Lewisham Health & Care Partners (1/7)

South East London Integrated Care System

Vision

Lewisham Health and Care Partnership aims to achieve a sustainable and accessible health and care system, to support people to maintain and improve their physical and mental wellbeing, to live independently and have access to high-quality care, when they need it. Our commitment is to make Community Based Care that is **proactive and preventative, accessible and co-ordinated.** https://www.selondonics.org/in-your-area/lewisham/

Deliverables / Improvements since 2023/24

- Waldron Community Hub refurbishment with free space for community
- Delivered and evaluated neighbourhood Hypertension community training
- Review of practice based Multidisciplinary Meeting to improve anticipatory case finding
- Second GP youth clinic opened the south of Lewisham
- Opened fourth Family Hub
- Embedding the Virtual Ward service, a single point of contact with the Urgent Community Response team, and ability to treat patients at home rather than hospital
- Launch of a Lewisham Community Anticoagulation services
- Atrial fibrillation detection for undiagnosed patients through Community Pharmacy
- The Same Day Emergency Care unit at Lewisham Hospital expanded
- Creation of a housing protocol for health and care reducing delayed discharges
- Continuation of the Primary Care Network (PCN) Health Equity Fellow programme for local health inequalities initiatives
- Increased access to personalised creative wellbeing activities, working with ICS SEL Creative Health Lead
- Black Therapists Hub set up, referral through local black-led community organisations and IAPT
- Enhanced the delivery of the Start for Life programme to increase reach
- 'Should I really be here' project: to increase mental health/wellbeing literacy within black Caribbean and black African communities, for young males ages 16-25 yrs
- Extension of the Joy Social Prescribing Platform
- Initiated Hypertension service and Atrial fibrillation identification service across primary care and the Voluntary, Community and Social Enterprise Sector (VCSE)
- Initiated Proactive Wellness Service for Older People
- Expansion of Primary Care Mental health team capacity
- All age Autism Hub launch and operational

Key Challenges / Opportunities Remaining

- The continuing development of integrated working between primary care and community services, and between primary care and mental health services can transform the delivery of our services to impact on outcomes and patient experience.
- Working within a neighbourhood footprint that is not coterminous with PCNs can present challenges, there is a need to flex across these boundaries. Also, recognition that within the 'neighbourhood' there are also hyper local communities
- The Neighbourhood model relies on data sharing and digital systems for coordinating care between multiple service providers
- Expanding our Population Health Management data to include housing and benefit support information will help us to respond to the wider determinants of health
- Implementing the Neighbourhood model requires a well-trained and adequately resourced workforce. If staff are not trained in integrated care models, multi-disciplinary work, or using new technologies, they may not be able to deliver the program as designed
- Access to equitable estates across the borough to support a consistent neighbourhood offer
- Improve the uptake of immunisations using the family hub model and improve links with primary care for all ages
- Expand GP youth clinics model to cover the whole borough
- Maintaining the Start for Life offer (Perinatal and Infant Mental Health)
- Opportunity to use the partnership arrangements bridge work between the family hubs, mental health services, Integrated neighbourhood Teams (INTs), adult learning, employment, housing
- Optimising the use of financial resources and ensure delivery of services which meet the needs of the local population and are sustainable in the long term
- Sharing of information to underpin activity and financial planning, and to better inform timely decision making around deployment of resources

Lewisham Health & Care Partners (2/7)

