South East London Integrated Care System

Lewisham Borough Overview

NHS South East London

Our population

Lewisham currently has a population of 300,600. It is the 14th largest borough in London by population size and the 6th largest in Inner London. In the next five years our population is likely to rise to over 310,000 and to over 320,000 by 2032. 52.5% of the population are female; 23.5% are 0-19 years of age; 9.5% are aged 65 or over; 67% are 20-64 years of age. The population of very young children aged 0 – 4 is larger in Lewisham than in England.

We have a significantly younger population compared with national averages, with more people aged between 25 and 44. There is a smaller population of those aged 65+. However, it is thought our population growth won't be evenly spread across the ages and we will see an increase in the older population and a slight decrease in the younger population and working age population. Almost half (48.3%) of our population are from an ethnic minority community. Between 2011 and 2031 it has been projected that the size of the population of children and young people 0-19 in ethnic minorities will grow much faster than the rate of children from white ethnic groups.

Health outcomes for our population

For female residents, Lewisham life expectancy (83.2 years) now exceeds the national average (83.1). However for male residents, life expectancy is significantly lower (78.8) than the national average (79.4).

The main cause of death in Lewisham is cancer (28%), followed by circulatory disease and respiratory problems.

Lewisham has lower average mental health scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is higher than in London (7.1%). According to the 2020/2021 ONS Annual Population Survey, 29% of Lewisham residents age 16+ reported high anxiety levels, compared to the London average of 24%, and 24% across England.

We are seeing an increase in the complexity of need and those needing care and the number of people living with multiple health conditions is increasing.

Inequalities within our borough

Lewisham is the 63rd most deprived Local Authority in England and within the 20% most deprived Local Authorities in the country. Bellingham, Downham, Rushey Green and New Cross are the most deprived local wards in the borough. Lewisham's Black and Minority Ethnic communities are at greater risk from health conditions such as diabetes, hypertension and stroke. In addition, Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, including psychotic disorder and Post-Traumatic Stress Disorder (PTSD), and experience inequalities in access to services. In borough we also see late presentations of lung and colorectal cancers.

Those in poorer health were disproportionately impacted by Covid. For some services, including the uptake of preventative healthcare such as health checks, immunisations and certain cancer screening, Lewisham is still to return to pre-pandemic levels. This is concerning in Lewisham, which even prior to COVID-19 was already seeing lower uptake and long-standing health inequalities such as notable differences in life expectancy depending on the area of the borough a resident lived.

South East London Integrated Care System

Lewisham Borough

NHS South East London

What we've heard from the public

Lewisham Health and Care Partners have engaged with stakeholders on the development of this local care plan. Through this engagement, the following common themes emerged.

1. The need to develop a truly integrated way of working across the local system and within neighbourhoods.
2. The need to provide timely and relevant care to children and families at their time of need that is truly person-centred and helps reduce inequalities in access.
3. The need to take a broad lens to access and inequality to better understand what the drivers are and how to address them
4. The need to ensure services are delivered by a happy, healthy workforce and recruitment and retention prioritised.

To support the delivery of this plan, Lewisham has committed to a new, co-designed model of engagement. The model will :

- Support local people to exercise power and contribute as equal partners.
- Build trust by acting on feedback and developing deeper relationships with local people.
- Reduce barriers to engagement (for example language barriers, resource barriers and cultural barriers).
- Work together to achieve more with what we have (recognising funding/time/capacity limitations).

Our People's Partnership will sit alongside and feed into the broader structures of the Lewisham Health and Care Partnership (LHCP) bringing patient and citizen voices and lived experience into supporting the strategy and delivery work of the LCP

South East London Integrated Care System

Lewisham Borough

NHS South East London

Our partnership aims

We are committed to achieving a sustainable and accessible health and care system to better support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Our plan supports the aims of Lewisham's current Health and Wellbeing strategy which are:

1. **To improve health** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
2. **To improve care** – by ensuring that services and support are of high quality and accessible to all those who need them, so that they can regain their best health and wellbeing and maintain their independence for as long as possible.
3. **To improve efficiency** – by improving the way services are delivered; streamlining pathways; integrating services, ensuring that services provide good quality and value for money.

Our plan also aligns with our commitment to make Community Based Care:

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.

