

# Southwark and Lambeth Integrated Care (SLIC)

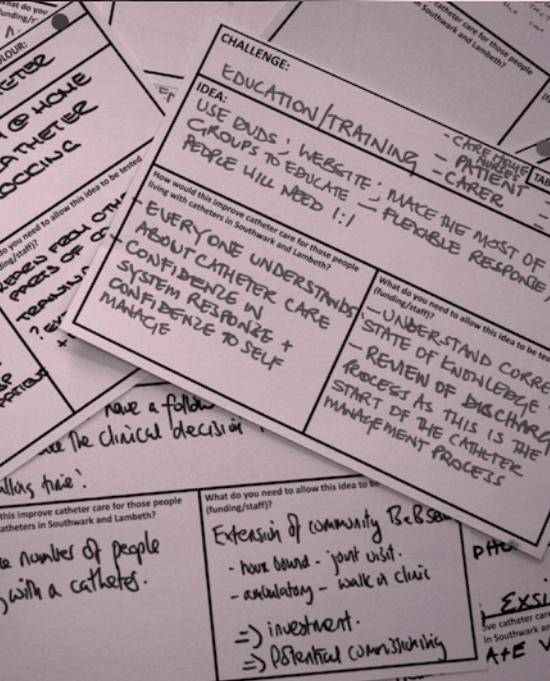
SLIC  
Programme

*Integrating Care in Southwark  
and Lambeth: What we did  
and how we did it*

*Abridged*



SOUTHWARK & LAMBETH  
INTEGRATED CARE



# Foreword

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When Southwark and Lambeth Integrated Care (SLIC) began in 2012, the concept of integrating care was seen as a radical departure from the status quo.

Our vision was for local health and social care systems to work in partnership to improve the way care is provided in Southwark and Lambeth, so that local people's needs are recognised and they can be supported to lead healthier and happier lives. And we had to do this while taking into account tough financial constraints.

Four years on, this vision is being made a reality, largely due to the Guy's and St. Thomas' (GST) Charity for their significant investment, and for the constructive challenge and support they have provided to the partnership.

There is no doubt that together we have made a difference to the people of Southwark and Lambeth.

Take, for example, 95-year-old Joe who, thanks to attending Strength and Balance classes, not only feels more confident but has made new friends and started wearing a shirt and tie once again. Or 79-year-old William who, after numerous visits to hospital with painful catheter problems, now has an individual care plan to prevent catheter blocking and A&E attendance.

Out of the 27 SLIC projects, 24 have now been mainstreamed or chosen for continued testing – in itself an indicator of success. That, coupled with the fact that we have stabilised emergency admissions and attendances in Southwark and Lambeth while other boroughs have seen a steep increase, is testament to the hard work of all involved in SLIC. This is an extraordinary success.

Today we are in a strong position. But how we arrived here is just as important as the destination. The story of SLIC is the story of a journey and the unexpected twists, turns and detours the partnership encountered to get where it is today.

Although our vision has remained the same, the programme developed significantly beyond its original scope and aims as it progressed. Initially set up to improve the quality of care for elderly people, partnership work broadened over time to become a much wider and more ambitious programme of system transformation, fundamentally altering how the £1 billion Southwark and Lambeth care budget is used. A 'resilience'-based approach was developed, focusing on people in the holistic (not just medical) sense. This approach supported people to take control of their health and wellbeing instead of

being dependent recipients of care. It improved the quality of care and also demonstrated how making best use of existing resources in the community could have real impact and save money.

That is why SLIC is, at its heart, a story of learning. Arguably the main success of the programme – and the biggest lesson learned – cannot easily be measured. It is the relationships, trust and leadership that have flourished during the programme that lie at the root of our achievements. Getting to this point was no mean feat – we had to change a culture of competition between providers into a culture of collaboration. This has built a strong foundation for integrated care in Southwark and Lambeth, and that will allow us to move even faster with the next stage of system transformation.

During its four years as SLIC, the partnership has not only gained a deeper understanding of how to integrate care: it has shown that it is possible. As we move into the next phase – the Southwark and Lambeth Strategic Partnership – we have spent time reflecting and looking back to see how far we have travelled. It is important for us to understand the journey, celebrate what SLIC has achieved, act on what we have learned and share our experiences widely.

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It seems obvious that health and social care services should be working more closely together to provide better and more preventative treatment and care that empowers people, meets rising demands and cuts costs in wasted or duplicated efforts. But the evidence base for the value of integrated care is still emerging. SLIC sought to achieve three things: better health outcomes for patients; improved staff and citizen experience; and to cut costs in wasted or duplicated effort. Confirmation of the positive impact of integrated care on the first two aims is being reinforced, but its impact on costs is much harder to assess. While SLIC is unable to provide definitive evidence of the effect on costs, our feeling is that integrating care provides the single largest opportunity to improve the financial sustainability of the system and improve the outcomes for our population.