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	What are our priority areas for 2025/26 (Max 4)	Why has this been identified as a priority areas?
1	**To strengthen the integration of primary and community-based care** Through our Integrated Neighbourhood Network Programme, building on existing work across the partnership to improve the delivery and integration of community-based care at a neighbourhood level and will establish the model, infrastructure and framework required to deliver integrated neighbourhood working across health and social care, while ensuring there is alignment with family hubs and programmes for children and young people	Local, integrated services can make service provision less confusing for residents and for people working in the system. They will lead to better outcomes through more holistic support, addressing health inequalities and the links between some of the wider determinants of health, social care and health needs and improved outcomes. Integrated services that are designed and targeted based on population health needs data will also support system sustainability and reduce the duplication of resources. More targeted support will support people manage their long term condition and reduce the need for further acute services.
2	**To build stronger, healthier families and provide families with integrated, high quality, whole family support services.** Establishing the integrated model for family hubs across Lewisham and to identify the integrated pathways that can be delivered through family hubs.	Need to address poor outcome areas for children through increasing access to support in the community, including immunisations and healthy weight, development of prevention and early help interventions in relation to emotional wellbeing and mental health for children, young people and parents
3	**To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes** Reducing the inequalities experienced by those who are most disadvantaged in Lewisham, reducing the gap in poor health between the best and the worst off through dedicated programmes and by ensuring a health inequalities approach is incorporated into everything that we do, building on the progress achieved in the 2022-24 Health Inequalities & Health Equity Programme	Inequalities in life expectancy continue to rise in Lewisham (Marmot,2024). The main causes of death in Lewisham are cancer, circulatory disease and respiratory problems. Lewisham's under 75 mortality rate from Ischemic heart disease (IHD) is higher than the rate for England. There is around 26% of the population with long term conditions, and nearly 10% with more than one long term condition. The Birmingham and Lewisham African & Caribbean Health Inequalities Review (BLACHIR) gathered insights on health inequalities experienced by Black African and Caribbean communities to inform our health inequalities programmes.
4	**To maximise our roles as 'anchor organisations', be compassionate employers and build a happier, healthier workforce.** Working together we will establish joint initiatives to attract and retain staff; provide opportunities for shared career pathways; promote health and care careers; and address workforce inequalities	There are opportunities to create more entry level roles by leveraging each individual organisation's anchor institution status. Increasing employability for the community, resolving workforce challenges and contributes to wider local economic development in Lewisham. Working together on joint learning for frontline staff enhances partnership working.

Lewisham Health & Care Partners (3/7)

South East London Integrated Care System

Priority Area:
Strengthening the integration of primary and community based care

What are the actions we will deliver in 2025/26

- Establish the new Integrated Neighbourhood Model and Teams (INTs): targeted proactive support and identification of preventative needs for people with 3+ LTC.
- Improve Multi-disciplinary Meetings for most complex patient cohort working and management of discharges of significantly complex patients
- Developing new Community Hubs, building on the model established in the Waldron Centre
- Continuing primary care access improvement plans
- Admission Avoidance: averting crisis attendances at Emergency Department, developing Urgent Community Response, Assistive Tech pilot to reduce fallers in the community/care homes
- Discharge/ 'home first': Virtual Ward and reducing the barriers to discharges direct into care homes
- 111 re-procurement and delivery of a same day urgent care shadow running from autumn 2025
- Primary, community and secondary care working jointly to improve referral pathways
- Proactive Ageing Well Service to identify frail people who will benefit from a geriatric assessment
- For mental health, implementing the VCS co-operative project, the 24/7 Community Model in Neighbourhood 2, and developing alternative opportunities for early intervention and support

Population Health and Inequalities Impact

- Our approach is driven by population health data to help us understand the unique needs and challenges faced by our patients. We will focus on factors that put patients at rising risk if not managing their Long-term Condition and potentially becoming complex and frail and to identify people who do not regularly access health and social care services.
- A key focus of Urgent and Emergency Care work is supporting over 65's to remain more safely at home and to return home after an unexpected event leading to a hospital stay

System Sustainability Impact

- Increase proportion of resources used to support people to stay well for longer, by reducing unnecessary hospital attendances, outpatient referrals, hospital admissions and reduced demand on mental health beds, long term residential and nursing placements and care packages
- Create capacity, reinvested to scale the model sustainably and improve cost effectiveness.
- By taking approach to prevent, delay and/or stabilise frailty, we are expecting a reduction in hospital admissions, Emergency Department attendances and admissions to Residential Care.

Lewisham Health & Care Partners (4/7)

South East London Integrated Care System

Priority Area:

Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services

What are the actions we will deliver in 2025/26

- Review of the GP Youth Clinic model and integration with wider adolescent health services, with the longer-term aim of creating an integrated Adolescent Health and Wellbeing offer.
- Establishing key elements of the Start for Life Perinatal and Infant Mental Health programme as a core offer in Lewisham.
- Bringing wider Children and Young People (CYP) community health services and primary care into the Family Hub model to replicate the Adult Integrated Neighbourhood model.