South East London Integrated Care System

Lewisham's priority objectives

NHS South East London

1. To strengthen the integration of primary and community based care	2. To build stronger, healthier families and provide families with integrated, high quality, whole family support services.	3. To address inequalities throughout Lewisham's health and care system and tackle the impact of disadvantage and discrimination on health and care outcomes	4. To maximise our roles as Anchor Organisations, be compassionate employers and build a happier, healthier workforce	5. To achieve financial sustainability across the system
We will work together in collaboration and with the communities we serve. We want to design, plan and deliver our services with service users, patients and residents. We want teams to work as close to the patient as possible and for services to be delivered through integrated multi-disciplinary approaches with organisational barriers no longer getting in the way.	*We will work together to join up services and to ensure all parents and carers can access support they need when they need it.* *We want to support and empower parents and carers in caring for and nurturing their children and enable all children and young people to thrive.*	*We will contribute fully to the delivery of the Lewisham's Health Inequalities and Health Equity Programme's objectives which includes improving system leadership and accountability for health equity; empowering communities; identifying and scaling up what works; and prioritising and implementing specific opportunities for action from the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR)*	*We will work together to create a range of employment opportunities for local people and create an environment that fosters wellbeing in our staff. We want to create more entry level roles and contribute to wider local economic development. We want to deploy resources more effectively and creatively to help address employment gaps.* *We want to improve the health and wellbeing of everyone who works for us.*	*The ongoing financial constraints are an impetus for change and we will work together to overcome the financial hurdles ahead.* *By working more closely and smartly we want to alleviate the pressure on services across the system – enabling our budgets to be stretched in ways that support effective service delivery.*

South East London Integrated Care System

Lewisham - our priority actions

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As partners we will take the following priority actions in support of our objectives. More detail on these actions are set out in the following pages and in LHCP's programme and delivery plans.

Strengthening the integration of primary and community based care	Our priority action is to establish the model, infrastructure and approach required to enable effective integrated working at a neighbourhood level. Through this approach we will establish local models of care for at least two long term conditions and to support older people. We will also expand the provision of early intervention and community support for mental health.
Building stronger, healthier families and providing families with integrated, high-quality, whole-family support services	Our priority action is to establish the integrated model for family hubs across Lewisham and to identify the integrated pathways that can be delivered through family hubs.
Addressing inequalities throughout Lewisham health and care system	Our priority action is to build and implement an agreed infrastructure through which initiatives to address health inequalities and achieve health equity in the borough can be delivered.
Maximising our roles as Anchor Organisations, being compassionate employers and building a happier, healthier workforce	Our priority action is to identify opportunities for joint apprenticeship programmes. We will also implement joint initiatives to promote health and care careers and develop tools and approaches to inform workforce planning and address workforce.
Achieving financial sustainability	In partnership we will work to optimise the use of resources, align our financial planning and maximise financial resilience to system pressures.

Lewisham - Our Programmes

Our programmes

We aim to deliver a substantial improvement in health and care outcomes within our priorities. These new priority areas sit alongside other established programmes of work, including all age mental health, planned care and long-term condition management, urgent and emergency care and children's community health.

Delivery of our plan is managed by the partnership's programme boards and associated delivery plans. These include the Family Hubs and Start for Life Programme, the Older People and Frailty Programme, the Mental Health Alliance and the Integrated Neighbourhood Network Alliance. Other programmes of work, including those on planned and unplanned care, workforce and estates also contribute to the achievement of our strategic aims and priorities.
The success of our partnership working and the progress we make against our agreed programme and delivery plans will be overseen by our partnership boards and health and care alliances.

We are also establishing a joint programme management approach to provide Lewisham Health and Care Partners with the assurance that our partnership programmes are being delivered effectively and to time and budget.

South East London Integrated Care System

Lewisham – Our progress to date

NHS South East London

Key Successes in Delivery in 2023/24

- **Older Adults Transformation Programme** - Implemented and continue to develop the 'Capturing the Voice of the Older Adult group' who developed a series of 'I' statements for the programme. Business case for pro-active care prepared with partners for implementation in 2024/25
- **NHS@Home(virtual ward) -** successfully implemented hospital discharge pathways in addition to its' admission avoidance patient cohort.
- **Hospital Discharge**: The number of patients with a **length of stay of over 100 days** has reduced from 14 to an average of 6
- **Embedded the Health Inequalities** Programme and associated partnership workstreams
- **6 Health Equity Fellows** in post and to complete 2 year role in October 2024
- **All 6 Fellows have been matched** with a community organisation that has been commissioned to recruit and manage a pool of community champions
- **Aligned the Lewisham Community Champions** initiative to the PCN Health Equity Teams
- **Developed & delivered 4-6 week programme** for two cohorts to introduce 16 – 17 year olds to potential careers in health and care
- **CYP mental health:** Working with Black Thrive and as part of the national connectors programme, the ICB has engaged with two schools across Lewisham as part of wider SEL ICB work to co-produce a set of tailored interventions to support CYP mental health, particularly children and young people with Black heritage.
- **Access to Black Therapists Pilot –** A pilot has been put in place and the provider Wellbeing For Us will offer access to black therapists for talking therapies. The offer will also include non-Eurocentric therapeutic group work.
- **Conducted review of practice based Multi-Disciplinary Meetings**. Areas for action include adopting a more proactive approach to case finding and referrals, placing greater focus on patient outcomes measuring impact.
- **Population Health Team developed a neighbourhood data profile** to focus activity to support local health priorities in the N3/ Sevenfields PCN Project.
- **Successful implementation of Joy Social Prescribing Platform** across Primary Care, now provides social prescribing activity data across Lewisham system.
- **Family Hubs :** there will be three fully operational family hubs from Aril 2024 comprised of additional staff that offer a wider range of service provision for families
- **Expansion of the Children's Community Nursing Service** to include an allergy nurse and Continence and Constipation Service to reduce children's outpatient appointments and improve outcomes for families.
- **GP-Led Youth Clinic implemented** at The Mulberry Hub, evaluation completed and second year funding sourced to develop model in south Lewisham.