Our hope is that our experiences can contribute usefully to the debate about the value of integrated care, and our intention is that this report will be a useful resource, both for the GST Charity and for the partnership going forward, but also for others considering undertaking a similar journey.

As you'll see, it has not been easy. As with any large-scale change

programme, we've had to learn from our mistakes, respond to unexpected developments and adapt accordingly. But most of all we've had to learn to work together, and invest time in building trust and relationships. The partnership has relied on the expertise, enthusiasm and commitment of its staff, clinicians and citizens to bring about change and it is this that has seen us through difficult times and seen us emerge, if not unscathed, then in a much better place. The SLIC story is their story too.

We are now at a critical point in our journey. Holding the partnership together to bring about further change is not easy, as the system's resources continue to be squeezed. Keeping the partnership going will require courage, trust and significant investment from all involved, along with often uncomfortable leaps of faith.

However, when we see the positive impact that partnership working and new interventions have had on local people – and professionals – we know that we have to keep going. There is no alternative, and no turning back. During the past four years there have been times when we have struggled to reach a consensus, but there is one thing we all agree on – we are heading in the right direction.



**Helen Charlesworth-May**

Strategic Director – Children, Adults and Health, Lambeth Council



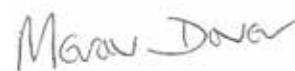
**Dr Jonty Heaversedge**

GP and Chair, Southwark Clinical Commissioning Group



**Sir Ron Kerr CBE**

Executive Vice Chair, Guy's and St. Thomas' NHS Foundation Trust



**Merav Dover**

Chief Officer, SLIC

May 2016

# Executive summary

SLIC was commissioned by GST Charity to produce an ‘end of grant’ report to understand the impact of its £10.6m grant towards delivering the partnership’s vision of helping local people to lead healthier and happier lives. The report draws on previous evaluations of the programme, in particular the King’s College London (KCL) evaluation published in May 2016. This report defines SLIC the partnership and SLIC the programme; outlines its aims, successes and challenges; discusses its impact; and shares lessons learned. It also signals the future direction for integrated care in Southwark and Lambeth.

## Key points

- SLIC is a partnership of local commissioners and providers across health and social care, along with local people, working together to improve the value of care for people in Southwark and Lambeth. SLIC is also used as a term to describe the partnership’s £39.7m four-year programme of interventions.
- SLIC came into being in 2012 in response to the realisation that the status quo of providers working in a fragmented system focused mainly on reactive, not preventative, care would not be sustainable or affordable in

tackling the issues associated with an ageing population with increasingly complex health and social care needs.

- The partnership had three aims: to identify and address care needs at an early stage; join up care around people and across providers; and provide care in the most appropriate setting – and to do this within tough financial constraints. To succeed required more than just ‘joining up’ services: the partnership knew it would need to bring about a fundamental culture change, radically redesigning models of care and commissioning approaches, and breaking down silos.
- SLIC developed a programme of interventions to bring about this transformation, but how it went about change was just as important as what it did. Key to its success was addressing ‘enablers’ such as building trust and relationships; investing in leadership, governance and a strong support team; and facilitating citizen and clinical engagement. The approach came to make good use of a ‘test and learn’ quality improvement methodology, alongside co-production with stakeholders to ensure interventions were innovative

and based on user need, and that the potential of the expertise and resources that already existed in the health and social care system, including the voluntary and community sector, were utilised.

- The process of transformation was not linear and SLIC had to be adaptable and honest, flexing in response to learning and need and changing over time. While SLIC brought about positive change, it was not an easy process and mistakes were made, including a lack of engagement and no systematic measurement. This meant the partnership got off to a slow start and it began to gain traction only when it addressed these issues, co-designing interventions with stakeholders, building trust and relationships, and measuring interventions.
- The programme began by focusing on the needs of people over 65, supporting them to remain independent in their own homes, for example via Enhanced Rapid Response nursing and @home services. Over time, partnership work broadened to develop a ‘resilience’ based approach which focused on people in the holistic, not just medical, sense and that supported them to take

control of their care instead of being dependent recipients of it.

