demand is relatively contained in Lambeth, due to a series of successful local admission avoidance services, the complexity and acuity of patients who do have an unplanned admission is increasing, as are the associated costs. Acute planned care has seen significant growth, particularly via GP referrals.

It is clear that new models of care are needed to better manage demand, 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 in Lambeth and we must build upon these:

- The number of emergency admissions of Lambeth residents is contained – this unplanned care growth containment must be continued and new care approaches 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 are placed in residential and nursing care mostly associated with advancing dementia. However we are now seeing many home based packages of care exceeding the cost of bed based care in the community, which place challenges on how to offer choice of types of care to. For many people who go home from hospital with intensive support when required; a particular 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 shows 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.

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9 Source: Integrated Contracts and Delivery Team analysis, 2018
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.

3.6 What this means for the future of Local Care Networks

There is a clear need for change at a greater scale and pace, building on existing work and collaborative efforts. The future model proposed for LCNs, outlined in detail in section 4, seeks to realise the aspirations of integrated care to better meet the health and needs of local people in Lambeth, within the context of demand and capacity issues, financial pressures and varying health outcomes for different communities in Lambeth.

It presents a significant change, to an integrated community-based care model, with a shift of resources towards prevention and early action, a stronger relationship with the voluntary and community sector and a better use of Lambeth’s community assets recognising the need for holistic care. It builds on the partnerships, relationships and collaborations that have already been developed, with an ambition to integrate at scale and pace. It is underpinned by one alliance contract that will bring partners across health, care and the voluntary and community sector together, working to shared outcomes and priorities within a single overall budget. The foundations and success of this model rest with cultural change and a change in ways of working across health and care providers and those in the voluntary and community sector.

Amongst the strengths of this model is that it allows for neighbourhoods to take differing needs of their local communities into account, providing care in an equitable way to meet different needs. With the correlation between deprivation and poor health outcomes with higher incidence of long term conditions and earlier onset of disease; and some ethnic groups experiencing 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), neighbourhood based models are better placed to address these challenges.

The proposed model also allows for a refocus on early interventions and prevention, working closely with community services and with the voluntary and community sector. The broader ambition of this model includes influencing the social-economic factors that impact on health of people in Lambeth.

**Case study 2: Reducing social isolation through community connections**

A multiagency wellbeing tea party was facilitated by a local pharmacy- Hills Pharmacy- in partnership with Voluntary Community Sector organisations following connections made at a LCN forum meeting.

The event enabled older people living in sheltered housing to connect with agencies who were able to provide them with social and wellbeing opportunities locally. This resulted in residents engaging with physical activities through Black Prince Trust and befriending and social activities through South London Cares. There was also some interest in advanced care planning with support from Compassion in Dying.
4.0 Re-imagining Local Care Networks: Neighbourhood Based Care and Wellbeing

4.1 Vision and aims
Our vision, developed by local partners and community stakeholders is focussed on improving health and wellbeing; and quality of care in neighbourhoods is to:

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

The aims of Neighbourhood Based Care and Wellbeing are:
- Maximising wellbeing
- Working together
- Achieving value and quality

We will know we have achieved this when local people tell us they¹⁰:
- Live independently as they want and can
- Live the life they want
- Are part of their community
- Are as healthy as possible
- Are at the center of their care and support: where care is organised around them
- Experience the smallest possible disruption to their lives when crisis happens
- Manage their own conditions and get support to do this if they need
- Feel safe and respected, their dignity is maintained and they do not experience discrimination or harassment

Success requires:
- Fundamental change in culture, behaviour and ways of working
- All staff to work beyond organisational boundaries
- Strong connections between statutory service and local voluntary and community sector initiatives
- Shift to person-centered holistic care where social interventions are considered equally alongside medical ones
- Clear focus on early help and prevention, taking a holistic approach, so people in neighbourhoods feel able to help themselves and one another, accessing support (medical, social and community) when they need it.

*Neighbourhood Based Care and Wellbeing* will focus on population health across the borough and within neighborhoods in Lambeth as illustrated overleaf in Figure 11.

¹⁰ Engagement themes from over 40 local initiatives
This will be underpinned by one integrated alliance contract, bringing partners together to collaborate, co-design and agree shared priorities and outcomes, within a single budget. To achieve this transformation, all partners will need to embrace collaborative leadership, moving away from traditional concerns of eligibility, resource protection and risk management, towards what makes communities healthy and well. Resources to support living a healthy life will need to be understood as more than traditional services or stand-alone offers. Rich community assets will need to be acknowledged, with trusting relationships between partners, where all offers are valued equally.

4.2 Building on Lambeth’s community assets – health and wellbeing in neighbourhoods
A large proportion of our health outcomes and needs derive from social and economic determinants outside our existing health and care system\(^\text{11}\). Inherent within our neighbourhood model 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 health and wellbeing.

Through the on-going engagement with local voluntary and community sector organisations through LCNs, it is clear that to utilise local community assets fully, we need to:

- Support community assets to develop, grow and thrive
- Facilitate connections between community assets so that they can function as a network or group
- Facilitate connections of people to 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 with staff across health and care provider organisations e.g. training (e.g. MDT), staff forums, networking.

\(^{11}\) https://health.org.uk/publication/healthier-life-all
We recognise that we need more time to further develop our approach and foster the required conditions to begin changing culture, and will be collaborating with colleagues from Living Well Network Alliance and Children and Young People /Lambeth Made to collectively scope how we can support health and wellbeing initiatives in neighbourhoods. There are a wide range of local community assets that can help support and improve health and wellbeing that are not fully utilised, are fragmented and are not connected to the health and care system. 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 and care system.

