Lewisham Health and Care Partners

working together

LEWISHAM: DEVOLUTION PILOT

Outline Business Case:

November 2017

Common Introduction

Over the past eighteen months, local and sub-regional areas have been working to make rapid improvements to health and care within existing powers and exploring how more local powers, resources and decision-making could accelerate the improvements that Londoners want to see at the most appropriate and local level. Different parts of London have diverse communities, health challenges and quality of health and care services. It is therefore entirely appropriate that different solutions are developed for different areas and that enabling tools, such as devolution, be adopted at different pace and scale based on local appetite.

In this spirit, the approach to London health and care devolution has been for five 'pilots' to develop shared local plans for health and care transformation and then identify opportunities to accelerate these plans through devolution. Each pilot business case aims to describe this local transformation vision, priorities, governance and delivery plans. The pilots have wide partnerships including local authorities, Clinical Commissioning Groups, providers of health and care services, clinical leaders, the voluntary sector and wider public sector partners. The visions and plans developed by the pilots aim to further this collaboration and accelerate health and care transformation, not just through devolution but also by accelerating progress within existing arrangements. These business cases have been developed locally and are owned by the individual pilots.

Over the past eighteen months, the work of the pilots has demonstrated that the benefits of devolution are as much from indirect as direct effects. The potential of devolution has galvanised local plans, local ownership and local partnerships and made sure that the potential of existing arrangements has been fully explored and implemented. But it is also clear that devolution itself would provide significant benefits to enable the delivery of these local ambitions.

The pilots, London and national partners have worked together explore the proposals set out in these business cases. Where there was a clear case that proposals would assist, enable or accelerate improvements to the local health and care system, steps have been taken towards devolution, delegation or sharing of functions, powers and resources currently exercised by national partners. The London Health and Care Devolution MoU contains details of the specific devolution commitments made by Government and national partners.

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1.0 Executive summary

1.1 Introducing the strategic partnership

Lewisham Health and Care Partners (LHCP) is a strategic partnership of health and social care commissioners and providers working towards achieving a vision of a viable, accessible and sustainable health and care system for Lewisham. Members of LHCP are drawn from:

- London Borough of Lewisham (LBL)
- Lewisham Clinical Commissioning Group (LCCG)
- Lewisham and Greenwich NHS Trust (LGT)
- One Health Lewisham (Federation of all Lewisham GPs)
- South London and the Maudsley NHS Foundation Trust (SLaM)

1.2 Our vision and objectives for a healthier Lewisham

Our vision is to achieve a sustainable and accessible health and care system which:

- Better supports our local population to maintain and improve their physical and mental wellbeing, and to live independently;
- Provides access to high quality care when people need it.

Our key objectives are to achieve:

Better health: making choosing healthy living easier – providing people with the right advice, support and care in the right place at the right time to enable them to choose how best to improve their health and wellbeing.

Better care: providing the most effective personalised care and support where and when it is most needed – giving people control of their own care and supporting them to meet their individual needs.

Stronger communities: building engaged, resilient and self-directing communities - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

Better value for the Lewisham pound: focusing on delivering population-based health and wellbeing outcomes and higher levels of service quality within the financial envelope available to us.

To assist Lewisham Health and Care Partners in this journey, through the Devolution Pilot we will identify the specific flexibilities and freedoms that would support developments in two key areas: **estates and workforce.**

1.3 Building on a strong foundation

Lewisham has a long history of strong partnership work. In 2008, Lewisham's Strategic Partnership brought together representatives from the borough's public, private, voluntary and community sectors to examine how, by working together, the quality of life of Lewisham's citizens could be improved. A 12-year Sustainable Community Strategy was developed that engaged all partners in broad strategic development to improve the quality of life of Lewisham's citizens. The vision for the borough which was developed then remains as pertinent today: *'Together, we will make Lewisham the best place to live, work and learn.'*

The approach has shaped the current regeneration of the borough. The Council has attracted additional investment in Lewisham by building positive relationships with developers who share our vision for a better borough – one that is connected to opportunities in central London and beyond, with a stronger business base, supporting cohesive, diverse communities to maximise these benefits to Lewisham residents and businesses.

The town centre has been transformed with both new and improved housing. 2,516 new homes were created between 2008/09 and 2015/16. This is 21% of the total completions across the whole borough (a total of 12,102 units were completed across Lewisham in this period). Lewisham has completed one of the most ambitious school building and refurbishment programmes in the country. More than £300m has been spent on rebuilding or refurbishing over 20 of the borough's schools as well as building two new schools. In 2015, Lewisham's parks and open spaces won 20 Green Flag Awards (the London average was 9 Green Flags).

During this time, major leisure developments were also completed:

- 2008 saw the opening of the extension to Wavelengths leisure centre in Deptford.
- The redeveloped Forest Hill Pools opened in September 2012.
- The RIBA award-winning £3.5m TNG youth centre in Sydenham opened in 2013.
- Glass Mill, a new award-winning £20m leisure centre in Lewisham town centre, was opened in June 2013.

This approach to partnership working has continued and is reflected in the way in which LCHP have sought to develop a sustainable and accessible healthcare system within the borough. This has been evidenced through our work to date which has seen the achievement of the following: (see section 3 for more detail).

These include:

- The creation of a Joint Commissioning Unit (through a section 75 agreement between LCCG and LBL).
- Innovative approaches to working with the voluntary sector that have led to the development of successful new preventative programmes such as Community Connections and Safe and Independent Living aimed at supporting vulnerable adults to improve their social integration, health and wellbeing and reduce isolation.
- Enhancing enablement services to maintain independence, to reduce unplanned emergency admissions and to reduce lengths of stay in hospital. The percentage of persons still at home 91 days later after reablement rose from 87.9 % in 2014/15 to 98% in 2015/16, reflecting the effectiveness of Lewisham's approach in this area.
- The creation of virtual Neighbourhood Community Teams comprising District Nursing, occupational and physiotherapists and social care staff aligned to GP neighbourhood areas.

1.4 Our transformation plans

LCHP's overall aim is to achieve an accessible and sustainable health and care system and which, for community based care, is preventative and proactive, accessible and co-ordinated. These wider transformation plans include:

- Reframing the commissioning role and commissioning frameworks.
- Establishing new provider models and vehicles for the delivery of community based care.

- Giving particular focus to the estate requirements for the delivery of health and care in Lewisham.
- Developing new ways of working and the skills and competencies needed in our future workforce.

1.5 Devolution for estates and workforce

Lewisham Health and Care Partners (LHCP) are committed to working in new and different ways to deliver real benefits for our population. Devolution offers a significant opportunity to accelerate specific elements of our overall transformation plan and contribute to the delivery of our vision. In particular we welcome the commitments set out in the London Devolution MoU around estates and workforce, enabling us as devolution pilot to:

- Remove unnecessary restrictions that apply to the use and disposal of our estate. This will enable us to unlock the capital for re-investment within our own borough to provide fit for purpose premises, and make services more accessible and develop new provision where required.
- Develop a more flexible workforce to work and support residents in their own homes. These roles need to be generic, bridge organisational differences and focused on outcomes.

Please refer to the *capital and estates* and *workforce and skills* sections of the MoU for further detail.

1.6 Expected Outcomes

The activity to be progressed as part of the devolution pilot is expected to contribute to Lewisham's overall key outcome measures which are being developed for Community Based Care:

Community Based Care (CBC) - Outcome Framework
Better health and care outcomes, including reducing inequalities, through: • An increase in Healthy life expectancy at birth • A reduction in under 75 years mortality of the major causes of death – including, cancer, Respiratory, CVD, serious mental illness etc. • A reduction in the gap in key health outcomes between Lewisham and England by 10% over the next 5 years • A reduction in potential years of life lost from causes which could be addresses by health care • An improvement in disability-adjusted life year (DALY)
Improved Wellbeing, including reducing inequalities, through: • An improvement in self-reported wellbeing – people with a low happiness score • An improvement in 'State of Health' measured by anxiety/depression; pain discomfort; mobility; self-care and activities – source GP Patient survey • An increase in the proportion of people feeling supported to manage their long term conditions • An increase in health related quality of life for those with long term conditions (physical and mental health) • An increase in social care related quality of care • National Well-being measures are available at a Borough level

System wide sustainability across health and care in Lewisham: • Balanced financial plans and performance that are affordable within commissioner resources, across the system • Performance is better than our peer Boroughs - source Rightcare • Culturally competent workforce with equal access to training and development, recruitment and retention and a lack of bias in bullying and disciplinary processes – Source WRES metrics • Increased workforce's health and well-being, satisfaction and engagement – National Staff survey • Shared information system underpinning commissioning and providers joint working
Community Based Care Children and Young People: Outcome framework
Better health and care outcomes, including reducing inequalities, through: • Preparing for a healthy and confident pregnancy and an increase in health and wellbeing outcomes in the first 1001 days • Reduction in avoidable attendances and admissions in ED • Improved discharge rates from ED • Reduction in suicide / self-harm rates • Reduction in Infant Mortality • Holistic, personalised and high quality care close to home
Improved wellbeing, including reducing inequalities through: • An increase in the proportion of children and young people and their families feeling supported to manage their health and wellbeing (including long term conditions and mental health) • Improved access into child and adolescent mental health services • Improved choice and control in care received, including choice of where to give birth
System wide sustainability across health and care in Lewisham: • Better performance for CAMHS, maternity and community health services than our statistical neighbours • Reduced number of avoidable attendances and admissions to ED, including of under 18s into mental health inpatient units • Workforce development to support management of children's health in the community across the Partnership

Specifically our work on estates will strengthen our ability to deliver integrated services locally to attain these outcomes and our work on a new workforce approach to those supporting people at home is particularly pertinent to improving wellbeing.