- The realisation that the delivery of care couldn't be integrated unless the systems underpinning it were also integrated was a key milestone in the programme. For example, the Local Care Record, by enabling the real-time sharing of electronic patient records between partner NHS hospitals and local GP practices, gives clinicians faster and more secure access to patient information, allowing them to view all relevant information before making clinical decisions and avoiding duplication of test requests and appointments.
- Not all SLIC successes involved large-scale system change. Some of the most effective projects have been co-designed, with professionals and citizens working together to design new services and test new approaches, such as the Falls Prevention project, which won the 2016 HSJ award for Value and Improvement in Community Health Service Redesign. The voluntary and community sector has also proved to be an invaluable asset, for example, Age UK 'Care Navigators' working closely with GP practices to help manage the social needs of their older patients.
- In considering the extent of SLIC's success, the report highlights the fact that of the 27 SLIC projects, 24 have now been mainstreamed or chosen for continued testing. In addition, during the period of SLIC (2012–2016), despite the population of Lambeth and Southwark aged 65 years and over growing by 5%, hospital admissions and bed days were stabilised and residential and nursing home placements were reduced.
- It is not only the figures that give a true sense of the impact of SLIC – it is the experience of real people that SLIC has affected, for example Bella, who, after having a Holistic Assessment, has a reduced risk of stroke and a better quality of life. It has also had a positive effect on professionals by fostering a sense of 'interconnectedness' – for example, GPs and geriatricians working together via the Telephone Advice and Liaison (TALK) helpline.
- Although the originally envisaged cost savings were not met, there is no doubt that SLIC brought a host of benefits, both to the providers and recipients of care, and that some people have experienced better care as a result. As the KCL report stated in its conclusion: "There is a view among many stakeholders that the system is in a better place, taking together aspirations, relationships and service redesign, than it would have been in the absence of SLIC."
- During its time as SLIC, the partnership not only gained a deeper understanding of how to integrate care; it has shown that it is possible. Many lessons have been learned – both what to do and what not to do – as well as inherently difficult issues that still require further consideration by the partnership. The SLIC Framework for Success condenses SLIC's learning and sets out the elements that need to be addressed in taking forward any programme of integrating care.
- The 12 elements are grouped under three headings – producing the plan and communicating the vision; planning to deliver; and how will you know if you're successful? Specifically, the partnership highlights the importance of agreeing the balance between cost saving and improving outcomes and patient experience; the relative priorities between new models of care and the enablers to support them; and the timescales required for delivery. It also states the necessity of robust measurement and evaluation; co-creating and communicating a vision; creating the conditions, time and space for change and strong leadership and effective governance and ownership.
- While SLIC has laid the foundations for integrated care, to fully achieve integration will require further sustained effort. The SLIC phase of the partnership ended on 31 March 2016, making way for its next incarnation – the Southwark and Lambeth Strategic Partnership. The Strategic Partnership is using the lessons learned in SLIC to continue working towards achieving the vision of improving the value of care for local people.

FIGURE 1 SLIC Framework for Success. Our 12 key principles for integrating care



# The case for change in Southwark and Lambeth

Four years ago, in common with other boroughs, Southwark and Lambeth were struggling to deal with the pressures of an ageing population with increasingly complex health and social care needs.

The resources available to support the provision of local services were diminishing, and those services were fragmented and operating in isolation, largely focused on treatment and not prevention. Despite hosting many of the UK's most talented clinicians, professionals and leaders, the system made it difficult for them to work together, and communication was poor. This meant that people often struggled to navigate their way through the system, and this had a negative impact on their experience of care.

As well as hampering efficiency and clinical outcomes, this way of working wasn't financially sustainable. Analysis carried out by McKinsey showed that, if nothing was done, health and social care spend in Southwark and Lambeth would increase by 35% by 2018/19, with a projected funding gap of £339m.

SLIC was set up in 2012 to address this collective problem with collective action.

Recognising that they would need to do things differently to be able

to deliver high-quality care for patients in the years ahead, local GP practices, the three local NHS Foundation Hospital Trusts – Guy's and St. Thomas', South London and Maudsley and King's College – along with Southwark and Lambeth Clinical Commissioning Groups and local authorities, agreed to work together as a partnership.

Our vision was to improve the way care is provided to the people of Southwark and Lambeth, supporting them to lead healthier and happier lives. We would do this by:

- identifying and addressing health and social care needs at an early stage;
- supporting individuals and communities to take control of their health and wellbeing;
- improving people's experience of care and ensuring more consistent quality; and
- addressing the tough financial pressures the local system is under.

To succeed, we knew we would have to do more than just 'join up' services: we would need to bring about a fundamental culture change, breaking down silos and radically redesigning our models of care, commissioning approaches and provider partnerships. And we would have to do all this while ensuring we lived within our means.