We therefore propose a 6 month process to engage with a wider range of stakeholders to co-design how best to maximise health and wellbeing in neighbourhoods:

- Applying a “co-productive” approach where all participating have equal voice and value in the process.
- Engaging 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).
- 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 are outlined in Appendix C.

*Case study 3: Personalised support and care coordination for people who frequently attend Accident and Emergency (A&E)*

A 65 year old male with learning difficulties was identified as requiring support due to attending A&E 32 times in the last quarter. The client lives in supported housing with a care package (support workers visiting 4 times a week).

The client has a urinary catheter and all of his attendances at A&E related to the catheter (many for non-urgent reasons). The client also appears to suffer from boredom. When he has money he goes to the pub, but often spends long periods alone.

A high intensity project worker visited the client frequently. An incentive scheme was established to encourage the client not to go to A&E for non-urgent catheter related issues. The worker offered to escort the client to the hospital if there were any problems with the catheter and this offer was explained to his support workers.

The client was referred to Platform One Café which provides work placements for individuals with learning difficulties as the client has previously done a basic catering qualification. The client had a fungal scalp infection. The worker supported the client to get medicated shampoo from the pharmacist. The worker visited on a number of occasions to wash his hair with the medicated shampoo. This responsibility has now been returned to his support workers.

The worker has liaised with the GP and encouraged support workers to book appointments with GP as the client initially refused to attend the practice. As a result of the support provided by the high intensity project worker the client’s A&E attendances have since reduced to zero.
A co-ordinated and connected voluntary and community sector is a core component of neighbourhood based care and wellbeing and performs a range of different roles: acts an agent and voice for the local community, supports the health and wellbeing of local people, and connects people with each other and with support in their area. The case study above, and the figure 12 below illustrate the potential of sustainable collaborations between health, care, and communities to maximise health and wellbeing.

4.3 Neighbourhood Based Care

We propose that neighbourhood based care is organised around neighbourhoods that reflect natural geographies and communities of the borough and mirror the places where local people live their lives. These should not be artificially designed; in fact most of the collaborations progressed through our locality based Local Care Networks have taken place in local neighbourhoods e.g. Minet Green, Stockwell, Kennington, Clapham Park. We would expect to see 9 - 12 neighbourhoods in Lambeth and are not proposing ‘hard’ boundaries, rather boundaries between neighbourhoods will be intelligent and permeable, offering a seamless service to residents with capacity for collaborative service delivery and sharing of resources.

Neighbourhoods will work to a single common purpose, promoting continuity of care for local residents, with health and care professionals working together with local voluntary and community groups to take a more holistic approach to health and wellbeing. Some examples of how services could work in this model are:

- **Neighbourhood based community nursing**\(^{12}\): nurses will work in 9-12 small teams, visiting their patients by foot (max. 20 minute walk) enabling them to spend more time with their patients whilst also taking a more holistic approach e.g. as well as changing a

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\(^{12}\) https://www.buurtzorg.com/about-us/buurtzorgmodel/
dressing or giving medication, connecting patients with care navigators to access support through community assets, addressing loneliness or isolation for example.

- **Neighbourhood community support**: home-care support in the community are closely linked in with the community nursing team so that support is aligned, and strong close working develops between staff, teams and local families/clients/customers.

- **Neighbourhood GP clusters**: General practice is at the heart of our neighbourhood model as the first port of call for many providing accessible, expert, generalist, whole-person care. Clusters of practices are coming together geographically to collaborate with a focus on neighbourhood working and sharing of resource and skills. This will enable practices to develop stronger relationships with each other and other system providers, improve the quality of care, support workforce development and increase positive patient experience.

- **Neighbourhood connectors and navigators**: there are a wide range of people who connect, signpost, navigate in their local area. These will be networked, sharing assets, resources, information and supporting local people to access community support. Community referrals (also known as social prescribing) will be accessible and tailored to local neighbourhoods.

There will be better communication between staff and teams, who will often be co-located, eroding perceived care boundaries and addressing people’s experience of fragmented care. This will 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, sharing data and recording systems, thereby making the best use of resources available.

**Case study 4: Improving health and wellbeing of people with complex health conditions through care coordination**

A 47 year old female was seen by a practice in Clapham for a health and wellbeing assessment as part of the care coordination pathway. She had been caring full time for her father for 13 years and he had recently passed away. She was socially isolated and had lost all her confidence. It was agreed during the assessment to make a referral to Age UK Safe and Independent Living (SAIL).

When the SAIL navigator visited her at home, she reported that she was not eating very well and that she had no friends. She would like to get a job as she sits indoors all day just staring out of the window. She was suffering from the loss of losing her father and felt that she didn’t have a purpose.

The SAIL navigator explored what was important to her and what she would like to change. The SAIL navigator supported her to sign up for an IT class (a small class of 5 people which was less intimidating for her). She attended the class and really enjoyed it. She even went for a coffee afterwards with one of the other women that started the class that day.

The SAIL navigator phoned her after a few days to check in with how she was doing and she was getting ready to go to her class for the second week and is now thinking of volunteering for Age UK to become a befriender. A change in her mood was noted, she was more positive and energised. The SAIL navigator will continue to follow up with the woman until they both feel she is able to cope.
support broader health and wellbeing. This will increase holistic and preventative care, whilst also utilising the resources of the voluntary sector and community assets\(^{13}\) in a more coherent and comprehensive way.