Population Health and Inequalities Impact

- Community based activity closer to families helps remove barriers to access, especially for those who may be put off attending other health centric centres. Integrated services providing a single-point of access with reduced handovers between services, increase efficiency in access.
- Early evaluation of the GP Youth Clinic model shows positive uptake by Black and Mixed heritage young people compared to specialist mental health support.
- Interim evaluation of the Start for Life offers show equal access by parents across IMD and age groups, and high levels of uptake by Black and Mixed heritage parents.

System Sustainability Impact

- Family Hubs and GP youth clinics contribute to the improvement of community based services for children and young people. these provide a joined-up, early intervention approach across a number of services, helping redirecting activity away from more intensive and costly interventions and support.

Priority Area:

Addressing inequalities throughout Lewisham health and care system through taking partnership action

What are the actions we will deliver in 2025/26

- Actions focusing on specific wider determinants areas in line with new Health and Wellbeing Strategy – poverty, housing and education e.g. testing poverty proofing approaches for 2-3 key clinical pathways in Lewisham.
- Through work across neighbourhood areas piloting debt/benefits advice based in health and social care settings i.e. in selected GP practices within target PCNs.
- Working closely and investing in local VCSE groups to bridge gaps between statutory services and communities, for instance to improve cancer screening rates
- Working with partners to identify opportunities to intervene earlier and prevent ill health, better recording of risk factors and management of CVD related LTCs in primary care
- Tackling risk factors of preventable causes of death and ill health such as smoking and rolling out new services to improve management of hypertension and atrial fibrillation

Population Health and Inequalities Impact

- Gap in health outcomes between the worst and best off in the borough should stabilise and begin to reduce (slope index of inequality)
- Populations will feel more able to self-manage their long term conditions, living longer with less time in poor health (health life expectancy)
- People from different community groups that do not currently access primary care supported to engage in proactive and preventative measures to improve their health outcomes (ethnicity data for cancer screening & NHS Health Checks, deprivation data for services)

System Sustainability Impact

- Over the next five years reduced acute admissions for CVD and smoking related conditions
- Decrease in the number of emergency attendances and admissions at ED for ambulatory care conditions

Lewisham Health & Care Partners (5/7)

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Priority Area:

Working together we will establish joint initiatives to attract and retain staff; provide opportunities for shared career pathways; promote health and care careers; address workforce inequalities

What are the actions we will deliver in 2025/26

- Community workforce and integrated neighbourhood teams
  - To look at entry level roles – strong preference for the AHP type of support worker role with also a suggestion about health and well-being coaches
  - Areas for consideration: development pathway through rotations, employment and transfer between organisations; access to apprenticeships
- Co-ordinated and joint recruitment initiatives: shared calendar of recruitment events to co-ordinate planning; establishing links between recruitment teams and council's "Lewisham Works" team for joint advertising of roles and joint recruitment events
- Joint training and OD approach to improve joint working and making every contact count

Population Health and Inequalities Impact

- Increased entry level employment opportunities for local populations
- Roles that contribute to health needs at a neighbourhood level, connecting with local populations

System Sustainability Impact

- Flexible workforce to reduce vacancy and turnover rates
- Better use of apprenticeships and ARRS funding opportunities
- Better use of training opportunities across the partnership

Lewisham Health & Care Partners (6/7)