1.7 Working in partnership - SEL STP, OPE and wider London system

In addition to the NHSE 5 Year Forward View, LHCP's vision for the transformation of health and care in the borough aligns with the following sub regional and local strategies and plans shape and drive activity in Lewisham:

<u>Our Healthier South East London (OHSEL):</u>

Lewisham CCG and Council have been working collaboratively with the five other South East London boroughs as part of the Our Healthier South East London (OHSEL) Strategy to collectively:

- respond to local needs and aspirations
- improve the health of people in south east London
- reduce health inequalities
- deliver a health care system which is clinically and financially sustainable

The strategy complements and builds on activity in Lewisham. It has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together.

Sustainability and Transformation Plan:

The OHSEL Strategy provided the starting point for the Sustainability and Transformation Plan (STP). The STP has developed this work considerably further both in terms of collective governance and scope of plans for both commissioners and providers across the system. The strategy for south east London is clinically-led and developed, with over 300 clinicians, nurses, allied health professionals, social care staff, commissioners and others developing ideas through the six Clinical Leadership Groups (CLGs). Patient and public voices feed directly into the CLGs and support the work streams.

The STP has 5 priorities and areas of focus:
- Developing consistent and high quality community care and prevention
- Improving quality and reducing variation across both physical and mental health
- Reducing cost through provider collaboration
- Developing sustainable specialised services
- Changing how we work together to deliver the transformation required

One Public Estate:

Lewisham has successfully secured funding to support the delivery of our One Public Estate (OPE) submission. Lewisham's OPE submission outlined three interdependent schemes:

- Regeneration – activity focused on shared development of four specific geographical areas that will deliver new homes, employment and fit for purpose assets whilst retaining the 'look and feel' of thriving neighbourhoods and distinct communities.
- Collaboration – activity to enable and support the expansion of community based care services, new models of care at home, primary care development and the integration of adult social care and health facilities.
- Strategic Estate Planning – activity to maximise the use of existing facilities and co-location of services.

The activity to support the 'Collaboration' and 'Strategic Estates Planning' schemes is aligned to the MoU commitments set out in the capital and estates sections and would maximise the potential of the freedoms and flexibilities requested.

1.8 Timescales

The two areas identified for development within the devolution pilot have specific milestones that sit within a wider Roadmap for the delivery of an accessible and sustainable health and care system; one which is whole system, population based, evidence based and outcome focused, and one which provides a joined up and holistic approach to the needs of our residents.

The timetable for our devolution pilot work on estates mirrors that within OPE which sets out activity phased over the next 5 years – attached as Appendix 1. This work focuses primarily on undertaking disposals, feasibility studies and improving current and future utilisation of existing buildings.

The freedoms and flexibilities in relation to utilisation of buildings, as referenced in the Memorandum of Understanding, will be explored through the devolution pilot to ensure effective and efficient use of our estate.

For the workforce element, a new service approach will be developed and piloted by June 2018, conflating aspects of personal and health care. This will include defining hybrid roles across these services and identifying the freedoms and flexibilities to enable us to harmonise salaries, terms and conditions and management structures across organisations.

2.0 The case for change

2.1 Our population and health and care outcomes

Lewisham is a diverse inner London borough with a growing population, projected to increase from 297,325 to 318,000 by 2021. Lewisham is projected to see the second fastest rate of population growth in inner London up to 2037 and the eighth fastest in London overall. [1]

Lewisham is the 15th most ethnically diverse local authority in England (46% of the population are from black and ethnic minority groups). Around 26,000 residents are above 65 years of age and over 3,400 are aged over 85 years. Lewisham's over 60 population is projected to increase by around 15,000 by 2040. The Index of Multiple Deprivation 2015 ranks Lewisham 48th of 326 districts in England and 10th out of 33 London boroughs. There are nearly 40,000 one person households in Lewisham.

We recognise that the current system is not sustainable nor is it achieving the health and care outcomes that it should. For example:

- Life expectancy remains lower than the England average. Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%) in Lewisham. Too many people die early from deaths that could have been prevented by healthier lifestyles.
- There are significant health inequalities in Lewisham. People living in the most deprived wards, in Lewisham, have poorer health outcomes and lower life expectancy compared to England's average. Lewisham is one of the most ethnically diverse areas of the country and African and African Caribbean residents are disproportionately over-represented in mental health admissions.
- Too many people live with ill health. 29% of Lewisham's population have 1 LTC (about 86,570 people) – such as diabetes, high blood pressure and mental illness. Over 50% of those aged over 75 are likely to have two or more long term conditions.
- Demand for care is increasing, both in numbers and complexity. 14% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities. That is equivalent to around 38,000 people.
- High quality care is not consistently available - the quality of care that patients receive and the outcome of their treatment can vary depending on when and where they access health and care services.
- The prevalence of serious mental illness is higher than the England average. There has been a statistically significant increase in the prevalence of depression in adults (from 5.90% in 2013/14 to 6.40% in 2014/15).

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[1] *People, Prosperity, Place*, Lewisham Regeneration Strategy, Mid-term Review: July 2015 (page 5)

- Lewisham is an outlier in the number of emergency admissions for the top 10 ambulatory care sensitive conditions.
- The number of emergency appointments at Lewisham Hospital increased by 12% between 2014/15 and the same period in 2015/16.

<table>
<tr><th colspan="2">The main health risks by age group</th></tr>
<tr><th>Children</th><th>Young people</th></tr>
<tr><td>• Premature delivery
• Low birth weights of babies
• High levels of obesity
• Exposure to toxic stress
• The level of child poverty in Lewisham is significantly worse than the England average
• The rate of family homelessness is also worse than the England average</td><td>• Mental health issues, often as a consequence of exposure to toxic stress during early development
• Sexual ill-health - high levels of teenage pregnancy and rates of sexually transmitted infections (STIs)
• High levels of obesity
• Tobacco, alcohol and cannabis use also adversely affected</td></tr>
<tr><th>Adults</th><th>Older people</th></tr>
<tr><td>• Increasing numbers of people diagnosed with long term conditions and their management, in particular, diabetes, COPD, CVD and hypertension
• Level of mental health needs for both common and severe mental illness is significantly higher for adults in Lewisham than comparative borough
• Lewisham is only identifying 52.9% of people with dementia; increasing the low diagnosis is a national challenge
• High levels of drug and alcohol misuse</td><td>• The likelihood of having a long term condition increases with age, with over 50% of those aged 75+ having two or more long term conditions
• Dementia as it increases markedly with age and the level of diagnosis is low (see Adults section)</td></tr>
</table>

2.2 The Challenge - Estates

LHCP have recognised that a number of our health and care sites are not fully utilised, not ideally set up for the services using them, and/or need upgrading or improving. LHCP have committed to developing a joint strategy to reconfigure sites and enhance the gain for residents. This informed our application to One Public Estate which also addresses housing and employment needs as well as the reconfiguration of health and care services. Reconfiguring sites to address these challenges requires greater flexibility in relation to the use of resources to enable reinvestment in Lewisham's health and care system.

In addition, the availability of estate suitable for co-location of integrated teams or, even at a minimum, space where teams can come together on a regular basis to collaborate is limited.

The OPE bid outlined our intention to establish Neighbourhood Care Hubs, to co-locate services within the same building. Four possible sites were identified for these hubs but there are restrictions around the use of three of the sites. In brief:

- *The Waldron Health Centre* was developed as part of the LIFT Programme and currently houses GP surgeries and some district nursing office space. The building is under-used and could be occupied to full capacity. However, the arrangements in place for leasing and developing the space are complex and the under-utilisation is costly.

- *Downham Health and Leisure Centre* is a PFI building that opened in March 2007. The centre includes health care facilities, library, community hall, and leisure services (including a 25m swimming pool, teaching pool, gym, studios, floodlit Astroturf and multi-use games area, and playing fields). It is managed by 1Life (formerly Leisure Connection Ltd) operating through an Industrial and Provident Society (IPS), Downham Lifestyles Limited.

- *Sydenham Green Health Centre* is owned by Lewisham and Greenwich NHS Trust and houses a GP practice. Although there is considerable potential to develop the usage of the building and the site beyond primary care, it is proving difficult to achieve this.