![Figure 13: Neighbourhood based services and assets (illustrative)](image)

Whilst all neighbourhoods in Lambeth will have agreed an overarching set of health and wellbeing priorities, there is not a single ‘recipe’\(^{14}\) or answer on how to achieve these goals. Care delivery, service roles and local provision will be co-designed for what is ‘best’ for individual neighbourhoods. The strength of a neighbourhood based model is that it provides scope for health and prevention priorities to be locally decided, based on the needs and preferences of local people. This, in turn, will reduce inequalities by targeting services and support around the health and wellbeing needs of local residents.

### 4.4 Key features of the borough model

We propose the following features for borough based services (based on national and international best practice\(^{15}\).) These should be further developed, co-designed and co-produced by partners working together with local people as a delivery alliance. How borough services work within neighbourhoods will be a critical development priority.

These key features are:

- Further streamlined points of access - integrated for health and social care including more signposting to 3rd sector.\(^{16}\)
- Enhanced effective multi-disciplinary teams for time limited interventions for complex patients resulting in lower bed utilisation and fewer delayed discharges.

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\(^{13}\) North Manchester integrated neighbourhood team

\(^{14}\) Better care together Morecombe bay ICC

\(^{15}\) Case studies including Morecambe Bay, North Manchester, Salford, Canterbury New Zealand

\(^{16}\) [https://moderngov.denbighshire.gov.uk/documents/s18921/App%201%20SPOA%20Report.pdf?LLL=0](https://moderngov.denbighshire.gov.uk/documents/s18921/App%201%20SPOA%20Report.pdf?LLL=0)
A continued shift towards holistic, and multi-morbidity services and interventions with a demonstrable reduction in specialist secondary care costs.\textsuperscript{17} An increased 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 clinics (providing 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. A wider range of professionals in primary care and in neighbourhoods e.g. pharmacists, physiotherapists etc.\textsuperscript{18} 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). Public health support, population health orientation and preventative interventions. Integrated teams for specific conditions avoiding complex pathway service navigation and fragmentation.

### 4.5 Potential Benefits

The features set out in the future model for Neighbourhood Based Care and Wellbeing are based on international and national best practice, many of which describe benefits achieved elsewhere. We have mapped these benefits to illustrate the potential impact of this new model of care in Lambeth in the shorter and longer term if implemented effectively. Further detail is outlined in Appendix D.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Public health, population health and preventative interventions | • Wide range of health and wellbeing benefits dependent on type of intervention  
• Many are cost effective or provide a return on investment (including within 5 years) |
| Integrated dataset | • Reduced A&E admissions and unscheduled admissions |
| Integrated teams for specific conditions | • High patient satisfaction and holistic care  
• Improved condition and risk factor management  
• ↓ admissions and shorter lengths of stay  
• Reduced costs |
| Wider range of professionals working within neighbourhoods | • ↓ prescribing costs and medication side effects  
• ↓GP workload |
| Further bringing together of urgent response services | • ↓A&E attendances and emergency admissions  
• ↓ risk of future admissions (e.g. falls prevention) |
| Involvement of the voluntary sector and community assets | • ↑Happiness, wellbeing, self-confidence and community contact in volunteers  
• Reduced social care costs  
• Increased voice and control for people, equity and social connectedness  
• ↑health literacy, motivation confidence and skills in self care\textsuperscript{i}  
• Protective effect on service demand\textsuperscript{ii} e.g. A&E, outpatient appointments, admissions.  
• ↓GP visits  
• ↓Cost/ return on investment  
• ↑Quality of life |

\textsuperscript{18} https://www.england.nhs.uk/gp/case-studies/wallingbrook-health-group/
Use of care navigators/well-being advisors

- ↑ assessment and identification
- Support for discharges
- Improvement in self assessment scores

Integrated local MDT working

- Reduced secondary care use- A&E, outpatients, admissions
- ↓ admissions and length of stay for care home patients.
- Improved staff satisfaction and retention
- Improved patient experience
- Reduced wait time for GP appointments
- Patients receive care closer to home
- Community led health and wellbeing initiatives
- Population health benefits

Local care Record and integrated care records

- ↑ efficiency, including ↓ clinician time.
- ↓ referrals and investigations ordered
- Positive effects on patient/clinician relationships and on workforce.
- ↓ missing notes/records

Use of community spaces

- ↑ social inclusion, prevent isolation
- ↑ social and emotional wellbeing
- Supports volunteer led activities

Table 2: Benefits from integration evidence

4.6 Scope of Contract and Financial Value

The funding envelope for a contract from 2020 will fall within an estimated range of £125million to £175million. This is an indicative value which will be subject to change over the shadow 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.

There are a wide range of service areas across the health and care system in Lambeth which fall within the scope of the Delivery Alliance and which we anticipate will come under new contracting arrangements from 2020 as set out below. However, this is not exhaustive and may change over the development phase:

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

- Proportion of acute care, specifically in relation to:
  - People with multiple long term conditions/multiple morbidity
  - People with ambulatory sensitive care conditions
  - Older peoples services (including mental health)

- Primary care services, such as:
  - Extended access services
o Transformation and delivery of whole population interventions around prevention and optimisation (such as long term condition management, access hubs, care coordination)
o Relevant primary care prescribing schemes

- Range of voluntary and community sector services
- Adult social care for older people and physical disabilities, including community and domiciliary support
- Staying healthy services
5.0 Making things happen

5.1 Enablers of change

Key partners in the delivery alliance will need to work to create the following conditions for success\(^\text{19}\) to deliver the vision and ambition:

- **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 is 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.

- **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 neighbourhood based care and wellbeing.

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

\(^{19}\) Engagement Review, 2018, C.Hobart
5.2 Implementation and phases
The major changes proposed will be phased so there is a collective focus on common 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.

