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SOUTHWARK & LAMBETH
INTEGRATED CARE

Update
Southwark CCG Governing committee
June 2013

NHS Lambeth

NHS Southwark

Southwark Council
Social care

Lambeth
Social care

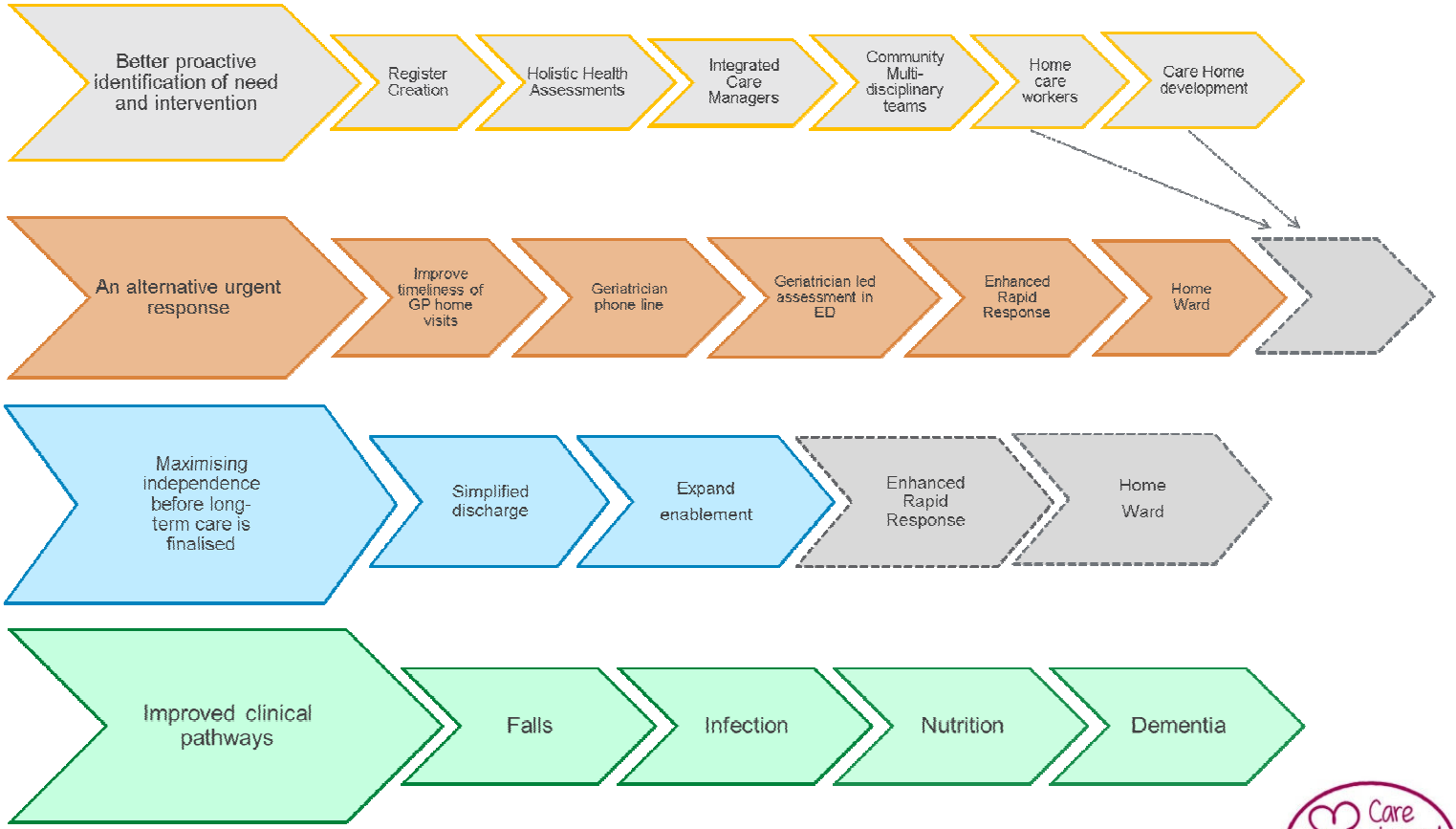
KING'S HEALTH PARTNERS

This report covers:

- An update on the older people's programme, currently live
- An update on supporting workstreams (finance, IT, governance, reporting)
- A look forward – our early plans for people with long term conditions
- Proposals to bid to be an integrated care 'pioneer'

The older people's programme:

- Is introducing a number of interventions (see below) to improve proactive care and urgent response
- Is intended to reduce emergency hospital bed days by 14% and placements in residential homes by 18%, by 2015