In addition we propose to have a larger hub in neighbourhood 2 on the hospital or adjacent LBL land, which will help divert patients from A&E, provide a range of more specialist services plus training and educational facilities. The ability to reuse capital receipts in the development of our neighbourhood hubs in critical to the achievement of this aspect of our future vision.

2.3 The Challenge - Workforce

There are recruitment challenges across the system with shortages in a range of staff areas including qualified and experienced social workers, occupational therapist and nurses. 24% of Healthcare Assistant positions in primary care are vacant, the highest of any general practice staff group. Staff shortages are restricting face to face time with health and care professionals.

Inflexibility around job evaluations across organisations slows down and in some cases halts the creation of new roles that cross current professional boundaries. In addition, where new roles that blur professional boundaries are being considered, rules relating to clinical governance and regulation can hinder developing and embedding these new roles.

While ConnectCare, Lewisham's information sharing system, has enabled significant progress in relation to integrated working, in some areas information sharing remains restricted. Further enhancement of ConnectCare offers an opportunity to create a generic overarching information sharing process to enable all key stakeholders, including residents, to collaborate and safely store information to support integrated care that will enable them to deliver joint assessments, care planning and care coordination across organisational boundaries, a core benefit of integration. Effective access to information and interoperability across systems is critical to the development of joint and hybrid roles. LHCP consider an integrated approach to Population Health (see 8.3) as a key enabler to delivering new integrated models of health and care.

2.4 The Challenge - Financial

The south east London health economy faces a considerable affordability challenge over the next five years. The STP estimates this to be £1015m by 2021/21 on a 'do nothing' basis. Adult

social care and public health funding also faces a significant challenge as local authority funding diminishes. Gross expenditure within adult social care alone has fallen every year since 2011/12. The cumulative reduction to date is 13%.

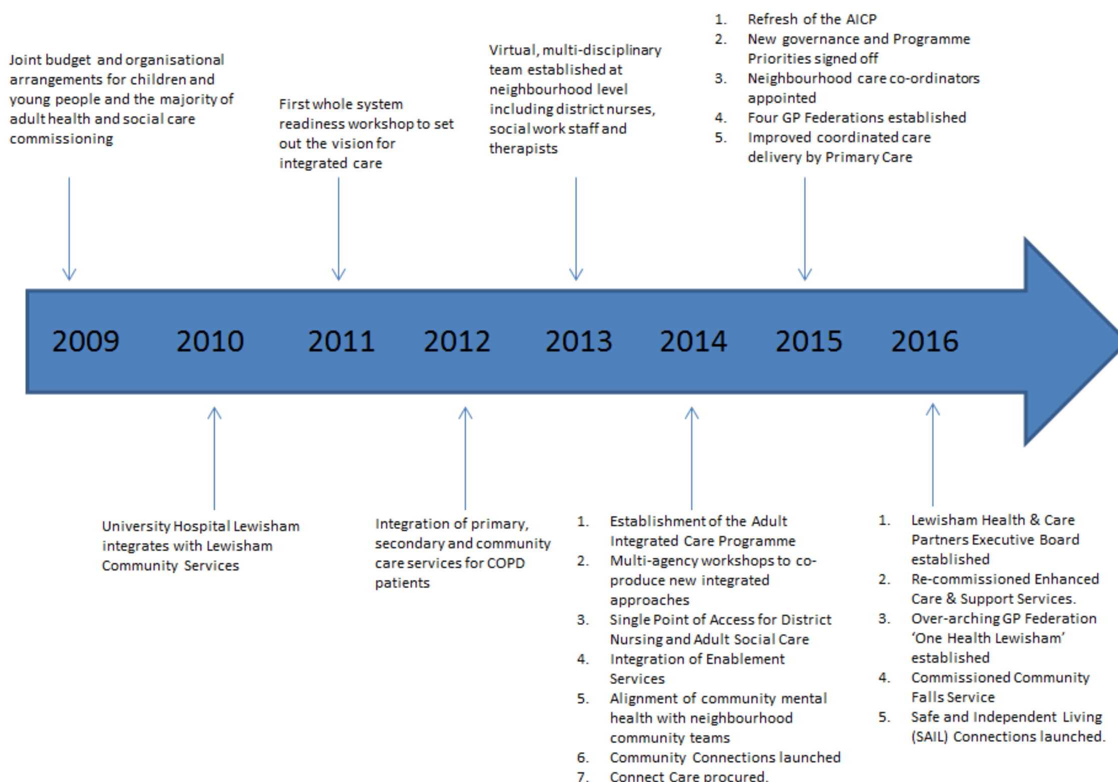
Our experience of joint working has thus far realised considerable savings across all parts of the system. However, there needs to be considerable streamlining and more effective targeting of interventions to save on staff costs and provide more effective outcomes.

Across the system, Lewisham recognises the need to pool resources across the borough and to target them more effectively in order to help meet this challenge. This aspiration drives the proposals within the devolution pilot.

3.0 Our track record of collaborative working

Lewisham Health and Care Partners (LHCP) have been working together to develop and deliver integrated services since the integration of acute and community health services in 2010 (see Figure 1 for a timeline of key developments in relation to the development of integrated services). Until recently, the integration of services for adults was primarily overseen by the Adult Integrated Care Programme (AICP) Board. The AICP Board was incorporated into the Lewisham Health and Care Partners Executive Board, which has a wider remit to include areas relevant to CYP and which reports to the Health and Wellbeing Board.

Figure 1: Timeline of local integration to date in Lewisham



Since 2016, LHCP's plans for the development of its population health system, to further integrate the work of local commissioners and providers, have been endorsed by the Health and Wellbeing Board.

LCHP has successfully delivered a range of complex partnership initiatives. These include:

(a) *Establishing a Joint Commissioning Unit* - in 2010 Lewisham Council led the development of a Joint Commissioning Unit, bringing together key commissioning functions across Lewisham Clinical Commissioning Group and the local authority. The Joint commissioning arrangements are governed by a section 75 agreement which supports the commissioning of health and social care services, aligning health and social care budgets. The Unit has led on the development of annual partnership commissioning intentions, identifying joint priorities and seeking to secure the best use of limited health and social care resources.

The Unit has also led on the commissioning and service redesign of a number of pathways, including the reconfiguration of adult mental health community services, day care for older adults and people with learning disabilities, end of life care and has delivered on the transforming care agenda for people with learning disabilities.

The Unit has managed the delivery of social care and health savings jointly, ensuring that savings decisions are made jointly to minimise cost shunting and ensure the best value and best outcomes within the limited joint resources available.

The Unit has successfully established a joint health and social care continuing health care team to ensure that all CHC assessments and reviews are carried out in a timely manner and that those with the most complex needs have access to effective case management. The Unit has been successful in reducing the number of delayed transfers of care, and ensuring that packages of care and placements are funded jointly where appropriate.

Currently the Unit is leading of the development of a joint health and social care market position statement which will analyse the current market, identify future trends in demand and capacity and identify gaps and opportunities in the market that will support the development of integrated care in Lewisham.

(b) *Integrating Enablement services* – bringing together domiciliary care and intermediate care to achieve improvements as highlighted above.

(c) *Establishing services on a neighbourhood footprint* – LHCP agreed to focus all adult health and care services outside of the acute sector along the neighbourhood footprint established by GPs in 2008. In 2015, those four neighbourhood clusters were consolidated into four neighbourhood GP Federations. A fifth pan-Lewisham provider is also now in place. A range of services, including services delivered by the voluntary sector, are now organised on a neighbourhood basis. See Appendix 2 for details of the four neighbourhoods by GP practice.

Children's health and early intervention services have been aligned at the front line of delivery for number of years in Lewisham. Many health and early intervention services are co-located on a neighbourhood model, including those services for children with complex needs on a children's centre neighbourhood model.

(d) *Establishing integrated Neighbourhood Community Teams* – four virtual multi-disciplinary teams of social care staff, district nurses and occupational and physio therapists have been created along the neighbourhood footprint. The teams are aligned to GP practices and

multi-disciplinary meetings now take place in each practice. This way of working has enabled greater information sharing and collaboration across the system.

Four Neighbourhood Co-ordinators, funded by pooled budget arrangements, work across health and social care to improve multi-disciplinary working for those people with complex health and social care needs. The team facilitates effective liaison between formal and informal health and care providers across Lewisham. The Co-ordinators have been in post since November 2015 and the role is now considered to be highly beneficial by the Neighbourhood Community Teams. In 2016/17, the team responded to 1254 requests for support.

(e) *Establishing a virtual patient record* – 'ConnectCare' has been developed to deliver a 'health and social care portal' for the populations of Bexley, Greenwich and Lewisham. The first phase, a read only shared record of acute, community, primary, mental health and out of hours health services, has been developed with a shared investment of some £1.2 million over the past 30 months. The ConnectCare programme aims to support and enable a fully integrated health and social care service for Lewisham by:

- Providing a common health and social care record, accessible when and where needed.
- Enabling multi-disciplinary team working for individual care delivery.
- Supporting identification and risk stratification of health and social needs for cohorts of the population.