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Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
To strengthen the integration of primary and community based care	• Delivery of services and management of care for people with long-term conditions (LTCs) that are proactive, holistic, preventive and patient-centred, with collaborative personalised care planning • An established model of care for older people with Proactive Care, Admission Avoidance, Integrated Discharge and Intermediate Care for this cohort • Improve access to primary care and community therapy waiting time	• Reduction in non-elective admissions for LTC conditions • Reduction in unplanned admissions and attendances for Older People • Reduced variation for GP appointments per 1000 patients, in line with the SEL average • Reduction in waiting time for community therapy
To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	• An increase in uptake and completion of immunisations. • A reduction in the number of children with excess weight at Reception and Year 6, to show a reduction of 2% from 2023/24 to 2025/26 • CYP using range of locality-based and digital wellbeing offers as alternative to CAMHS and other specialist social care services metrics for treatment waiting times.	• % uptake of childhood immunisations • % of children with excess weight at Reception and Year 6 • A reduction in waiting times for specialist mental health services (CAMHS).
To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes	• Increased cancer screening rates by population demographic • Reduction in smoking rates by population demographic • Improved recording of risk factors and ongoing management of LTCs in primary care • Longer healthier life expectancy	• Cancer screening rates for breast, bowel and cervical (medium term) • Reduction in smoking rates (short term) • Use of non-health related data in identifying those at risk of decline, i.e. housing/frailty and reducing risks of falls
To maximise our roles as 'anchor organisations' as employers	• Enhances local employment opportunities, make full utilisation for organisations of their apprenticeship levy, and help to overcome workforce challenges in specific areas with high vacancy rates such as community and AHPs	• Numbers of local people starting entry level roles

Lewisham Health & Care Partners (7/7)

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What do we need from enablers and partners to deliver?

- Workforce: a programme around workforce and employment is a key priority for Lewisham. We want to enable further collaboration and integration of workforce plans and aim to improve succession planning, increase the use of joint appointments, adopt joint recruitment approaches and have the flexibility to rotate roles across the local and SEL system.
- Digital: shared data and patient records are fundamental to joint working, while ensuring digital inclusion and patient and stakeholder engagement in developing new assistive technology, digital tools and platforms
- Estates: as partners we want our estate to support service transformation and collaboration and integration across the health and care system, to enable us to work smarter and more effectively in delivering community based
- Communications & Engagement: provide an overarching plan to support our priorities, particularly on integration, ensure that stakeholders and partners are appropriately engaged

How will we work in collaboration with our system?

- Our LCP board provides the strategic direction and oversight of the partnership priorities and delivery. The board is supported by a number of other forums within our local governance structures. All of our key groups have full representation from across the partnership, and the LCP board has increased its representation from the VCSE sector to improve representation from our black communities in particular.
- Our clinical and care professional leadership group plays a key role in all of our transformation programmes and includes secondary and primary care clinicians, and from medicine, nursing and allied health professions.
- Where engagement and leadership with primary care is needed we work the Primary Care Leadership Forum which connects with GPs, community pharmacy and the Local Dental Committee.

How will we engage with our population?

- The Lewisham People's Partnership sits alongside and feeds into the broader structures of the LHCP bringing patient and citizen voices and lived experience into the work of the LCP. It is developing a more strategic focus, a hub and spoke approach and an outcomes framework to demonstrate how the views and lived experiences of people and communities influence LHCP decision making and are utilised in future planning and commissioning. Its work is particularly focused on co-production and engagement work in neighbourhood development, long-term conditions and hypertension, and with primary care improvement.
- Family hubs and GP youth clinics will provide continual engagement of young people and parents in the design of the offer as it expands across the borough.
- Through the All-age Mental Health Alliance, share learning from existing transformation and pilot projects via Mental Health specific community engagement sessions
- For neighbourhoods, we have developed a framework for building inclusive citizen and community engagement in Lewisham. This is about ensuring local people are at the heart of our plans for improving health and wellbeing.
- Work with the Lewisham Black Voluntary Network to shape and develop a tailored co-design approach with Black Led Community Groups.

How will we monitor and share progress?

- The LCP board monitors progress against our priorities while the Place Executive Group monitors programme delivery through programme boards including urgent and emergency care, integrated neighbourhood network alliance, all-age mental health alliance, and the population health management board.
- We use our existing and established communication channels to provide regular progress reports on our programmes through stakeholder bulletins.
- Our various community and citizen engagement arrangements also provide opportunities for progress review with partners in the statutory and voluntary sectors.
- Partners in the Family hubs and GP youth clinics provide dashboards which feed back to the Integrated governance boards for CYP to provide updates and monitoring for delivery of the programmes.