Key Challenges in Delivery in 2023/24

- **Older Adults Transformation Programme** - Systems and processes to have a shared understanding across the system of the population that the Proactive model of care is seeking to support and the mechanism for identifying them
- **UEC Programme** - High levels of attendances at ED leading to significant pressures on hospital
- **UEC Programme -** Attendant pressures in community due to increasing levels of homelessness and complex social/MH issues leading to difficulties in discharging from hospital.
- Difficulties in identifying suitable care home placements in a timely way
- **Implementing year 3 of CMHS** –Limited development and progression against agreed priorities for 2023/24 as majority of MHIS and SDF Funding had to be used within the acute MH care rather than community.
- **Understanding the impact of community mental health transformation**: It has been difficult to quantify the impact of the investment into community mental health teams, although an Expert Reference Group led by SLaM Quality Centre has been established to quantify this for Lewisham Adults.
- **Acute and crisis pathway** – continued number of high presentations to emergency departments with long waits for inpatient beds. Limited movement in the number of patients clinically ready for discharge resulting in longer lengths of stay.
- **Neurodiversity** – Demand continues to outstrip the current available capacity across children's and adults, particularly for ADHD and ASD diagnosis. Staffing challenges also impacting the ability to reduce the back-log and waiting times for autism assessments for children and young people .
- **EHCP Assessment** - Increasing demand for health assessments for EHCPs leading to increasing numbers of assessments completed later than statutory timescale.
- **CYP Mental health** – SLaM financial position and the impact on delivering the CYP EWB&MH Transformation priorities, particularly eliminating 52+ week waits
- **Partners reported challenges in capacity to support and deliver -** in each workstream and a lack of ability to engage effectively during the design stage. As a result, we reduced the number of workstreams and focussed on one Neighbourhood at a time, the objective being to test new ways of working and scale.
- **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.
- **Pilot workforce toolbox -** which articulates minimum standard of training for frontline staff

Learning and Implications for Future Delivery Plans

Older Adults Transformation Programme - Developing a collaborative learning and supportive culture to enable system working
UEC programme - focus on improving discharges with the Home First programme. In 2024/25 we will continue to address the key issues causing discharge delays, through piloting a Hospital Care Homes liaison post to improve links between care homes and the hospital teams, and focus on improving joint working and patient outcomes with enablement and therapies teams.
Ensuring effective acute flow to enable investment and focus on other areas: Pressures on the mental health urgent and emergency care pathway have dominated the focus in 2023/24. It's important the system ensures the appropriate capacity and flow is in place for 2024/25 to then enable the system to focus on the wider pathway.
Streamlining the deliverables for each financial year: Recognition that plans for 2023/24 were perhaps ambitious across all the key priorities and therefore moving into 2024/25, there will be a streamlined approach to service delivery.
Focus on data and outcome recording and improving the quality of this data: Common datasets across the six boroughs will be a key focus in 2024/25 to ensure the system can appropriately and effectively understand the impact of the investment and transformation for our local residents. There will be a concerted effort across both mental health trusts to improve the data quality within the mental health services dataset (MHSDS).
For successful neighbourhoods working building relationships and trust in the community is critical, this takes time and must be incorporated into planning approach.
Important to align our work and learn from what works well in other settings for example working with Health Equity Fellows and aligning work with opportunities for action outlined in BLACHIR. Report.
Agreed and shared approach to tracking the impact of initiatives across the Lewisham system and early agreement on how to mainstream successful initiatives.

Lewisham priority action 1: integration of primary and community based care (1)

Integrated Neighbourhood Networks

Through our Integrated Neighbourhood Network Programme, we will build 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 .

How we will secure delivery

Actions for 24/25

- Review impact of 23/24 actions
- Update PCN and neighbourhood data profiles
- Update neighbourhood plans to address priorities identified from data profiles
- Progress multi-disciplinary working areas for action including approach to anticipatory case finding and suggest any additional GP contract changes
- Finalise framework for neighbourhood working with a view to scale up to other neighbourhoods
- Deliver and evaluate neighbourhood community training
- Implementation of new South Lewisham mental health youth hub
- Deliver phase II of the Social Prescribing Personal Health Budget Scheme
- Development of cross borough working arrangements with Greenwich and Bromley focussed on the Horn Park Pilot