The on-going running costs for the system are shared by the stakeholder organisation in proportion to their user base.

The programme board for ConnectCare is chaired by the Chief Executive of Lewisham and Greenwich NHS Trust, and has senior representatives from the stakeholders on the board.

An on-going patient and public consultation and engagement programme is in place via direct communications, patient and client panels, publicity in GP, community, and local authority premises

(f) *Establishing LIMOS, an award winning medicines management service* - LIMOS was developed by LCCG in collaboration with Lewisham and Greenwich NHS Trust and Lewisham Council. The service works across health and social care services to support patients who are at high risk of medicine related problems to manage their own medicines and remain as independent as possible. An evaluation of the service demonstrated that for every £1 spent on delivering the service, £2 is saved across the health and social care system. The service has generated direct and indirect savings of £600,000 p.a. across the system with reductions in social care support, hospital admissions and A&E attendances. LIMOS won the HSJ Patient Safety Award (Managing Long-Term Conditions) and HSJ Value Awards (Value and Improvement in Medicines Management).

(g) *Improving dementia detection rates and support* – the dementia diagnosis rate increased by over 8% in 2015, reflecting more effective collaborative working between general practice, the Memory Clinic (provided by SLaM and Lewisham & Greenwich Trust) and Mindcare's information and support service. The waiting time between referral and diagnostic assessment is now 6 weeks. New voluntary sector services have been developed, such as Sydenham Gardens' 'Sow and Grow' project. This provides therapeutic support through gardening for individuals diagnosed with Dementia and reports very high satisfaction rates from service users

(h) *IT development to support virtual meetings* – the virtual meetings will also seek to draw on the shared information available through ConnectCare and the development of IT to support the delivery and focus on population health.

4.0 What our patients and clinicians have told us

To inform the planning, development and delivery of our transformed health and care system, LHCP have held a range of engagement and consultation events to establish the views of our residents, staff and service users. The information gathered from these events has in turn contributed to the specific development of our work around estates and the proposed workforce approach for our extended neighbourhood community teams.

Key themes in terms of what our communities want from health and care services have emerged from our consultation and engagement activity:

- More face to face time with health and care professionals.
- Improved access to mental health services and resources, with better signposting to the full range of services available.
- Improved access to GPs and walk in centres, especially out of office hours.
- Better communications, information and integrated record sharing across service. providers and more diverse communication channels about available services.
- Integrated person centred services with a single entry point for patient information.
- Staff across the system to have the skills and knowledge to help and support residents to look after their own health and wellbeing, to direct their own care and to choose the support and services they need.
- Better care co-ordination and improved support for people to navigate the health and care system.
- More health and wellbeing services and support for carers.

5.0 Our wider plans for transformation

5.1 Taking a whole system approach to health and care

Lewisham Health and Care Partners have long recognised that many of the challenges they face can only be addressed and resolved by working in partnership at a local borough level.

Our strategic aim is to work in partnership to transform the environment in which people live and the way in which health and care is delivered so local people:

- live healthier lives and maintain their independence
- have better health and care outcomes
- have access to more effective, better quality, more affordable services

We believe that we can achieve this at a system level by creating an environment for the delivery of community based care that promotes and facilitates health and wellbeing, and prevents illness and dependence. A system which is:

Proactive and Preventative – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively.

Accessible – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.

Co-ordinated – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

5.2 Community Based Care (CBC)

The transformation of Community Based Care is a critical part of Lewisham's overall vision to achieve a sustainable and accessible health and care system. To date the LHCP have taken a number of steps to improve the delivery and integration of existing Community Based Care: raising quality and improving effectiveness through multi-disciplinary working across services by establishing integrated teams, such as the Neighbourhood Community Teams and enablement teams, developing a Home Ward, a Rapid Response Service, redesigning the Single Point of Access and specific services such as the Falls service.

LHCP recognise that these developments would benefit from strengthened governance and partnership arrangements. Therefore, over the next few years, LHCP will continue to focus on the infrastructure, staff and delivery structure that is needed to achieve Lewisham's vision and further develop and integrate community based care. Lewisham's community based care arrangements will continue to link primary, community, specialist teams working in the community, mental health and social care colleagues together to manage the health and care of local registered populations of between 61,720 and 116,583 people. LHCP have agreed to establish a new Lewisham Partnership approach and model for the delivery of CBC. Progress of the development of the new partnership approach and model for the delivery of CBC will be a key priority area of focus for LHCP over the next year.

Our changing demographics will increase the burden on our physical infrastructure and demand for services. Our estate should support service transformation and the collaboration and integration across the health and care system. Our buildings should enable us to work smarter and more effectively in delivering community based care and contribute to the improvement of patient experience and satisfaction.

We want the majority of health and care services to be accessible outside hospital and where possible provided at the neighbourhood level.

Working with our partners in housing and regeneration, we are also committed to achieving the goals of the Government's One Public Estate initiative to stimulate economic growth; provide integrated and customer-focused services; generate capital receipts; and reduce estates and facilities running costs.

6. Estates as an enabler

6.1 Our ambition and proposed delivery model

As set out in OPE, Lewisham aims to have a care network in each of the 4 neighbourhood areas to support the delivery and integration within community based care and to develop connections across communities and better support the delivery of health and care.

Within each neighbourhood area, the delivery of community based care and the neighbourhood care network will be supported by a neighbourhood care hub.

The over-riding principles are that the hub services should supplement and not duplicate other care services, and should facilitate co-location or collaboration with other voluntary sector support services where appropriate. The hubs should be recognised as centres which do as much to promote health, wellbeing and self-care as to provide appropriate care for those with ill-health.

It is envisaged that the Neighbourhood Care Hubs will house:

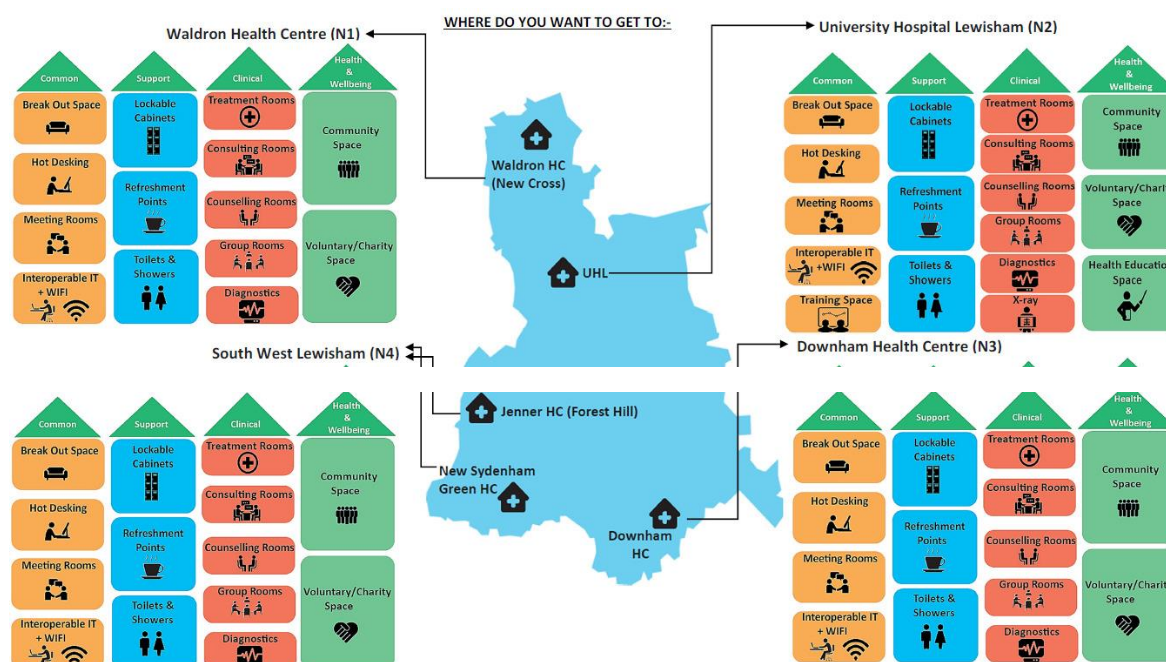
- Integrated health and care teams, such as the Neighbourhood Community Teams and the community mental health teams.
- Touch down space for other services which are part of the Neighbourhood Care Network including the voluntary sector.
- New services to promote and expand primary care.
- Bases for local social enterprises.
- Information and advice and help with accessing digital services and making choices.
- Bookable space for shared use.
- Diagnostics.
- Urgent care and extended access.

One of the hubs, in Neighbourhood 2, is proposed to be developed on the LGT hospital site. It will host a larger range of services than the other hubs, making use of existing diagnostic facilities onsite, education and research capacity and more specialist clinical advice and back up.

The other proposed Hub sites are:

Neighbourhood 1	Waldron Health Centre
Neighbourhood 3	Sydenham Green Health Centre / Jenner Health Centre
Neighbourhood 4	Downham Health and Leisure Centre

Figure 2: The vision for the Proposed Hub Sites



*It is proposed that x-ray remains centrally located in the borough at the UHL hospital site, only. Alternative diagnostic services will be available at the other hub sites. If it is subsequently deemed necessary, x-ray can be designed into the new hubs or retro-fitted into existing sites, subject to suitable space and infrastructure.