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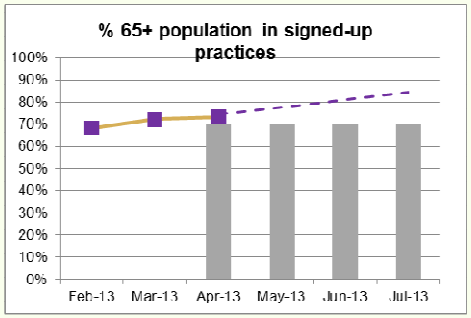
Progress - older people's programme:

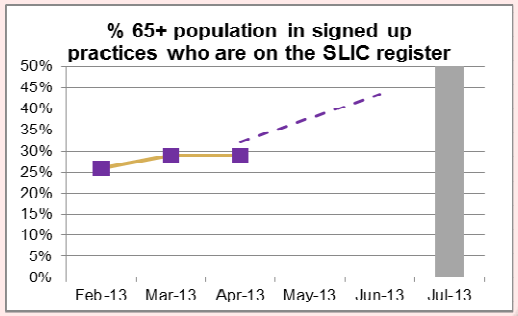
- The older people's programme has made good progress in getting GP signup (75% coverage), establishing CMDTs (all localities covered) and supporting establishment of a range of services (eg geriatrician-led raid assessment)
- However, activity in general practice (holistic health assessment, case management – paid for via a LES) is far lower than expected and for this reason, the programme is unlikely to deliver its intended benefits in 2013/14.
- The operations board has agreed to change the model of delivery so that recruitment to and management of key case management roles is supported centrally, to assist practices with capacity issues – work currently in progress
- In addition, the Ops board have prioritised the next wave of development work as:
    - Dementia
    - Home Care workers as early identifiers of need
    - Simplified Discharge
- We are continuing to implement the clinical pathway improvement work of:
    - Falls
    - Infection
    - Nutrition

Older people's programme: progress on general practice interventions

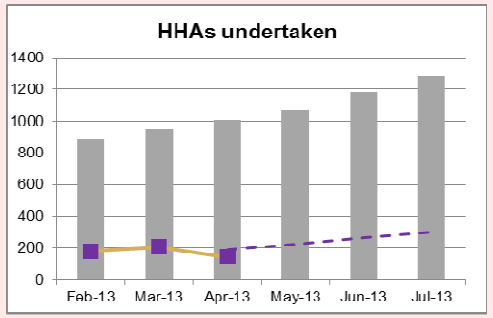
Practice sign up



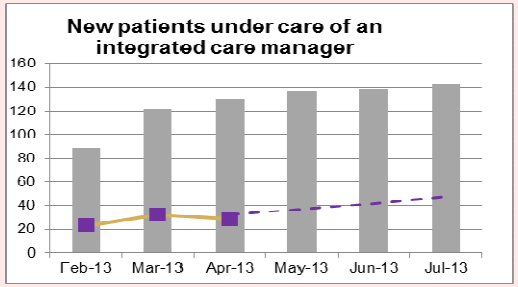
Register Creation



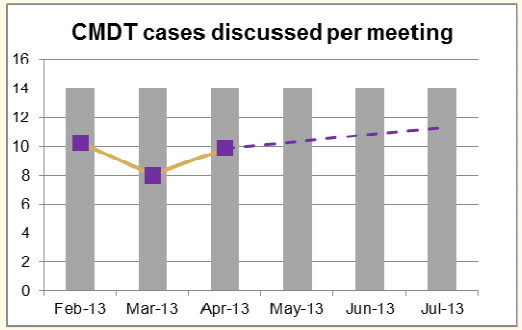
HHAs



Integrated Case Management



CMDTs



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Long term conditions:

we need a new paradigm to support people

Already today we must do better

In Southwark and Lambeth:

- LTCs are under-diagnosed
- Too many people with LTCs die prematurely
- QOF scores for LTC management are well below London average in 7 of 17 LTC diagnoses

The 'Scissors of Doom' - Growing demand with less funding

- Population in S&L expected to grow by 18% in next 10 years
- Aging population
- People live longer with LTCs
- Funding for NHS, Public Health and Social Services is falling well behind growth in demand

Doing more of the same better will not be enough

We must shift the LTC care paradigm from people being dependent recipients of care to enabling and supporting people with LTCs to live independently and optimally with their condition.