Actions for 25/26

- Design and delivery of training package to support integrated neighbourhood working
- Embed framework for integrated neighbourhood working
- Improving access to Personalised creative wellbeing activities, working in partnership with ICS SEL Creative Health Lead
- Scale up of successful approaches to improve MDM working and implement new contract changes
- Undertake evaluation of Waldron ground floor refurbishment and use by community
- Review and evaluation of the Social Prescribing Platform

Intended outcomes in 5 years time

- Strong Neighbourhood Alliance(s) in place
- Integrated and coordinated neighbourhood teams in place
- Personalised health and care services coordinated around population needs
- Improved local awareness of services available
- Established social prescribing networks that support the needs of the Lewisham population
- Improved and timely referrals between services
- Effective multidisciplinary working/teams in place following best practice

Lewisham priority action 1: integration of primary and community based care (2)

Older People's programme

The Older people's programme is an LCP priority that through formulation of a preventative and proactive approach aims to shift activity from unplanned to planned whilst keeping those over 65 living independently in their home for as long as possible. Through the Older People Transformation Board, we will shift over 65 Emergency Department attendance and Unplanned Admission activity to the community thorough the implementation of the Proactive Model of Care outlined in our Business Case (2024). For the purpose of this update, the focus is on the Proactive Care model.

How we will secure delivery

Actions for 24/25

- Invest £200,000 to launch and implement the Proactive Model of Care in collaboration with LGT colleagues
- LGT finance team to build a 'record and report' system which will produce the analysis required to monitor impact of the Proactive Model of Care
- 'Capturing the Voice of the Older Adult' group will monitor impact of the Proactive Model of Care on achieving the 'I' statements and produce an annual report
- Support colleagues at LSE to evaluate (i) the circumstances of older people with moderate care needs and their Unpaid Carers, (ii) the support they receive (iii) the consequences for their wellbeing of different support and (iv) the implications of different care arrangements for costs and value for money of the care system.
- Continue to nurture the professional relationships with LGT senior colleagues building on the collaborative approach adopted to draft the Business Case
- Ongoing engagement with professionals through the Professionals Group

Actions for 25/26

- Invest £300,000 embed the Proactive Model of Care in collaboration with LGT colleagues
- LGT finance team to continue to monitor impact of the Proactive Model of Care through the 'record and report' system. This information will be used by LGT colleagues to mainstream the Proactive Model of Care from 01 April 2026.
- 'Capturing the Voice of the Older Adult' group will continue to monitor impact of the Proactive Model of Care on achieving the 'I' statements and produce an annual report
- Use the findings from the LSE study to support commissioning intentions for community services

Intended outcomes in 5 years time

- Sustained 4% reduction in ED attendances for over 65s
- Sustained 4% reduction in Unplanned Admissions for over 65s
- An annual sustained increased proportion of Older Adults remaining at home.

South East London Integrated Care System

Lewisham priority action 1: integration of primary and community based care (3)

NHS South East London

Long Term Condition management

Working across the Lewisham Local Care Partnership, we will establish models of care for the proactive detection, management and reduction of Long Term Conditions, including for those with complex multi-morbidities, wider wellbeing challenges and where inequalities exist in how different patient cohorts experience LTCs.

How we will secure delivery

Actions for 24/25

1. Improve how we use Lewisham and SEL datasets to robustly understand population health dynamics, proactively shape our priorities and target finite resources.
2. Review Community Dermatology Services and agree long-term provision.
3. Improve the low rates of hypertension control in Lewisham, including primary care quality improvement, patient activation and VCSE development.
4. Redevelopment of MSK services in line with national and SEL guidelines. Scoping the cost-value benefits of the 'getUbetter' app used in Lambeth and Southwark to date.
5. Review and improve access to community respiratory services, including adult and paediatric spirometry and supporting management within primary care.
6. Scale and spread of learning from the Chronic Kidney Disease Multimorbidity Model of Care pilot, to develop intensive, holistic multidisciplinary management of people with CKD, multiple LTCs and social wellbeing concerns.
7. Referral optimisation between primary and secondary care, including the Emis Referral Optimisation Protocol and promoting Consultant Connect, Advice & Guidance and PLTs.

Actions for 25/26

- Utilise the integrated neighbourhoods model to establish a sustainable MDT approach for people with LTCs, including proactive identification, community-led risk assessment and voluntary sector capacity building.
- Support a holistic review of all community services within the LGT block contract with a view to re-designing or re-configuring provision to secure best practice, reduce waiting times and improve Value for Money.

Intended outcomes in 5 years time

- Reduction in the number of people living undiagnosed with LTCs.
- Delivery of services and management of care for people with long-term conditions that are proactive, holistic, preventive and patient-centred.
- Patients have an active role with collaborative personalised care planning at the centre of everything we do.
- Clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress.
- Care planning for local populations makes best use of local authority services (including social care and public health) and community resources, alongside more traditional health services.
- Increased motivation and ability of patients to self-manage and support, ensuring they access the most appropriate services in a timely and safe manner.
- Improved patient experience through early and accurate diagnosis of disease with effective treatment closer to home.