Where possible, existing assets will be used, however, new assets may be required in certain areas. A great deal of work is required to deliver this vision and it will be necessary to dispose of assets, exit leases and consult with staff and patient groups about how services will transform and subsequently improve.

A set of guiding principles have been developed to support our work on One Public Estate as well as forming a framework, for the work within the Devolution Pilot:

1. Consideration of new housing opportunities should be priority in all areas of asset reconfiguration and disposals whilst recognising the need for infrastructure review to support a growing number of residents where possible.

2. Our assets should be used to full capacity and should be financially and geographically accessible for health and well-being services required by residents.

3. For those assets that remain in community and public use there should be a clear purpose and rationale for the redevelopment and use of the building(s).

4. Back office, infrastructure and administrative support should be shared where possible, streamlined and housed in buildings that lend to greater use of touchdown, and digital services.

5. Capital receipt gained from asset rationalisation should be used where possible to contribute to the reconfiguration of services and service improvement.

6. Capital receipt acquisition from other partner organisations should not impact negatively on another partner's financial stability.

7. Community assets should look to house a wide range of both statutory and voluntary services where appropriate and develop simple, effective lease and payment systems to accommodate these.
8. All redevelopment of sites should continue to contribute to economic development and the look and feel of the borough.
9. A memorandum of understanding will underpin the legal and best value requirements for asset disposal and development across the partnership.

6.2 Our journey so far with existing powers

In each neighbourhood we have already adapted buildings that are publicly subsidised in order to support both co-ordinated and integrated health and care services. The Kaleidoscope building, for example, delivers integrated community health services for children. More recently, adult day care centres have been transformed into multipurpose sites to provide preventative support services. These centres will continue to be used for day care opportunities for people with learning disabilities but will now provide:-

- Streamlined information and advice services to residents covering all information and advice support and in particular help with self-management, self-care and making informed choices about future care
- Assistance to residents to be able to access services digitally
- Back-office shared spaces for voluntary sector organisations in return for a contribution to improved health and wellbeing services
- Physical activity, dance and movement to assist in social prescribing

Over the last year, Lewisham has undertaken work to develop a strategic approach to estates. A review of the level and positioning of assets across the system has established the current pattern of use, lease/ownership arrangements and how the location of services affects their delivery. Lewisham also owns a number of community centre sites that could be more fully utilised in relation to the provision of health and care services. In addition, a number of the Council's Children Centres are also used by Health Visitors, something that is intended to increase as shared use of buildings becomes more common.

For health partners, individual estate strategies have formed the bedrock of each borough's submission to the Sustainability and Transformation Plan (STP). There is a recognition that each borough can benefit its residents significantly from cross partner estate working locally, taking account of and contributing to the most effective and efficient provision of health services across south east London and the need for assets that are fit for purpose to support these services.

6.3 Remaining challenges

Lewisham's devolution pilot focuses in particular on developing estates that support the delivery of community based care and using buildings to support multi-disciplinary approaches and new ways of working. Over the next year, LHCP will be developing a new partnership approach and model for the delivery of Community Based Care. Partners want the arrangements to permit an agreed level of responsibility and delegation which providing sufficient accountability for

sovereign bodies across the partnership. The work on these two areas must be done in parallel, so that the estates work is fully aligned to future service need.

Accordingly, work with NHS Property Services, CHP, London partners and sub-regional strategic estates boards will explore the potential to facilitate the release of primary care and hospital estates to support the development of Community Based Care and the connections across Neighbourhood Care Networks and release relevant resources for transformation.

Many details now need to be considered in this, including:

- Criteria and benefits for the co-location of services
- The commercial basis on which buildings are managed to enable more flexibility
- New ways of working for staff which are likely to require different premises such as touch-down bases for staff working in the community.

Appendix 3 outlines some of the current challenges we face in developing the Waldron site.

6.4 Devolution ambitions for estates

Lewisham's estates devolution proposals aim to enable the sites identified for the Neighbourhood Care Hubs to be reconfigured and fully utilised for the benefit of Lewisham's communities. This is a complex programme that will involve the disposal of assets, the termination of leases and consultation with staff and patient / user groups about how buildings can support the delivery of services in the future. It will be important to ensure that S106 and CIL contributions are maximised and primary care funding bids for NHS England, Estates & Technology Transformation Funds (previously Primary Care Infrastructure Funding - PCIF) are fully utilised. All other sources of funding need to be identified in order to deliver this ambitious programme of change.

Please refer to the Memorandum of Understanding for the full detail of proposals and commitments on estates.

6.5 Impact analysis

The final configuration of the service offer within each hub has not yet been formalised and detailed impact analysis can only take place once that configuration has been agreed.

However, each hub is expected to expand the availability of primary care health services in terms of opening hours and proximity to where people live. It will also widen the scope of what can be offered in one place and will include any number of GP services, pharmacy, ophthalmology and mental health services.

The additional space that a hub can offer allows for an expansion of service, which in some practices and health centres is at present constrained by space, and what can be offered by one centre. Each hub offers the potential for more flexible, co-ordinated services across a neighbourhood. The newly constituted GP Federations could, for example, offer clinics / services extended opening hours by visiting the hubs on a peripatetic basis. The hubs will form part of a bigger canvas in each neighbourhood which will see some planned GP mergers and site reconfigurations that will ultimately define which cluster of services need to be within each hub.

A list of potential services that could be offered in a Neighbourhood Care hub is included as Appendix 4.

Ultimately our aim is for Neighbourhood Care Hubs to improve health and care outcomes through:

- The provision of fit-for-purpose, flexible, adaptable and able to facilitate the shift of services out of the acute hospitals into the community.
- Local accessible centres of excellence
- Facilitating multi-disciplinary working
- Enabling the voluntary sector to better connect to formal health and care providers
- Realising a reduction in maintenance and back office costs.

7. Workforce as an enabler

7.1 Our ambition and proposed delivery model

A key aspect of our collective approach to workforce development has been the creation of Neighbourhood Community Teams. Building on the integration of health and care staff in other services across Lewisham, for example Enablement Services and Joint Commissioning, four virtual multi-disciplinary teams (Neighbourhood Community Teams) of social care staff and district nurses have been developed. There are approximately 200 staff working within these Neighbourhood Care Teams.

These teams are organised on the neighbourhood footprint aligning with the 4 GP Federations. The aspiration is to develop the model for the neighbourhood community teams to encompass domiciliary care and community mental health, and to co-locate them in each neighbourhood, creating fully integrated teams.

Our aim is to develop these Neighbourhood Community Teams further – establishing combined health and care roles across domiciliary care, district nursing, social work, therapists and community mental health workers. The model being developed under the devolution pilot aims to combine and flex the roles of those health and care professionals who visit and support people in their own homes, and will build on the achievements to date within the existing Neighbourhood Community Teams.

7.2 Our journey so far with existing powers

To date, our achievements in relation to the Neighbourhood Community Teams include:

Establishing a team of Neighbourhood Co-ordinators - central to the effective operation of the Neighbourhood Community Teams has been the development of a team of Neighbourhood Co-ordinators. One Co-ordinator has been operating in each neighbourhood since February 2015. The co-ordinators are funded through our pooled budget arrangements and work across the system, improving communication and patient flows both within social care, district nursing and primary care but also between the NCTs and wider health and care services including mental health, enhanced care and support services and housing.

Implementing a workforce development plan for the NCTS - a workforce development plan to deliver the culture change and training needed to support the integration of the Neighbourhood Community Teams (NCTs) was initiated in May 2015 and implementation is ongoing. Workforce development is aligned to activity to develop joint processes. Joint approaches to pressure care, referral pathways and information flows have been co-produced and piloted with the staff in the Neighbourhood Community Teams. Guidance to standardise the approaches to multi-disciplinary meetings and case conferences has been co-produced with the NCTs and primary care. A new team has been established to work across the partnership with funding from the Better Care Fund to develop the key processes required for integrated teams: single assessments, single care plans and joint key working arrangements. These processes will be co-designed with front line staff and will be in place within the next 12 months.

Improving quality - considerable work has been undertaken to improve the quality of practice, particularly in relation to district nursing.

Aligning mental health - key mental health services are now aligned on a neighbourhood basis. Multi-disciplinary approaches to responding to people with mental health issues in crisis have been agreed. Regular interface meetings between professionals now take place. Activity to improve the referral and escalation processes have been undertaken.

Developing voluntary sector activity – since 2010, Lewisham Council has invested approximately £1,300,000 annually in innovative voluntary sector initiatives to develop new preventative services to support people to stay well in their communities. *Community Connections* is a key project within this scheme (see case study included as Appendix 5). Delivered by a consortium of voluntary sector providers, there are 3 strands of activity that take place in each neighbourhood: community facilitators provide an alternative approach to brokerage, working with people to identify opportunities for their needs to be met in their communities; community development workers support organisations to develop activities to respond to un-met need; volunteer co-ordinators encourage volunteering and improve the connectivity between volunteers and people needing their support.