Careful planning of key developments will be needed to turbo-charge or manage rate limiting aspects of 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, where benefits realisation can be clearly aligned across a range of inter-related pre and post contract phases as illustrated below.

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 based
care and wellbeing model, and much service improvement be approached actively as a joint
endeavour amongst providers and partners, whilst retaining the organisational oversight of
progress required.

5.3 2019/20 Shadow Phase
April 2019 to April 2020 will be a Shadow Phase. 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.

Subject to securing agreement in common at the current LCN Leadership Group, it is
proposed future governance will align relevant pathway and service developments across
primary care, community services (health and social care) and communities. It is proposed,
that the projects that support neighbourhood transformation and integration during
2019/2020 are aligned and develop as a coherent programme of work during this critical
year.

Implementation plans for the shadow phase outlined in table 3 will include:

- **Governance**
  - Agree 19/20 governance and decision making
  - Confirm SRO and leadership for specific transformation priorities e.g. HSC integration/ NBC and wellbeing/ borough wide service developments

- **Coproduction and engagement**
  - Coproduction framework- health and wellbeing in neighbourhoods, community of practice,
  - Culture and ways of working- embed principles of alliance working, prevention, inter-disciplinary/agency working
  - Engagement/ coproduction plans- especially with marginalised groups

- **Scope and development**
  - Finalise services in scope
  - Finalise aims and objectives- ensuring that align to individual organisations aims and objectives
  - Training in QI and change methodologies- development and use of driver diagrams; logic models; PDSA learning built into schemes
  - Partners have internal change teams matrix working across organisations
  - Finalise outcomes framework and agree KPIs and how measure them.

- **Communication**
  - LCN proposal/ scope;
  - care coordination refresh;
  - NBC and wellbeing

- **Finance/ contracting and procurement**
  - Benefits case and realisation plan
  - Integration agreement signed by partners giving transformation programme board delegated authority around decision making and performance management
  - Clearly defined savings plan
  - Agree shared performance improvement and sustainability plans
  - Agree shared financial management principles- risk/ gain
  - Agree specification for procurement
  - Commence procurement

- **NBC and HWB**
  - Develop and agree shared principles for working across neighbourhoods
• Borough wide service alignment to neighbourhoods agreed
• Communications between and within neighbourhoods- patient flows, seamless transfers of care not referrals
• Neighbourhood connectors- identify and agree resourcing and support
• Further public health data analysis at neighbourhood level to support reduction in health inequalities and service developments
• Establish mechanism of maintaining a local voice in NBC developments
• Finalise model of HWB in neighbourhoods

Enablers
• Data sharing agreements across neighbourhoods
• Close links with estates strategy- ensuring that estates considerations are taken across sectors not in silo’s
• Explore digital solutions to support service developments
• Evaluation of care coordination and care coordination refresh

Care coordination

Workforce
• Stocktake of workforce within neighbourhoods e.g. vacancy rates/ sickness/ training and development needs/ diversity
• Develop workforce plan- allowing for targeted/ personalisation of input. Shared recruitment and retention strategies; joint training

Early preparation is underway to fulfil the checkpoint and Gateway requirements, as illustrated in the checkpoints below

5.4 Developing outcomes
Our new model of Neighbourhood Based Care and Wellbeing will require a set of granular outcomes to underpin them. These will need to be developed with local people and local staff over the next few months and build on the following principles which will guide their
design. Whilst the final scope is yet to be agreed, we do know that two (overlapping) ‘populations’ that are likely to be scope:

i) An older, frail cohort in need of home-based support and possibly at risk of social isolation.

ii) People with complex multi-morbidity (e.g. 3 or more LTCs – the Care Coordination cohort)

These populations could 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 designed with specific populations with similar needs, rather than more generic outcomes that relate to a ‘whole population’.

The granular outcome set will 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.

5.5 Procurement Process
The procurement timeline is illustrated below, subject to Council and CCG approval. Although an alliance contract has previously been considered the preferred approach. Options will be considered on the preferred contractual and integration model for this delivery alliance.

![Proposed procurement process and timeline](image-url)
5.5 Risks
Risk management will be overseen by refreshed governance (subject to approval) in 2019/20 during the shadow phase. High level risks and mitigations are set out in Appendix 5, and mitigations are reflected in the 19/20 Implementation plans above.
6.0 Conclusions and Recommendations

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

We are now recommending:

- Agreement to overall scope of Local Care Networks (LCN)s for Neighbourhood Based Care and Wellbeing
- Agreement to develop a proposed procurement approach, subject to formal decisions of CCG/ Council in quarter 4 2018/19. This will include shadow arrangements for 2019/20 and full contract arrangements for 1920/21
- Agreement to seek formal support across partner organisations to endorse these recommendations and approach - to include securing commitment for the 1919/20 shadow arrangements.
7.0 Appendices
Appendix A Changing Needs of Lambeth

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. Lambeth has a significantly lower rate of diabetes diagnoses in adults aged over 17 compared to England, which may suggest 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. Error! Bookmark not defined.

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), 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. 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 that 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 may also partly explain this low prevalence of MLTCs. The prevalence of MLTCs 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.

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20 Resident population refers to the population of people living in Lambeth, in contrast to the population of patients registered with a Lambeth GP (registered population)
21 Registered population refers to the population of patients registered with GPs in Lambeth (Lambeth CCG)
Appendix B Why Neighbourhoods? How are they different?

Different age groups tend to have different health and social care needs. Streatham South has significantly fewer residents aged 20-29 and 30-39 than the Lambeth average, and significantly more of its population is aged 40-64 and 65 and over. By contrast, Tulse Hill and Stockwell both have significantly smaller proportions of residents aged 65 and over than the Lambeth average.