Lewisham priority action 1: integration of primary and community based care (4)

Early Intervention and Community Support

In partnership we will expand the provision of early intervention and community support for all-age mental health services.

How we will secure delivery

Actions for 24/25

- Development of an integrated single point of access for all CYP services.
- Ongoing delivery of the adult community mental health transformation programme, maximising the investment made available and learning from the stocktakes and evaluations of programme delivery from 2023/24.
- Development and design of a new community model of care building on the models from Scandinavia and Trieste(Italy).
- In partnership with South London Listens Programme, and in collaboration with residents and Voluntary, community and social enterprise sector (VCSE), continue to develop, build and test alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population.

Actions for 25/26

- Continue to embed delivery of community and primary care mental health and wellbeing services.
- Through Local Care Partnerships, and in collaboration with residents and VCSEs, to continue to develop and build alternative models and opportunities for early intervention and support for mental health and emotional wellbeing, including for the Core20Plus population.
- Flexible approach to delivering MHSTs in schools and rolling out Wave 12

Intended outcomes in 5 years time

- For CYP, have implemented the i-Thrive Framework including joined-up approaches to deliver an integrated single point of access in place for mental health and emotional wellbeing support.
- 100% coverage mental health support in schools.
- Each PCN to have a fully established adult integrated community mental health teams bringing together health and social care and VCSE providers.
- Contacts through community mental health to have increased 5% on average every year, with contacts representing the demographics and need of our local population.
- Increases in the number of people accessing employment support.
- Increased access to Talking Therapies (including for people with long term conditions) and equitable recovery outcomes for all population groups.
- Increased investment in VCSE providers with noted improvements in the diversity of the VCSE provider landscape for adults.
- Upskilling of at least 40 community leaders and volunteers as Be Well Champions, and establishing hubs providing regular wellbeing activities/spaces and signposting

Lewisham priority action 1: integration of primary and community based care (5)

Urgent and Emergency Care

Through our local programme we will support colleagues across SEL and Lewisham to reduce the need for ED attendances and acute admissions where these could have been prevented by earlier intervention. We will work closely with all system partners to ensure that appropriate attendances are quickly managed, and inappropriate attendances are minimised through referral away to suitable alternatives. We will seek to fully embed the Home First approach and ethos in Lewisham, resulting in a high proportion of patients discharged home, with excellent follow up support where needed.

How we will secure delivery

Actions for 24/25

- Same Day Urgent Care mapped and interfaces improved
- Increase referrals to SDEC
- Improve use of Consultant Connect
- Pilot in place to trial referrals away from ED
- Data reliability achieved with ward/patient level dashboard
- Intermediate Care Strategy Developed to support improved hospital discharge pathway
- Care Homes liaison post pilot in place
- Improve Weekend discharges
- Consolidate successes of the Virtual Ward by expanding capacity to 75 beds (adults) and 5 beds (paeds), including seamless step down pathways for respiratory, frailty and Heart Failure as a minimum and a step up offer to primary care

Actions for 25/26

- Review of performance against agreed actions for 24/25
- Further use of population health data to assess activity
- Agree new partnership actions

Intended outcomes in 5 years time

- Same Day Urgent Care model is well understood and provides access to same day urgent care for Lewisham residents
- Integrated model of NHS@home including UCR in place
- Reduction in patients discharged to care homes to best benchmarked peer borough
- Increase in proportion of patients not needing further care/support following enablement
- Attendances at UHL ED are more appropriate
- Increase in number of discharges before 5pm
- Increase in weekend discharges

Lewisham priority action 2: integrated, high-quality, whole-family support services (1)

Family Hubs and Start for Life Programme

In partnership, we will establish five Family Hubs in Lewisham to provide accessible, physical and virtual points of contact for families, children and young people aged 0-19 (or aged up to 25 for young people with special needs) and to deliver integrated pathways. As of April 2024, Lewisham will have three new Family Hubs fully operational with additional staff based on site and additional services for parents, including a new Family Navigator role to support families to access services across the system.

How we will secure delivery

Actions for 24/25

- Integrate Children and Family Centres into Family Hubs by March 2025 to create a sustainable model when the Start for Life funding ceases in March 2025
- Spring 2024 Expand the offer of community health services through Family Hubs e.g Immunisations and healthy weight
- Summer 2024 - Evaluate impact of year 1 of Family Hubs on outcomes for families, children and young people, including on key health indicators evidencing access to and outcomes from services.
- Summer 2024 - Review provision across Family Hubs and Early Years to ensure equal access to services, and make changes as needed
- Autumn 2024 - Open 2nd FH in area 1 (Honor Oak Youth Centre)

Actions for 25/26

- Spring 2025 – Sustainable offer in place following cessation of DfE funding
- Spring 2025 – Digital Family Hub offer in place, including web, apps, automation of processes
- Summer 2025 – Open FH in area 2 (location tbc). Likely to include a hub model for SEND and autism.
- Autumn 2025 – Evaluation of Family Hub and Early Years offer and review of health outcomes achieved

Intended outcomes in 5 years time

By joining up and enhancing services through our Family Hubs, including integrating Children and Family Centres, parents and carers in Lewisham will be able to access the support they need when they need it. The Family Hubs will be supported by a network of other services and families will be able to access information on services virtually or via outreach work. Parents and carers will feel supported and empowered to care for and nurture their babies and children, ensuring they receive the best start in life – Connect, Grow, Thrive.