7.3 Remaining challenges

Currently residents in need of care and support to remain independent and living in their own homes may receive a number of visits from different professionals, receive fragmented care and may have to request support from different services to meet their needs. LHCP are keen to develop a new approach to delivering health and care in people's homes informed by the Buurtzorg model developed in the Netherlands. Appendix 6 provides more detail on the Buurtzorg model.

Essentially the Buurtzorg model has no distinction between nursing and domiciliary care roles, whereas the system here has care tasks which are carefully timed and delineated across professions and roles. Consequently, there are considerable challenges to the development of hybrid and flexible roles which we are in the process of working through. These include:

- The potential for increasing costs as a result of harmonising with NHS salaries, terms and conditions. The overheads and minimum call rates currently payable to domiciliary care providers, however, would not be incurred.

- Currently, we are able to charge for personal care support. This may be more complex within a hybrid ‘nursing’ role within health which would conflate aspects of both personal and health care.
- How the right incentives system (outside of an insurance based model) could be built that would replicate its success in delivering good patient care and financial sustainability.

In addition, some mental health services are already organised on a neighbourhood basis and work has taken place to test how mental health professionals can be better aligned and integrated into the new model.

7.4 Devolution ambitions for workforce

Through the greater flexibilities offered by the devolution pilot, LHCP want to develop a more flexible workforce to work and support residents in their own homes. These roles need to be generic, bridge organisational differences and focused on outcomes.

Please refer to the MoU for the full detail of proposals and commitments on workforce.

Development and implementation of our plans, which may involve the double running of services and which will require investment in Connect Care, our data sharing system, is contingent on additional resources.

7.5 Impact analysis

The aim is to provide a whole family and person approach to care by making the most efficient and effective use of roles in the most flexible way. More preparatory work is required, however a financial assets paper detailing current spend is near completion.

We are aware that Buurtzorg expects its nurses to deliver the full range of medical and support services to clients. If something similar could be adopted we would expect, as in Buurtzorg, high patient and employee satisfaction and the provision of high-quality care delivered at home at lower cost.

We will evaluate how cost effective and outcome focused this approach could be if the ability to work across roles and differing national employee frameworks was in place. In conjunction with mobile working, good IT infrastructure, a local base and maximum use of the neighbourhood care networks, this approach is expected to release efficiencies.

8. IT as an enabler

8.1 Our ambition and proposed delivery model

We will continue to use technology to best effect, improving communication between health and care professionals, supporting integrated record sharing and providing co-ordinated care to residents, patients and service users more effectively.

Through technology and by promoting the use of remote and mobile working we will eliminate unnecessary paperwork and duplication of records, and reduce the reliance on clinical and office space throughout the borough.

Residents too will be able to use technology to maintain and improve their health and wellbeing. We will give them easy access to a wide range of information and advice available on line and to their own health and care records.

Planning for workforce development will also be aligned with broader technology programmes. Alongside the developments on Connect Care, Lewisham Health and Care Partners are seeking a more unified approach to IMT planning across the partnership. Partners want to ensure that IMT across the system supports staff in new ways of working, fully enables the use of mobile technology, provides users with better information and advice to support self-care, and gives staff and residents access to shared health and care information. The use of technology is also recognised as a tool to support residents to better manage existing conditions.

8.2 Our journey so far with existing powers

Lewisham's ConnectCare is our virtual patient record which enables information to be shared across health and care professionals. Building on ConnectCare, our existing information sharing system, we are developing a shared system which will bring together real time data and information from multiple sources to identify specific populations who may be at risk and to improve health and care outcomes across the borough. It will help us to focus on upstream health prevention and management and shift care from acute to community settings. Our shared population health system will also help us to help identify health and social care requirements and measure the impact of the changes we make.

8.3 Remaining challenges

The plan is to develop ConnectCare integrating information and data from specialist health and social care IT system suppliers. Our focus on a Population Health approach to improve health and care outcomes will be supported by developing IT which provides:

- Better communication, information and integrated record sharing across service providers
- Mobile devices to facilitate new ways of working in the community
- Online resources to provide information, advice and support
- Health apps to promote self-care and to help manage long term conditions
- Free patient Wi-Fi at all health and care facilities
- Teleconference capabilities linking health and care professionals across the borough
- Video conference capabilities to provide direct consultations to patients
- Virtual clinic capabilities to allow the review of patient records without the need for direct patient contact
- Medical grade photography to be viewed, shared and integrated with care records

8.4 Impact analysis

As outlined above, the availability to share real time information across health and care systems is critical to the successful implementation of hybrid and flexible roles that provide both personal and health care.

9.0 Programme governance

Representatives from Lewisham's Health and Care Partners formed a partnership board, LCHP Executive Board, which focuses on delivering their vision for health and care.

As well as overseeing the devolution pilot programme, as a partnership board, members:

- Oversee the development and delivery of the whole system model of care which achieves their vision for health and care in Lewisham
- Review options for the transformation of the whole system (for commissioners and providers) and their legal, financial, clinical and regulatory implications
- Identify and clarify benefits, risks and impacts
- Evaluate and monitor performance across the system and identify areas for improvement
- Develop the governance and delivery around community based care.

The LHCP Executive Board is overseen by Lewisham's Health and Wellbeing Board. A number of steering groups report directly to the LHCP Executive Board as shown on the diagram attached below. The LHCP Executive Board is further aligned to a number of partnership boards including Lewisham's Regeneration Board and the Children and Young People's Strategic Partnership Board.

Members of the Lewisham Health and Care Partners Executive Board are responsible for the delivery of OPE, oversight of the development of a whole system model of care, to agree the governance and partnership arrangements for the delivery of CBC and for the transformation and integration of adult health and care.

Members include**:** CCG Chief Officer, CCG Chief Financial Officer, CCG Chair, LGT Chief Executive, SLaM Chief Executive, OHL Chair, OHL Governance Director, LBL Director of Public Health, LBL Executive Director for Community Services, LBL Executive Director for Children & Young People.

For OPE additional members include LBL Executive Director for Resources and Regeneration.

Health and Wellbeing Board

Lewisham Health and Care Partners

Executive Board

(One Public Estate / Whole System Model of Care and Transformation and Integration of Adult Health and Care)

Aligned Partnership Boards

Lewisham Regeneration Board

Section 75 Partnership Board

Adult Joint Commissioning Group

Children and Young People Commissioning Group

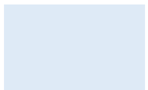
Stronger Communities Partnership Board

Enhanced Care and Support Steering Group	Neighbourhood Care & Prevention Steering Group	IT Steering Group	Communications & Engagement Steering Group	Finance Steering Group	Estates Steering Group	Workforce Development (Providers / Commi-sioners)
Responsibility: To develop and oversee the implementation of a coherent and co-ordinated set of ECS services.	**Responsibility:** To develop NCTs, have oversight of Prevention & Early Action activity; and manage the interface with other key activity.	**Responsibility:** To oversee the development and delivery of IT to support the Whole System Model of Care. To support the AICP Information & Advice Projects.	**Responsibility:** To develop strategic communication and undertake effective system wide communication and engagement activity.	**Responsibility:** To produce analysis and modelling that is sufficiently detailed to determine whether the transformed model will contribute to addressing the financial	**Responsibility:** To co-ordinate and enable the delivery of the Local Estates Strategy, the health and care objectives of OPE and the Devolution Pilot and for contributing to	**Responsibility:** To develop workforce capacity, capability, co-ordination and culture.