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Long term conditions: Our Agreed Programme Approach

A Functional Abilities	• Focus on improving / maintaining people's independent living and functional abilities
B Healthy Behaviours	• Encourage healthy behaviours and choices, especially self-care, to minimise consequences of LTCs
C Change Model	• Use a Change Model that addresses all system components who can enable sustained change
D Virtuous Spiral	• Rapidly sequence initiatives, start small and spread success and learning quickly • Use evidence to adapt actions at maximum speed and adjust implementation

Our LTC programme will focus on the required behaviour changes and types of support, not clinical diagnoses

Dept. Health defines LTCs as:
- "...a health problem that cannot be cured but that can be controlled..."
- "LTCs can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities."

NHS Mandate expects:
- Improvements in health-related quality of life
- People feeling supported in managing their condition
- Improving functional ability (e.g., ability to work)
- Reducing time spent in hospital
- Enhancing quality of life of carers
- Enhancing quality of life of people with mental illness
- Enhancing quality of life of people with dementia

Strong emphasis on improving independence and quality of active life (non-medical)

Suggestion:
Categorise LTC actions by the key behaviour changes and types of support, including self management, that improve health and well being most.

Promoting healthy behaviours – e.g.
- Smoking cessation
- Supporting exercise & fitness
- Enabling healthy eating
- Alcohol and sensible drinking
- Reducing social isolation

Optimising medication use – e.g.
- Regular medication reviews for those on multiple drugs – optimising use, minimising side-effects
- Helping people to take medications as prescribed
- Checking medication stock and home dispensation methods

Detecting and addressing risks early - e.g.
- Adaptations/skills, so those with impaired mobility / physical ability can do all the activities of daily living
- Support those with cognitive decline, to maintain their ability to run a household independently
- Facilities for those with epilepsy with frequent seizures and risk of injury
- Detecting people at risk and stratification (people with established diagnoses only, no screening or case finding)
- Early effective interventions
- Care management

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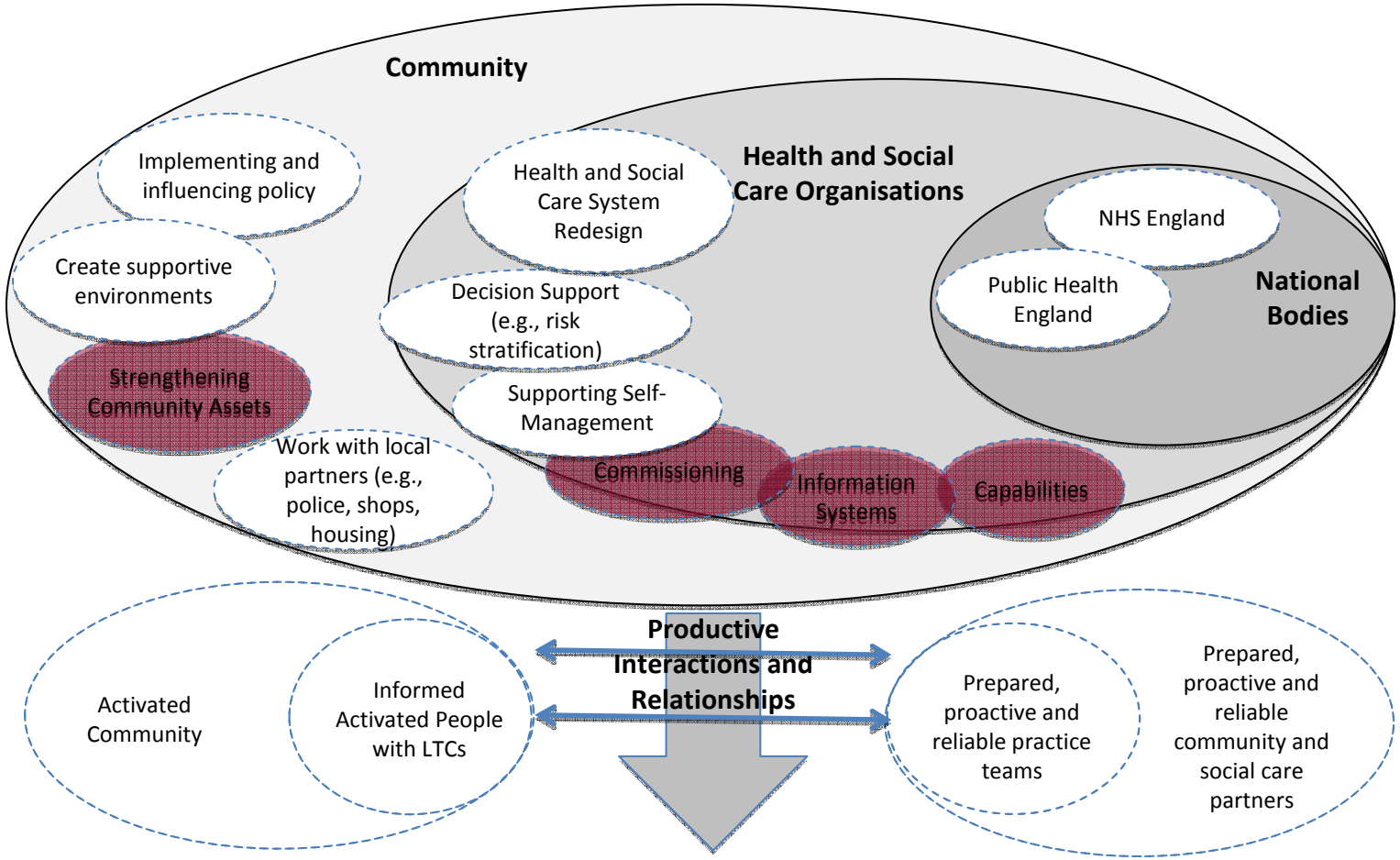
Our LTC programme will also build supporting resources in 4 key areas to enable a new community of care