Table 1: Age structure of three selected wards in Lambeth, and Lambeth.

<table>
<thead>
<tr>
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<th>0-19 years</th>
<th>20-29 years</th>
<th>30-39 years</th>
<th>40-64 years</th>
<th>65+ years</th>
</tr>
</thead>
<tbody>
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<td>Stockwell</td>
<td>22%</td>
<td>21%</td>
<td>23%</td>
<td>28%</td>
<td>7%</td>
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<tr>
<td>Tulse Hill</td>
<td>23%</td>
<td>20%</td>
<td>22%</td>
<td>28%</td>
<td>7%</td>
</tr>
<tr>
<td>Streatham South</td>
<td>23%</td>
<td>15%</td>
<td>20%</td>
<td>30%</td>
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</tr>
<tr>
<td>Lambeth</td>
<td>21%</td>
<td>21%</td>
<td>23%</td>
<td>27%</td>
<td>8%</td>
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</table>

The proportion of the population whose ethnicity is not ‘White UK’ is 61% in Lambeth overall, but 67.6% in Tulse Hill, 67.7% in Stockwell and 71.4% in Streatham South. The proportion of the population who cannot speak English well or at all is 3.7% in Lambeth overall, but 6% in Streatham South, 6.2% in Stockwell and just 3.4% in Tulse Hill.

Tulse Hill and Stockwell are in the most densely populated fifth of wards in Lambeth. Streatham South is in the least densely populated fifth of wards in Lambeth.

Wider determinants of health

Many factors in the wider living and social environment are associated with health and social care need. The proportion of pensioners living alone in Lambeth is 39.7%; in Streatham South this is 29.1%, but 41.9% in Tulse Hill. Overcrowding in these three wards ranges from 20.7% in Streatham South to 32.7% in Stockwell.

Use of healthcare services

Emergency hospital admissions for stroke vary widely across these three wards. Emergency hospital admissions for stroke can be measured against a baseline average for England of 100 (standardised admission ratio (SAR)). The emergency hospital stroke admissions ratio (SAR) in Stockwell is 179.6, i.e. 79.6% higher than the England average. The same measure for Streatham South is 88.9 i.e. 11.1% lower than the England average.

Table 2 below shows that Stockwell has higher emergency admissions (SAR) for stroke and COPD, but lower emergency admissions for heart attack. Of the three wards, Streatham South has lower emergency admissions rates for most measures shown.

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http://www.localhealth.org.uk/#sid=368;z=491201,190569,63519,43870;l=en;sly=wd16_DR;v=map13
Table 2: Emergency hospital admissions

![Bar chart showing emergency hospital admissions standardised admissions ratio in Stockwell, Streatham South, Tulse Hill, Lambeth and England]

**Stockwell**

Stockwell is one of the most deprived wards in Lambeth: all of Stockwell’s residents live in areas ranked in the two most deprived quintiles (fifths) in England. Stockwell has significantly more overcrowding, pensioners living alone, child poverty and older people in deprivation than England averages.

Stockwell has higher than England average emergency hospital admissions for stroke, with a standardised admissions ratio of 179.6 compared to 100 for England. Stockwell also has a higher than average standardised admissions ration for all causes.

**Tulse Hill**

23% of people living in Tulse Hill are aged 0-19; significantly more than the Lambeth average. Tulse Hill has significantly more overcrowding, pensioners living alone, child poverty and older people in deprivation than England averages.

Tulse Hill residents have significantly higher incidence of prostate cancer than the England average (standardised incidence ratio (SIR) of 180.6 compared to 100 for England and 147.4 for Lambeth). Of the three wards considered here, Tulse Hill has the highest SIR of prostate cancer and highest emergency hospital admissions for heart attack.

**Streatham South**

Streatham South is in the least densely populated fifth of wards in Lambeth. None of Streatham South residents live in the most deprived, or least deprived LSOAs in England. Streatham South has an older population structure than the Lambeth average, with significantly fewer residents aged 20-29 and 30-39 compared to Lambeth overall, and significantly more of its population is aged 40-64 and 65 and over.

Compared to other areas within Lambeth, many key health indicators are close to the average for England.
Appendix C Proposed approach to scoping health and wellbeing in neighbourhoods

From early engagement, we recognise we need more time to develop our thinking in this area and to engage a wider range of stakeholders in determining what health and wellbeing (HWB) in neighbourhoods will look like in Lambeth.

1. Discovery Phase (November 2018 to February 2019)

We plan to run a series of co-production workshops in the discovery phase to develop our thinking on HWB in neighbourhoods. The workshops will aim to:

a. Identify the assets and individuals in our community that can contribute to HWB in neighbourhoods.

b. Identify existing groups/ networks and forums in Lambeth and explore how they support HWB.

c. Engage a wide-range of stakeholders in the concept of HWB in neighbourhoods to understand different perspectives on:

   i. What does HWB means to them, what would good look like and how might this be supported at a local level?
   
   ii. Principles, culture and ways of working – What level of culture change are we expecting, what level of co-creation/coproduction?

   iii. Do we adopt a new mindset/approach - eg Co-production, Appreciative Inquiry, Asset-based community development, a learning culture?

   iv. What could they contribute to HWB in neighbourhoods and what assets exist in Lambeth that we could build on

   v. What is the need for Bridging/connector roles

   vi. What support/resources would be needed to develop and sustain HWB work within neighbourhoods

  d. Build co-production skills and capabilities of a cohort of practitioners, managers and others from organisations across the sector, including statutory, CVS and community (see below).

  e. Develop close, trusting relationships between the participants to enable them to collaborate in the future to develop, design and integrate service delivery options locally.