Appendix 1: Estates Activity over the next 1 to 5 years

Property	Description	Financial Support Needed for	Activity	Who Benefits
North Lewisham (N1) Hub - Waldron	The utilization of this modern LIFT building is poor. 30% - 40%.	Feasibility, specifically about new models of occupation and proactive centre management and delivery	Consultation with CHP, LBL and SLaM about taking space and other occupiers about reconfiguration and enhanced centre management. Plus, looking at community support/health & wellbeing space in the atrium. Needs concerted effort to have this flag-ship LIFT building working at optimum occupancy and efficiency. To then be used as an exemplar for the other hub projects mentioned below.	Partners and customers
Mulberry ASC Day Centre, New Cross	Replacement for the Day Centre	Phase 1 - Feasibility Study	The site of the Mulberry would be redeveloped for housing but, cannot be relinquished until a replacement facility has been constructed.	LBL and customers
Central Lewisham Hub (N2)	Through the CCG Local Estate Strategy work, 4 area hubs are planned. The hub for Central Lewisham has been identified as a potential super hub with access to diagnostics, training and educational facilities.	Phase 1 - Feasibility Study	Develop a brief for a feasibility study which will strive to not duplicate work across devolution, ETTF, adult social care but to try and bring service transformation and collaboration into one area.	Partners and customers
South East Lewisham Hub (N3)	Through the CCG Local Estate Strategy work, 4 area hubs are planned. This one	Phase 1 - Feasibility Study	This feasibility will strive to not duplicate work across devolution, ETTF, adult social care but to try and bring service transformation and collaboration into one area.	Partners and customers

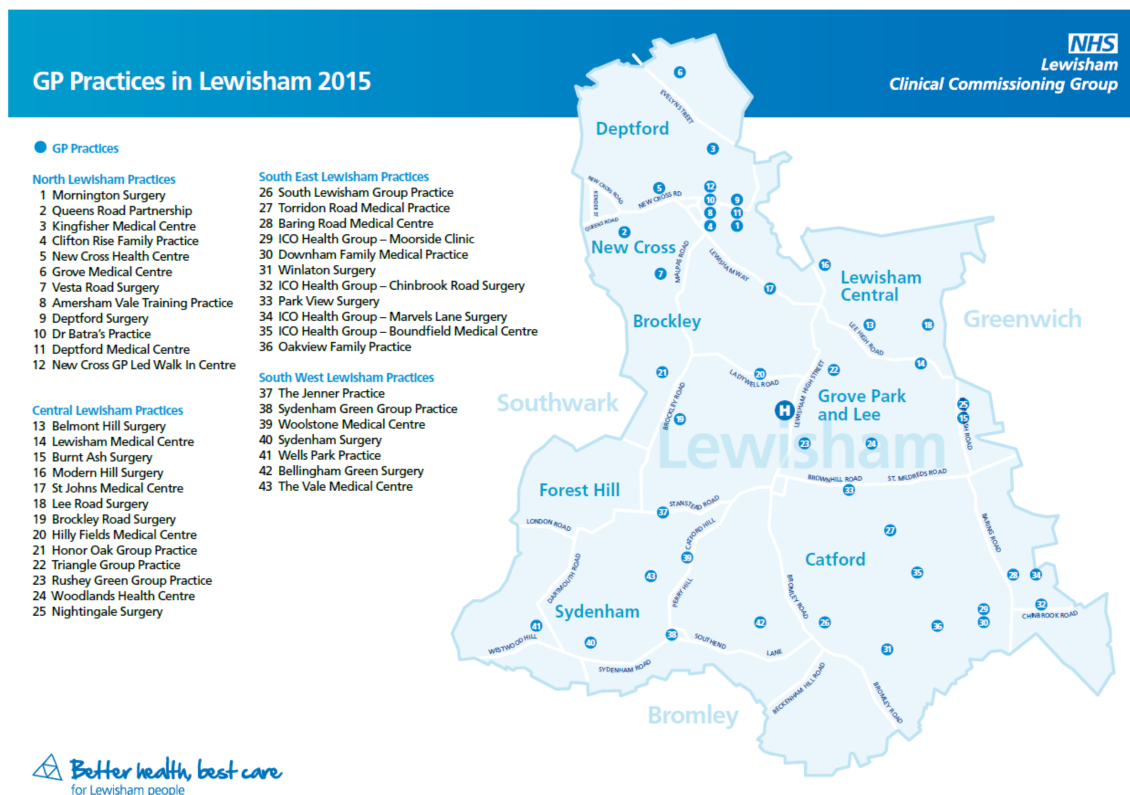
	for Grove Park will work with local practices, LGT, potentially SLaM and LBL to provide a hub in the SE of the borough and will complement Downham Health & Leisure Centre.			
South West Lewisham Hub (N4)	Through the CCG Local Estate Strategy work, 4 area hubs are planned. This one is potentially for Sydenham Green and will work with local practices, LGT, potentially SLaM and LBL to provide a hub in the SW of the borough and will complement the services at Jenner Health Centre.	Phase 1 Feasibility Study	This feasibility will strive to not duplicate work across devolution, ETTF, adult social care but to try and bring service transformation and collaboration into one area.	Partners and customers
Lee Health Centre	Purpose built health centre constructed circa 1978, extending over 2 storeys – ground and first floor (1,121.29 sq. m. GIA).	Phase 1 Feasibility Study	This building does have development potential and this needs to be quantified and explored.	GPs, LGT, SLaM
Hither Green	Freehold building, previously occupied by the sterile services provider. Currently used as a file	Phase 1 Feasibility Study	This building does have opportunities beyond its current use, which is a file store. This needs to be quantified and explored.	LGT



	store.			
Reprovision of Mental Health Beds in Ladywell	The building is nearing the end of its economic life and therefore work is required to provide options for its future.	Phase 1 - Feasibility Study and Business Case – SOC/OBC	The current Ladywell Centre is in need of investment.	Partners and customers
Decant of SLaM Ladywell unit	Subject to the above, if part of all of the Ladywell unit is relocated a robust plan will be needed to determine the new location for the occupants.	Included in the above.		
Back-office Consolidation	The partners and other public sector departments to collaborate over the potential of consolidating and sharing non-clinical support functions in a centralised office location within the borough	Phase 1 – initial workshop and feasibility study followed by options development and business cases.		Partners
Programme Management	To deliver this complex programme of projects a multi-skilled team will be required.		.	Partners
Speedwell	A feasibility study is required to determine the future of this building and its occupants.	Phase 1 Feasibility Study	The current building and layout is not fit for purpose.	Speedwell – Possibly but need a relocation

				plan
DilwynClose	Feasibility Study to determine the future use of this building and its occupants.	Phase1 Feasibility Study	The current building and layout is not fit for purpose.	

Appendix 2 – GP Practices by neighbourhood footprint



Appendix 3 - Case Study on the Waldron

The Waldron Health Centre is situated in the North of the Borough in Lewisham. It is a large health centre and there is a multiplicity of providers utilising space in the premises.

The Waldron is a 6000sq m LIFT building, for which Community Health Partnerships (CHP), is the Head Tenant and income is receivable on all the space within the health centre. Building Better Health - LSL is the LIFT Company who own the building and are responsible for the physical upkeep and their contract is overseen by CHP.

The users comprise four separate GP practices, a variety of Community providers including NHS Lewisham and Greenwich NHS Trust plus a walk-in centre commissioned by the CCG.

The building is deemed to lack flexibility. The LIFT dimension adds to the complexity, in that any changes to the building configuration need to be approved and implemented by the LIFT provider. This can also lead to potential increases in service charges if the new use involves extra cost to the LIFT company. The interface with the LIFT company is entirely the responsibility of CHP.

By common consent, all parties are agreed that the health and care system is not making the best use of this facility and utilisation studies demonstrate that areas are significantly under-utilised and that the footfall is disappointing. There are issues concerning the quality of the management and the perception by users is that the building is not well managed.

The current tenants believe that the costs of rent and service charges are high, but that the maintenance and general management of the building is not commensurate with the perception of high end cost. This leads to a general feeling of dissatisfaction, occasional crises and difficulty for CHP in collecting the charges due. Management of buildings of this type is not helped by the multiplicity of vested interests with no clear accountability. There is under-utilisation of the fully funded leased spaces held by different NHS providers. Therefore the health system is losing out and not getting value for money for the space that is paid for by different parts of the system. There are empty commercial units around it, which have never been let by the LIFT Company and which are permanently shuttered. There is poor upkeep of the adjacent areas by the Council. The approach and vicinity are not attractive to customers.

In addition to the under-utilisation of occupied spaces, there is some void space in the building and the costs for these are borne by either Lewisham CCG or NHSE but as neither organisation manages or occupies the building, it is not totally straight forward to facilitate uptake of the space and no single provider or commissioning party is responsible for the management of the building.

Internally management is slow to respond to security issues and the supervision of the contracts for the upkeep, both in terms of repairs and soft FM, are less than optimal. In addition the reception area is drab, physical access to bookable meeting rooms is not well managed and needs a proper booking system. The CCG is paying for this space but has no direct responsibility for the building (the CCG does have a role regarding utilisation, through commissioning services into the space. However, it can only do so if space is made available.) The access to some of these bookable spaces is physically restricted – without a swipe card, the lift does not open onto the meeting room floor and can only be used by visitors if individually accompanied.

The reception arrangements are not suitable for a building of this kind, the reception service does not serve the building well and the sign posting is poor. The vast atrium is not being fully utilised.

There is currently no operational user group and there has been no clear strategic management of this resource.

Vision

Lewisham's vision is for the Waldron to become a thriving neighbourhood community hub for which it is ideally suited, given its location in New Cross, close to a very large social housing estate. The quality of the building is of a high standard and if it were reconfigured or rearranged, it would be possible for it to host a range of additional services, which would benefit the whole system and ensure that the building was being utilised optimally.

To achieve this there needs to be much closer working between partners and CHP so that resource can be effectively organised on site to meet local priorities. Health and care partners need to have confidence in the building management and to feel that they can work effectively with that management to ensure that the building is fully occupied, be reconfigured if required and the services to building users are commensurate with the costs paid. Repair and other reasonable requests need to be resolved in a timely fashion. Customers need to be attracted to the services in the building and it needs to easily host health promotion initiatives on offer from voluntary groups and others.