This in turn will improve health and education outcomes for babies, children and young people and enable them to thrive. The planned outcomes for Family Hubs include:

- An increase in the number of parents accessing support for perinatal mental health
- An increase in the number of women from target groups accessing infant feeding support services
- An increase in the number of parents receiving structured support with parent-infant relationships
- An increase in uptake and completion of vaccinations
- A reduction in the number of children with excess weight at Reception and Year 6
- A reduction in waits for CAMHS referrals

Lewisham priority action 2: integrated, high-quality, whole-family support services (2)

Local Child Health Teams

Alongside our priority to establish Family Hubs, we will deliver an enhanced children's health offer in the community working alongside primary care that increases access to support closer to home. This will help develops our primary care workforce to deliver more efficient care to children and young people.
Integrated working will consider will help address inequalities by providing appropriate and accessible services for the communities in Lewisham. It aims to provide better support communities who at risk of adverse life outcomes and limited positive health outcomes due to health inequalities and adverse childhood experiences (ACE).

How we will secure delivery

Actions for 24/25

- Engage and consult with children and young people, primary care and acute services to develop an Integrated Community Model for Lewisham
- Work with SEL leads to develop a Lewisham model of integrated community based care, using established teams to help leverage improved outcomes. This will adapt best practice from areas already providing effective integrated models in SEL.
- Identify a PCN to co-design the neighbourhood model for integrated working.
- Engage with wider primary care to identify options to work with pharmacies.

Actions for 25/26

- Review the impact of the community model and integrated working with PCNs.
- Extend the Community Model to more PCNs by March 2026.
- Identify opportunities to develop services for LTC linked to the implementation of core offers for CYP Core20Plus5.

Intended outcomes in 5 years time

- Improve child health outcomes – a reduction in CYP follow up primary care appointments and admissions to hospital (ED and non-elective)
- Overall reduction in paediatric appointments as health needs addressed and managed efficiently in primary care
- Improvement in overall quality of care CYP receives
- Reduce inequalities in access to care – reach the local CYP population
- Strengthen the health system

Lewisham priority action 2: integrated, high-quality, whole-family support services (3)

Consistent and Sustainable Children's Community Services

To improve access, reduce variation and improve capacity in community care for children, young people and their families.
To implement the SEL Core Offers for Community Services based on the Core20Plus5 for CYP.
To improve access to asthma services within the community, to consider its links with air quality and the impact this has on vulnerable communities living in areas of deprivation.

How we will secure delivery

Actions for 24/25

- Continue to monitor core community services to identify areas of pressure across Therapies, Community Nursing and Community Paediatrics.
- Continue to monitor the demand for Education Health and Care Needs assessments and timely completion of health assessments for EHCPs.
- Monitor the recovery plans from LGT to reduce the waiting times for ASD assessments and implementation of the ASD Core Offer.
- Implement the core offers for Asthma, Respiratory Hubs, Epilepsy and H@H in Community Services.
- Implementation of the All Age Autism Wellbeing Service offering pre & post diagnostic support offer for CYP and families; and adults in Lewisham.

Actions for 25/26

- Ongoing development of Continuing Care policies, procedures and practice across SEL/London reduce variation in care and assessments.
- Review the impact of the All Age Autism Wellbeing Service on ASD waiting times.
- Ongoing review of waiting times for EHCNA and ASD assessments.
- Review alignment of Community health services with Family Hub model, and identify services which would be appropriate to co-locate.
- Review impact of core offers on health outcomes for CYP.

Intended outcomes in 5 years time

- 90% of EHCNA health reports completed within the statutory timescale. Waiting times outside of the statutory timescales reduced.
- Reduction in waiting times for ASD assessments to within 3-5 months target.
- Improved access to community nursing for health needs and enteral feeding support in specialist schools.
- Reduction in referrals to Urology and Constipation out patient clinics from Primary Care.
- 80% of community services have a core offer attached specifying CYP outcomes to be delivered at place.
- 70% of core offers are implemented at place.
- Reduction of inequality in health outcomes.
- Planned winter response and reduction in emergency attendance for CYP between December and February (annually).
- System capacity increased to meet the needs of approximately 300 additional places in specialist school over the next three years (impact capacity of Nursing and Therapy support services).

Lewisham priority action 3: Addressing inequalities

Addressing inequalities

In partnership we will build and implement an agreed infrastructure through which initiatives to address health inequalities and achieve health equity in the borough can be delivered. The implementation of specific opportunities for action and recommendations from Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) will have a fundamental thread throughout the Programme and each workstream will oversee the implementation of the BLACHIR themes and delivery of specific opportunities for action.