Population Health and Wellbeing Outcomes
Clinical and Functional Outcomes
Value-for-Money Resource Utilisation

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Supporting workstreams - highlights:

Finance:

•We are currently testing commissioner and provider ambitions to radically change the way we fund care (capitated budgets) to support integration

•To support this we have completed a significant piece of work to generate a person-level dataset including all activity and costs relating to an individual for a year

•Our successful bid to be a DH 'Year of Care Early Adopter' has generated insights into the drivers of cost

IT:

•We are currently implementing a range of interim solutions to improve datasharing between hospitals <> GPs <> social care <> mental health, and at CMDTs, with full implementation by the end of this calendar year.

Governance:

•We are establishing the citizen's board, interviewing for members on 13th June

Reporting:

•Our first phase reporting system is running (monitoring system outcomes and activity); this year information on patient views and costs will be encorporated

Our bid to be an integrated care 'pioneer':

- On May 14th, a national collaborative led by NHS England invited local health and social care organisations to express interest in becoming 'Integration Pioneers' by 28th June.
- **The SLIC sponsor board has agreed to submit a bid.**
- Pioneers are expected to work in a truly whole-system way (across health, public health and social care, and alongside other local authority functions and voluntary organisations), to achieve and demonstrate the scale of change that is required. They must also disseminate and promote lessons learned.
- There are a number of benefits of taking part:
    - Greatly increased local impetus for integration
    - Support from the national collaborative to unblock national-level issues (eg regarding nationally-held contracts, competition rules)
    - Potential support from the national collaborative for local issues (eg health economic and legal support)

What would our bid entail?

- We have a strong history to build on, helping us to meet the 'pioneer' criteria: of strong health-social care partnership in developing integrated care; of good involvement of local people and professionals in setting out a model of care; of establishing a sound financial business case; of leading innovation in financial models; of developing practical IT solutions.

- This is an opportunity to catalyse local thinking and set out a **radical, innovative proposal for integrated care**, that goes beyond the criteria. We know that there will be one or at the most two pioneers in London, so should ensure our application stands out.

- The sponsor board is currently working to define what our bid will set out but it may include the elements overleaf

What could our bid entail?

- A vision to transform planned and urgent care for individuals by taking a holistic approach not only for those already needing the most complex, coordinated care packages but also focusing on broad cross-cutting areas (smoking, obesity, isolation) that can prevent deterioration and ill-health earlier.
- Setting out a vision for a new relationship between individuals and services, with increased personal responsibility for health and self-care, with active community support
- Proposals covering a large area of Lambeth and Southwark, if not all of both boroughs (the criteria require a large footprint)
- A wide, strong partnership going beyond our existing partners to include community organisations and the voluntary sector as well as links to relevant local authority functions such as education and housing, including a clear rationale for this (what these new partners will contribute)
- A firm proposal to pool budgets or put all the money (including social care) in one pot, for example by introducing a shadow capitated budget from April 2014 (work and discussions already underway)
- Creation of a single person-level record and outcome tracking for individuals across the system (delivered through a Virtual Patient Record) (proposals currently on hold)
- Creation of a new Integrated Care Organisation for some or all of the patch, bringing staff (including GPs?) together
- Potential use of alliance contracting to underpin capitated budgets/the risk share/ICO (work currently underway)