However, the problems are partly systemic, in that following the property changes necessitated by the H &SC Act, there is a more fragmented set of accountabilities arising around all Community Estate/Health Centres. Landlord functions have been dispersed but also the commissioning functions have also been dispersed. This contributes to poor visioning for these buildings. The devolution project (and the OPE focus) does provide the flexibilities and freedoms as well as some capacity to establish something which will work and should endure and leave a lasting legacy.

Appendix 4 - Neighbourhood Care Hubs:

Work to define the scope of services and functions that would benefit from co-location is ongoing but each hub could deliver a range of services from the list below:

- A base for GPs working at scale.
- Space for Community pharmacists to improve medicines management.
- Access to Community nursing for adults and children.
- A base for Community Mental Health Teams promoting integrated working with mental health and adult social care teams.
- Community based diagnostic facilities e.g. blood taking, weight management, blood pressure monitoring, urinalysis, ultra sound, ECG, EKG and VTE assessments (but not x-ray).
- Group rooms to enable Patient and Care engagement groups
- Outpatient treatment facilities and acute oncology
- Social care teams
- Enhanced support to those receiving domiciliary care or those vulnerable patients in care homes or extra care housing.
- Clinic space for practice nurses practitioners to assess and treat emergency patients and those with minor illness or injury
- Clinic space for practice nurses to see patients for dressings, cytology and immunisations and vaccinations
- Dedicated space for MTD clinics in Leg ulcer clinic services, diabetic foot and lymphedema – which will be combined to run simultaneously with facilities for foot and lower limb soaking and dressing areas with stock cupboards for dressing materials
- Community midwifery services clinic space and also rooms for antenatal classes

Appendix 5 - Case Study – Community Connections

Lewisham Council commissioned a consortium of voluntary sector providers led by Age UK Lewisham and Southwark (AUKLS) to deliver Community Connections (CC) across the borough. A pilot project, led by ran from November 2013 to March 2015. In April 2015 AUKLS and its partners were awarded a three year grant by Lewisham Council to continue to provide and develop Community Connections.

Community Connections is a preventative community development programme aimed at supporting any vulnerable adult in Lewisham who may benefit from services to improve their social integration and wellbeing. Individuals are supported through person centred plans to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups and organisations in their local area.

Community Connections also works with local community based organisations to assist in their development and capacity building. This is key to the overall success of the work to ensure that there are strong and sustainable organisations, networks and activities in place so that individual older people and vulnerable adults can access the support and activities they are looking for.

The project has a team of 11 posts: a Team Leader, 4 FTE Community Facilitators (CF), 4 FTE Community Development Workers (CDW) and a part time Administrator. All staff are located within Lewisham Council offices in Catford.

Community Development Workers work closely with the CFs to understand the gaps and priorities in each area as identified through individual plans. They are then able to work with local groups and centres to sustain and develop services, and assist with capacity building and creating opportunities. The aim is to strengthen community resources offered to local people.

The CDW's receive and monitor all referrals, and pass them on to the appropriate CF. The system identifies referrals who are looking for information or signposting so they are dealt with quickly. Other referrals are then passed on to the appropriate CF who will make contact with the clients.

Community Facilitators work with individuals to develop a person centred plan to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups, organisations and activities in their local area. Each CF is also allocated to one of the four cluster areas in the borough. Their role with individuals is time limited with the aim of assisting people to identify their needs, to find solutions and put in place ongoing activities and support.

By the end of the pilot in March 2015, CC had received approximately 700 referrals from across the health and care system. Referrals from GPs has increased significantly since the project started as the project has become embedded in the neighbourhoods. 86% reported an improvement in their overall wellbeing following their support from CC in the pilot phase.

Case Study 1:

Olive is 91 and recently widowed. Although she has close family who live nearby, she only left the house to shop and was becoming socially isolated. Following a referral to Community Connections, Olive joined a seated exercise group at the South Lewisham Surgery every Wednesday morning. The group was welcoming and Olive immediately felt at ease. She enjoys tea with her new friends after every class. Olive also attends a monthly coffee club at Elim Church. On her first visit Olive was greeted with a friendly welcome and a hug. She has learnt to play Opon Ayo, a Nigerian game where players compete to be the one with the most pebbles. With the aid of her taxi card Olive is determined now to find more groups to attend.

Case Study 2:

Deborah is 53 and has clinical and depression and reduced movement in her shoulder. She was referred to Community Connections by an Occupational Therapist because she was socially isolated and had expressed an interest in volunteering. The Community Facilitator explored options with Deborah and she started attending cookery and healthy eating courses, joined a crafts group and a film club. She is now a member of a local Timebank and is volunteering with 3 scouts groups. Deborah feels happier, is active in her community and has new friends.

Appendix 6: Buurtzorg

Introduction

Buurtzorg is a unique district nursing system which was founded in the Netherlands in 2006/07. The system has garnered international acclaim for realising considerable efficiencies alongside improving outcomes for patients.

Buurtzorg was established by Jos de Blok (a former nurse) who wanted to develop a new approach to district nursing and home care services in the Netherlands which were considered to be fragmented, with patients being cared for by multiple practitioners and providers. Ongoing financial pressures within the health sector had led to home care providers cutting costs by employing a low-paid and poorly skilled workforce which was unable to properly care for patients with co-morbidities, leading to a decline in patient health and satisfaction.

The Buurtzorg model is founded on the principle of giving district nurses far greater control over patient care. In 2011, Buurtzorg employed nearly 4,000 district nurses and nurse assistants across 380 teams. By 2013, this had risen to 6,500 nurses (an increase of 62.5 per cent) across 580 teams. As of April 2016, the Buurtzorg workforce cares for over 70,000 patients of which approximately
50% have some form of dementia.

Buurtzorg is not the only provider of home care in the Netherlands. They operate in a competitive insurance-based marketplace where patients can choose their provider based on a number of considerations, including: cost, extent and quality of cover provided and reputation.

How does Buurtzorg work?

Nurses lead the assessment, planning and coordination of patient care with one another. The model consists of small self-managing teams, each with a maximum of 12 nurses. Sometimes a team will also oversee Nursing Assistants (the Dutch equivalent to Health Care Assistants). Teams provide co-ordinated care for a specific catchment area, typically consisting of between 40 to 60 patients. The composition of these teams in terms of specialty and level of practice varies according to the needs of each catchment area.

Each new patient relationship begins with high levels of support provided by the team. This is then gradually withdrawn as self-management aids and support from social care, voluntary and third sector organisations are identified, assessed and put in place. This approach is believed to cut long-term care costs by between 30 to 40% and supports a national policy aim of delivering care closer to home or in a homely setting.

In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community in which they work. This helps them to build good working relationships and strong dialogue with GPs, welfare and social care providers, police and paramedics. In terms of revenue, approximately 90 per cent of Buurtzorg's income comes from payments by Dutch health insurance companies.

What services does Buurtzorg provide?

Buurtzorg offers six key services. These are:
1. Holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment

2. Map networks of informal care and assess ways to involve these carers in the client's treatment plan
3. Identify any other formal carers and help to co-ordinate care between providers
4. Care delivery
5. Support the client in his/her social environment
6. Promote self-care and independence.

Buurtzorg cares for patients who are terminally ill, suffer from long-term conditions, dementia or require home care following major surgery. Most of the nurses who join Buurtzorg are trained at a 'generalist' level (similar but not directly equivalent to a UK Registered Nurse in Adult Care). Unlike in the UK, there is no formal district nursing qualification in the Netherlands and none of Buurtzorg's nurses are trained to be independent nurse prescribers. Typical interventions are consistent with those undertaken by Health Care Support Worker in the UK, for example: washing, assisting with dressing, applying compression stockings, applying leg emollients, etc.

Buurtzorg's successes

Buurtzorg has achieved notable breakthroughs, particularly in the following three areas:

- Higher levels of patient satisfaction - in 2009, the Netherlands Institute for Health Services Research (NIVEL) found that Buurtzorg had the highest satisfaction rates among patients in the country.
- Significant reductions in the cost of care provision - results have shown a decrease in unplanned care and hospital admissions when compared to other home care providers in the Netherlands. Buurtzorg has achieved a 40 per cent reduction in client costs when compared to other homecare organisations. Buurtzorg has achieved a 50 per cent reduction in hours of care due to health promotion initiatives and patient independence.
- The development of a self-directed structure for nurses. There are no leaders within the teams and individuals take equal responsibility for making decisions within the team solving their own problems. Buurtzorg's overhead costs are estimated at eight percent, compared to a competitor average of 25 per cent. In terms of staff efficiency, sickness rates for 2014 was four per cent, compared to a competitor average of six per cent.

The Buurtzorg model has involved a substantial investment in smart technology and training to help them update patient records instantaneously using this technology. The focus on simple, accessible IT systems has helped to reduce the bureaucratic workload so that patient-facing time is maximised.

The organisation's ability to facilitate this rapid expansion evidences an integral structural foundation, as well as a strong recruitment appeal.