How will we run the workshops

We are committed to adopting a co-production approach to the development of our thinking of HWB in neighbourhoods. We recognise that in order to do this we need support with embedding this methodology into the discovery phase workshops and, at the same time, learn the necessary co-production skills and tools that, as a system, we can adopt into future phases of the development of HWB in neighbourhoods.

The Community of Practices will:

a. Help us to understand and shift our approach towards one that embraces co-production on a number of levels and sustains a different relationship with partners, providers and the community.
b. Enable people to develop skills and knowledge in a safe, trusted space, to share their experiences and to critically assess each other's practice to deepen their knowledge and understanding.

c. Facilitate learning on specific topics. These will include appreciative inquiry, community building as well as co-production.

d. Support providers and frontline staff to understand the full potential that co-production has to offer, how to put it into practice on the ground.

e. The Community of Practice will act as a springboard for us to directly shape our thinking on HWB in neighbourhoods and to test out these approaches within our own working environments and communities.

In this phase we will also perform desk-top research to identify and learn from best practice elsewhere around embedding HWB into neighbourhoods and to understand the key elements for success and how this can be applied locally in Lambeth.

2. Define Phase (March 2019)

The community of practices would individually and collectively analyse and evaluate the learnings from phase 1 and co-produce a shortlist of propositions (2-3) for what HWB in neighbourhoods might look like in Lambeth that can be tested and refined with local stakeholders.

3. Develop and Approval Phase (April 2019)

Test and refine propositions for HWB in neighbourhoods with local stakeholders and gain consensus on which proposition(s) to take forward.

Approve, through consensus, the proposition to adopt. Develop a detailed implementation plan, budget and resourcing required to deliver it.
### Appendix D Benefits case of proposed interventions (illustrative)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Benefits</th>
<th>Quantified benefit</th>
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<tbody>
<tr>
<td><strong>Public health, population health and preventative interventions</strong></td>
<td>• Wide range of health and wellbeing benefits dependent on type of intervention&lt;br&gt;• Many are cost effective or provide a return on investment (including within 5 years)</td>
<td>• ROI varies by intervention and population size for example, ROI of £3.85 for every £1 invested in alcohol care teams in secondary care, family support projects to reduce antisocial behaviour with a ROI of £17-44 per £1 expenditure and £7 ROI for every £1 spent on conservation volunteering.&lt;sup&gt;iv&lt;/sup&gt;&lt;br&gt;• ROI is found for interventions focused on the wider determinants of health, e.g. housing and employment, as well health specific interventions.</td>
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<tr>
<td><strong>Integrated dataset</strong></td>
<td>• Reduced A&amp;E admissions and unscheduled admissions</td>
<td>• A&amp;E admissions ↓ by 3% and unscheduled hospital admissions fell 4% ([NHS Bolton’s GP urgent care dashboard])&lt;sup&gt;v&lt;/sup&gt;</td>
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<tr>
<td><strong>Integrated teams for specific conditions</strong></td>
<td>• High patient satisfaction and holistic care&lt;br&gt;• Improved condition and risk factor management&lt;br&gt;• ↓ admissions and shorter lengths of stay&lt;br&gt;• Reduced costs</td>
<td>• 75% rated the service as excellent.&lt;br&gt;• 30%↑ in those with blood pressure &lt;140/80; 62% increase in those with HbA1c &lt;7.5%.&lt;br&gt;• Unplanned admissions bed days ↓ 50% and 1.8 day reduction in hospital stay for patients ([Derby integrated diabetes service])&lt;sup&gt;vii&lt;/sup&gt;&lt;br&gt;• Care home admissions to hospital ↓ 25% per month; bed days ↓ 18% ([The integrated community ageing team (ICAT) for nursing homes])&lt;sup&gt;viii&lt;/sup&gt;</td>
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<tr>
<td><strong>Wider range of professionals working within neighbourhoods</strong></td>
<td>• ↓ prescribing costs and medication side effects&lt;br&gt;• ↓ GP workload</td>
<td>• 5% reduction in prescribing costs by practice pharmacist working with care home residents. ([Larwood and Bawtry Primary care home])&lt;sup&gt;i&lt;/sup&gt;&lt;br&gt;• Reduction in need for patient GP appointments by 30% ([clinical pharmacists, Wallingbrook Health Group])&lt;sup&gt;x&lt;/sup&gt;</td>
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<tr>
<td><strong>Further bringing together of urgent response services</strong></td>
<td>• ↓ A&amp;E attendances and emergency admissions&lt;br&gt;• ↓ risk of future admissions (e.g. falls prevention)</td>
<td>• Admissions following falls ↓ 50% and 74% of people referred managed at home ([Community rapid response service (West Sussex)])&lt;sup&gt;vi&lt;/sup&gt;&lt;br&gt;• 82% of referrals or 61 emergency admissions avoided per month (approx. 25 per 100,000 population) ([Camden rapid response team])&lt;sup&gt;xi&lt;/sup&gt;</td>
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<tr>
<td><strong>Involvement of the voluntary sector and community assets</strong></td>
<td>• ↑ Happiness, wellbeing, self-confidence and community contact in volunteers&lt;br&gt;• Reduced social care costs&lt;br&gt;• Increased voice and control for people, equity and social connectedness&lt;br&gt;• ↑ health literacy, motivation confidence and skills in self care.&lt;sup&gt;xii&lt;/sup&gt;&lt;br&gt;• Protective effect on service demand&lt;sup&gt;xxx&lt;/sup&gt; e.g. A&amp;E, outpatient appointments, admissions.&lt;br&gt;• ↓ GP visits&lt;br&gt;• ↓ Cost/ return on investment&lt;br&gt;• ↑ Quality of life</td>
<td>• Non-emergency hospital admissions ↓ by 30%&lt;br&gt;• 5.7% ↓ in social care packages and £ saving&lt;sup&gt;xv&lt;/sup&gt; ([Living Well Cornwall])&lt;br&gt;• 19 groups and activities have been established by the Champions, alongside a community café.&lt;br&gt;• Patient list ↑ by 57% without increase in primary or secondary care consultations and use of A&amp;E ↓ 10%&lt;br&gt;• 70% of volunteers felt happier, 68% had increased self-confidence, 85% made more friends, 71% cent had more contact with people in the community, 78% had increased knowledge of ways to improve mental wellbeing and happiness ([Robin Lane Health and Wellbeing centre- Health Champions volunteer scheme])&lt;sup&gt;xvi&lt;/sup&gt;&lt;br&gt;• ↓ GP visits by 20-68% ([Expert patient programme: Kingston CCG, Doncaster])&lt;br&gt;• ↓ patient list by 60-70% ([Expert patient programme: Portsmouth CCG, Portsmouth])&lt;br&gt;• ≥ 2.2% to 3.6% savings in social care expenditure ([Health Champions volunteer scheme])&lt;sup&gt;xvii&lt;/sup&gt;</td>
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### Use of care navigators/well-being advisors
- ↑ assessment and identification
- Support for discharges
- Improvement in self assessment scores