How we will secure delivery

Actions for 24/25

- Implement a Lewisham-wide **targeted hypertension project**
- **Improve awareness** of Black, Asian and Minority Ethnic communities groups of symptoms of cancer and screening programmes through the Lewisham Cancer Awareness Network., linking with Community Champions, Faith and Community Groups
- **Support Practices and PCN** to deliver cancer components of the PCN DES , working with the SEL Cancer Alliance
- **Deliver community projects/initiatives** through the PCN Health Equity Teams
- Have an established **preventative community-based outreach initiative** in place for Lewisham
- **Evaluate** the PCN Health Equity Fellows and Teams.
- **CYP mental health:** Working with Black Thrive and as part of the national connectors programme, the ICB has engaged with two schools across Lewisham as part of wider SEL ICB work to co-produce a set of tailored interventions to support CYP mental health, particularly children and young people with Black heritage.
- **Asylum & Refugee Lewisham Partnership Meeting:** a multi-agency approach addressing inequality of provision of accommodation and wrap around support for highly complex vulnerable families of asylum with management of associated risk factors managing interventions.

Actions for 25/26

- Align the work of the Lewisham Cancer Awareness Network with the PCN Health Equity Teams
- Refine and finalise the Lewisham Health Inequalities workforce toolbox for use across frontline health and care services in Lewisham
- Evaluate the targeted Tier 2 weight management service for Black African and Black Caribbean residents
- Implement learning from the Black Thrive programme within schools.

Intended outcomes in 5 years time

- Established and sustainable PCN Health Equity Teams in the 6 Lewisham PCNs with active Community Champions supporting community preventative initiatives
- Improved population coverage of Rapid Diagnostic Service
- An increase in uptake for all three main cancer screening programmes to reach the regional (London) average uptake - breast, bowel and cervical
- An increase in all childhood immunisation programmes to reach the regional (London) average uptake
- Improved uptake of NHS Health Checks in Lewisham above the regional average

Lewisham priority action 4: Maximising our roles as Anchor organisations

Workforce and Employment

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

How we will secure delivery

Actions for 24/25

- Complete programme to support health and social care staff wellbeing
- Design Health and Care Jobs Fair to raise awareness of local employment opportunities in entry level and support roles
- Develop an entry level apprenticeship scheme for therapy support workers
- Pilot workforce planning tool

Actions for 25/26

- Deliver further careers insight and employment opportunities programmes
- Extend the apprenticeship programme
- Develop partnership Black, Asian and Minority Ethnic communities leadership development programme
- Implement outcomes of workforce planning tool analysis

Intended outcomes in 5 years time

Vacancy rates will be reduced by at least 50%
75% of posts will be filled after first advert
An increase in Black, Asian and Minority Ethnic communities representation at senior management level.

Lewisham priority action 5: Achieving financial sustainability

Achieving financial sustainability

In partnership we will work to optimise the use of resources, align financial planning and maximise financial resilience to system pressures across the local Health and Care System

How we will secure delivery

Actions for 24/25

- During 2023/24 we will work collaboratively across the LCP to better understand how improvements in outcomes and experience in defined population groups can support sustainability of services, individual organisations and the system as a whole. We will link this in the first instance to our work being undertaken within our Older People and Frailty Programme.

Actions for 25/26

- Building on the work of 2023/24 described above, the LCP will aim to have agreed service improvement and associated service changes to achieve improvements in outcomes and experience and shared financial planning.
- Any contractual or financial arrangements that need to change will be agreed with local health and care partners and with SEL ICB.

Intended outcomes in 5 years time

The LHCP aims to have implemented plans for delivery of patient care which optimise 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.

The LHCP aims to have maximised financial resilience to system pressures through sharing of information to underpin activity and financial planning, and to better inform timely decision making around deployment of resources.

Lewisham enablers (1)

Workforce

Our workforce is our strongest asset but locally we continue to face recruitment challenges and staff shortages across the health and care system. Therefore, a programme of activity 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.

We believe that there are opportunities to create more entry level roles into health and care and use the assets and resources we have as local organisations to benefit the communities around us.

As a partnership we are also committed to working together to improve the health and wellbeing of everyone who works within the partner organisations and to be a compassionate employer.

Digital

Across the partnership we will seek 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. We will work with the ICS Digital Programme to:

1. Improve interoperability between health and care data systems maximising the use of our population health and care data management system
2. Embed a consistent approach to data sharing across ICS and across local organisations, particularly when involving third party providers (Voluntary, community and social enterprise sector)
3. Increase the use of authorised health technology to promote self-care and to help manage long term conditions
4. Increase the use of technology and flexible approaches to consulting to enable same day urgent care access for those who can/will use technology and to free up traditional capacity for those who cannot
5. Explore digital platforms which can accommodate video conference capabilities to provide direct consultations to patients/service users
6. Work across the system to reduce digital exclusion

Lewisham enablers (2)

Finance

The ongoing financial constraints across Lewisham are an impetus for change and we are working together to overcome the present and future financial challenges.