86 discharges managed through social prescribing
- ↑ Dementia screening and investment, by 117 and 38 respectively.
- Carers Register ↑ by 43 patients and Veterans Register ↑ by 20. ↑ Care plans by 396 and NHS Health Checks by 95

### Integrated local MDT working
- Reduced secondary care use- A&E, outpatients, admissions
- ↓ admissions and length of stay for care home patients.
- Improved staff satisfaction and retention
- Improved patient experience
- Reduced wait time for GP appointments
- Patients receive care closer to home
- Community led health and wellbeing initiatives
- Population health benefits

- Outpatient visits ↓ by 2620 and A&E admissions ↓ by 100
- 130K fewer miles travelled by Millom residents
- Elective admissions ↓ 6.3% and non-elective admissions ↓ 23%
- Admissions from care homes ↓ 10% (Millom integrated care community - population 8,500)
- 90% reduction in delayed bed days (over 1,000 to under 100)
- 1,100 bed days saved (Wye Valley Neighbourhood Team)
- 330 GP referrals to hospital avoided (BMG)
- Emergency admissions ↓ 8% (Larwood and Bawtry PCH)
- 87% of staff surveyed felt job satisfaction had improved (Larwood and Bawtry PCH)
- 78% felt PCH had decreased or not added to their workload
- 82% of staff felt that PCH had improved patient experience
- Average wait to see GP ↓ by 6 days.
- Flu vaccinations for patients with COPD ↑ 13% and 8 day reduction in length of stay for admitted care home residents (BMG)

### Local care Record and integrated care records
- ↑ efficiency, including ↓ clinician time.
- ↓ referrals and investigations ordered
- Positive effects on patient/clinician relationships and on workforce.
- ↓ missing notes/records

Estimated 9,400 hours of clinical time saved per year and estimated 1,233 referrals are avoided
- Most clinicians felt there was a reduction in records/ notes going missing and of phone calls answered or made and that there was a positive effect on relationships with patients and their own working day.
| Use of community spaces | • ↑ social inclusion, prevent isolation  
• ↑ social and emotional wellbeing  
• Supports volunteer led activities | • 42% said there was a reduction in number of investigations ordered and 78% of hospital clinicians said they could handle in a better way the speed and quality of treatment in their department (east London Patient Record- eLPR)xxii  
• Promote social inclusion, prevent isolation, and improve the social and emotional well-being (Memory Lane Cafés)xxiii  
• Facilities included an onsite café, arts events, a variety of support groups and over 60 free volunteer run activities. (Robin Lane Health and wellbeing centre)xxiv |
## Appendix E Risks and mitigations

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigations</th>
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<tr>
<td><strong>1. Scale of the transformation</strong>&lt;br&gt;Not achieving what we set out to do through ineffective design and mobilisation&lt;br&gt;Failure to manage business as usual and steady state during the phasing of the new model&lt;br&gt;Failure to manage transition&lt;br&gt;Failure to maintain engagement and interest of current LCN Forum members, particularly voluntary community sector during the transition/ shadow year&lt;br&gt;The ambition could be too big and not able to translate to organisational level&lt;br&gt;Failure to implement plans quick enough</td>
<td>Transformation programmes are underpinned by processes and methodologies that ensure effective design and delivery plans - particularly an ethos of co-production&lt;br&gt;Transition plans to be developed to ensure BAU and management of change and will be accompanied by resource where appropriate&lt;br&gt;All service level changes will be underpinned by operational protocols that manage access, continuity of care and risk. Incremental steps for transformation will be developed.&lt;br&gt;The LCN Leadership Group(^{26}) will scrutinise transformation plans on a monthly basis.&lt;br&gt;A Senior Responsible Owner (SRO) will be accountable and responsible for specific transformational schemes.&lt;br&gt;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.&lt;br&gt;Incremental phasing of the transformation will be agreed and delivered.&lt;br&gt;Milestone planning will be robust and realistic with programme management and co-ordination to ensure delivery.</td>
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| 2. Partner organisation participation | The LCN delivery alliance has support from the partner organisation leadership through the Lambeth Together Strategic Alliance Leadership Team. Any concerns regarding the detail of the alliance will be explored through the Strategic Alliance Leadership Team.<br>Commissioning intentions will reflect a clear scope of services to be included in the delivery alliance informing a clear procurement process.<br>There is a clear case for change outlined in the LCN proposal to support partnership buy in.<br>Partner organisations have all participated in the development of the emerging delivery model.<br>Clear risk and gain share arrangements will be agreed in the delivery alliance.<br>Partners will be supported through the Lambeth Together culture and ways of working workstream. |