By working more closely and transparently, we aim to better understand how improvements in outcomes and experience in defined population groups can support the sustainability of services, of individual organisations and of the system as a whole. We are linking this through our system intentions to work being undertaken within our Older People Programme and treatment of hypertension.

Achieving financial stability is a key local care and health partnership priority.

Estates

As partners we want our estate to support service transformation and 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 will ensure that our estates plans align with the South East London Estates Strategy and the PCN estates reviews. This work will be supported by the Local Health and Care Partnership's estates forum which brings together partners across the system. We will work with our clinical colleagues to ensure alignment of estates plans with clinical strategies.

Our programme leads will identify the estates requirements within programme and to ensure successful achievement of delivery plans.

Lewisham borough: Examples of local delivery of SEL priorities

Lewisham borough delivery of SEL pathway and population group priorities

Lewisham's Local Care Plan sets out our direction of travel as a partnership and outlines the priority areas on which we will focus over the next 1 – 5 years in support of the programmes, pathways and priority target groups identified in SEL ICB's Joint Forward View. Examples of how we are contributing at a local level to the overall aims of South East London are shown below.

Mental Health

The 'Should I Really Be Here' (SIRBH) initiative aims to identify and test community-based approaches that people say will help support early help-seeking & support for males, ages 16-25 who identify with African-Caribbean/dual or multiple heritage background. The initiative will improve ways of accessing this target group, ways of engaging and ways of supporting to make positive contribution to wellbeing. the project is currently in the scoping phase with partners and is intended to go live in 2024/25.

Access to Black Therapists Pilot – A pilot has been put in place where Wellbeing For Us will offer access to black therapists for talking therapies. The offer will also include group work for non-Eurocentric therapeutic interventions.

South London Listens and Goldsmith's University project - partnership currently being mobilised to increase the number of adults being able to access counselling and CBT, where access to counselling will be available through student placements and work closely with Be Well Hubs and Champions.

Population Health Management

Through Lewisham's integrated Population Health Management System, we use data from various health and care systems to improve the health of Lewisham's population, by understanding general trends and needs, and identifying those individuals to target for improved care.

By interrogating the data we can better support individuals by identifying those who we believe are at risk of a particular illness or condition and improve the way in which we plan services.

We are currently managing around 20 active projects, some examples being:

- Looking at overlapping patients across AF, HT, CKD and Diabetes to understand where we can approach patients collectively rather than for singly for one condition and to establish where patients may not have yet been tested for the other conditions
- Proactively managing older adults.
- Case finding those at risk of HT in the next 5 years time
- Waiting list dashboard management by picking out those we can optimise for surgery

Lewisham borough: Examples of local delivery of SEL priorities

Maternity – Mindful Mums

The ICS and local authority jointly commission Bromley, Lewisham and Greenwich Mind to deliver the Mindful Mums and Being Dads programmes, which are peer–led programmes of support with mental wellbeing and resilience for expectant and new parents.

The programmes have been successful in improving wellbeing, increasing resilience and reducing isolation amongst parents with emotional wellbeing needs in Lewisham.

Based on this success, the provider is currently piloting new programmes aimed at meeting the specific needs of new parents from ethnic minority backgrounds, young parents, and parents that identify as Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+).

Additionally, Lewisham Maternity Voices Partnership, the ICS and Lewisham and Greenwich NHS Trust have recently been shortlisted for an award from the Royal College of Midwives for their partnership work on Cultural Humility in Maternity Care. They developed a Quality Standard which sets out six principles for good and safe maternity care from the perspectives of Lewisham women and birthing people of diverse cultural backgrounds, and aims to increase the involvement of Black, Asian and minority ethnic service users in quality assuring services. A short film was created which can be viewed here: Quality Standard for Cultural Humility in Maternity Care - YouTube

Urgent and Emergency Care - Home First

Since May 2022, participants from across health, social care and the voluntary sector in Lewisham have co-designed and started implementing a blueprint for change that will enable the Lewisham system to sustainably support people being discharged home.

By working together, the Home First programme has been broken down into 90 day sprints. Every 90 days the group come together to review the achievements of the previous 90 days, decode the collective learning, and plan for the next 90 day sprint.

By working in this way and developing joint actions and initiatives we have implemented systems to identify patients with complex discharges earlier, reduced
intermediate bedded care LOS and improved intermediate bedded care patient outcomes. Following intervention and establishment of a LLOS group, the number of patients with an extremely long length of hospital stay has reduced significantly.

In the forthcoming period our priorities are:

- Improvement in issues causing delayed discharges under pathways 1 & 3
- Develop a “one team” approach across our teams who support people being discharged home in Lewisham
- Better alignment of capacity to demand in post-discharge enablement & therapies