| 3. Coproduction, involving local people, workforce buy-in and cultural change | Coproduction partner working across Local Care Networks and living Well Alliance. To develop coproduction framework for Lambeth that aligns with Lambeth Made<br>Establishment of ‘communities of practice’, supported by training from the coproduction partner to build understanding and capability across the system around coproduction<br>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<br>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.<br>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 |

\(^{26}\) Working title- transition governance arrangements to be agreed
| Failure to effectively engage and include the workforce (statutory and VCS) and local people with the proposed transformation | 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. |
| 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 | |

| 4. Integration | 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. |
| 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 | |

| 5. Avoiding fragmentation across neighbourhoods | The LCN leadership group will provide leadership, oversight and monitoring of service delivery. Any fragmentation will be identified early and addressed. All neighbourhoods will work to shared principles and there will be many services that will be provided across all neighbourhoods, while allowing for local delivery models that support equality of access. There will be alignment to neighbourhoods of borough wide services to ensure continuity of care is delivered. Data sharing, communications and partnerships will be strengthened both within neighbourhoods and between neighbourhoods. Referrals between neighbourhoods will be avoided and any transfers of care will aim to be seamless for person experiencing the services. A consistent approach across all neighbourhoods will be adopted around workforce development/ education and training. |
| Service delivery across neighbourhoods becomes fragmented and there are inconsistencies in the quality of service provision as the neighbourhoods develop their own uniqueness | |
| There is a disconnect between services delivered within an neighbourhood and borough wide services | |

| 6. Equality, diversity and health inequalities | Development of neighbourhood based care will recognise diversity of need and experience. There will be local understanding that will inform and shape local services and how to access them. Integrating health and wellbeing into neighbourhoods will involve a wider range of people to ensure that services reflect the local communities they serve. |
| Equality and diversity agenda is not prioritised and inequalities for marginalised groups persist. | |
### Health Inequalities Persist

- Many experiencing the effects of social exclusion and lack of social support
- Health and wellbeing within neighbourhoods will connect people to community resources.
- Groups/organisations working with marginalised groups/communities of practice/interest will be involved with the development and delivery of services across the neighbourhoods e.g. Black Thrive, DASL, social housing providers, faith groups and other voluntary community sector organisations.
- Public health data and local intelligence will inform the development of services within neighbourhoods to support equality of access and reduction in health inequalities.
- All providers will work together to ensure they have a diverse workforce, with the skills and capabilities to deliver high quality services.
- The work across the neighbourhoods will be informed by and report into the Lambeth Health and Wellbeing Strategy and Lambeth Together Strategy.

### 7. 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 and VCS leading to continue over reliance on statutory services and potential overburden on existing VCS organisations.
- Failure to embed prevention/health and wellbeing offer into the neighbourhood based care delivery model.
- 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.

### 8. 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 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.
9. Enablers

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

Failure to deliver a realistic digital strategy that supports communication, continuity of care, digital “interventions” and access to services.

Operational delivery of the new model will be inhibited due to an inability to effectively share data.

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.

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 front line staff, enabling integration and collaboration will be considered.

Estate will be considered across sectors rather than in silos (with commitment to avoiding variable and disproportionate pricing).

Where less than ideal estates solutions are available applications for new funding through national funding opportunities will be made as and when they arise.

New working patterns and enabling technology will allow greater flexibility and more efficient use of estate.

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.

There will be a shared data set developed by the provider organisations under the shadow LCN delivery group.

Local Care Record - care planning scoping and developments will ensure shared view and reduce duplication around the care plans.

MDT’s and integrated working will ensure close practitioner to practitioner relationships, enabling sharing of knowledge in the best interests of patients.

Development of a clear and comprehensive Workforce Strategy integrated across Providers.

Implementation of Integrated Recruitment and Retention strategies which make a compelling offer to the unqualified workforce not currently engaged in care.

A Senior Responsible Owner (SRO) will be accountable and responsible for enablers.

10. 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.

Change in allocation formula, or other government policy impact for CCG or Council that would create significant financial and sustainability challenge for

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.

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.

Clearly defined 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.

Financial due diligence undertaken during shadow year – common understanding of underlying financial pressures and the means by which these are managed.

Robust, realistic and stress tested plans for transformational and transactional savings and demand management approaches.

Investment, whether new or internally generated needs to be made on the basis where value can be demonstrated.

Alliance contracts need to reflect the pan-borough contracting approach to deal with financially challenged providers.

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

Shared set of principles to manage finances collectively, including appropriate allocation of risk, will be agreed and tested in the shadow year.
### 11. Contractual

Challenges associated with the movement away from historic contracting approach and huge uncertainty facing commissioners as to contractual 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

| Dedicated capacity and infrastructure to execute system wide plans will be agreed through the partnership |
| Alliance contracts need to reflect the pan-borough contracting approach to deal with financially challenged local providers as consistent with move to integrated care systems where this is appropriate. |
| 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 |

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1. PHE and NHSE (2015) A guide to community centred approaches for health and wellbeing
5. WHO Europe: The case for investing in public health, 2013
24. https://www.cqc.org.uk/location/1-594189072/reports