*Despite hosting many of the UK's most talented clinicians, professionals and leaders, the system made it difficult for them to work together*

# **SLIC Impact**

## We've created the building blocks



**Trust and relationships**



**Citizen involvement**



**Co-designing interventions**

## We've designed and tested interventions

### Supporting people to feel safe and cared for at home

**4,500**

people supported at home, preventing admission to hospital through Enhanced Rapid Response (ERR)

**4,000**

people supported by @home, reducing time spent on hospital wards

**90%**

of referrals to the Mental Health Care Home Intervention Team seen within seven days, reducing aggressive behaviour and prescribing of anti-psychotic drugs

**16%**

reduction of hospital readmissions from care homes

### Enablers of interventions

**100%**

of patient records are available to GPs and the three hospitals as a result of the Local Care Record, leading to;

**1m**

hits to the Digital Directory of dementia services in two years

**75%**

fewer calls from GPs to hospitals chasing information;

**200**

fewer hospital referrals each month; and

**2,000**

fewer requests for hospital tests each month

## We've stabilised system costs

### Stabilised emergency attendances and admissions for over 65s

In contrast to a marked rise elsewhere

### 61% reduction in residential and nursing home placements for over 65s



**Quality improvement methods**



**Leadership and governance**



**Systems to share information**

**Joining up care across providers**

**14,500**

people have benefitted from an Holistic Assessment (HA) offered by every GP practice

**2,000**

people with complex needs have had their care supported by a Community Multi-Disciplinary Team meetings (CMDTs)

**1,500**

calls to the TALK service resulted in 720 people avoiding admission to hospital through referral to the Hot Clinic

**175**

people had wider social needs met by Care Navigators within four months

**Getting involved earlier to improve lives**

**91%**

of the 600 people seen by the Community Dietetic Team met their dietetic goal, along with fewer pressure sores and urinary tract infections (UTIs)

**75%**

of people attending falls exercise classes reported increased confidence and quality of life, and no hospital admissions due to falls

**Stabilised emergency bed days for over 65s**

In contrast to a marked rise elsewhere

**Snapshot**

**Summarising our achievements**

These are just some of the things we've done to support people in Southwark and Lambeth to lead healthier and happier lives.

## Annex 3: SLIC project roll call

**@home** – A multi-disciplinary team providing acute clinical care at home which would otherwise be carried out in hospital.

**Acute to care home** – Improving transfers of care between hospitals and care homes.

**Care Navigation** – Creating closer links between the voluntary sector and primary care to enhance the delivery of Holistic Assessments and care co-ordination.

**Care home (Speech and Language Therapy)** – Improving the delivery of Community Speech & Language Therapy for nursing home residents with communication and/or eating and drinking difficulties.

**Catheter Passport** – A document that goes with the patient as they move through care settings to improve information-sharing and empower the patient to better self-manage their catheter.

**Community Multi-Disciplinary Teams** – A team of hospital, community and social care staff who support care managers and GPs with challenging care management or system blockages.

**Dementia (Care Home Intervention Team)** – A specialist mental health team to support care home residents with dementia who also exhibit challenging behaviour.

**Dementia (Digital Directory)** – An online directory of local dementia services for the public and professionals.

**Dementia (Psychiatric Liaison)** – Providing specialist support to the Emergency Department at Guy's and St. Thomas' Hospital for over-65s with dementia or mental health problems.

**Enhanced Rapid Response (ERR)** – Providing enhanced therapy, nursing and social work support to enable people to stay in their own homes and prevent admission to hospital, or support them to be discharged from hospital earlier.

**Falls prevention** – Providing a Strength and Balance Helpline which accepts referrals from citizens directly or through their GP or a voluntary and community sector representative to attend community exercise classes to help them reduce their chances of falling.

**Good to Go** – A simulation course for professionals to equip them to provide high-quality care transfers for older people.

**GP Emerging Leaders Programme** – A programme to build leadership skills across general practice to drive new models of care in Southwark and Lambeth.

**Holistic Assessment (HA)** – A proactive and comprehensive assessment of need for over-65s, undertaken in their GP practice.

**Hot Clinics and TALK** – A direct access phone line with rapid access to clinics for community staff and GPs to support immediate action planning and reduce unnecessary hospital admissions.

**Integrated Care Management** – Additional support for care co-ordination/navigation following an HA, for older people who are more vulnerable or with complex needs.

**Integrated Hospital Discharge Team** – Improving the discharge process on hospital wards by including a social worker, discharge co-ordinator, therapist, nurse, doctor and administration assistant on an Integrated Hospital Discharge Team.

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**Local Care Networks** – Networks led by staff and citizens, ensuring professionals work together effectively to create much more co-ordinated care.

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**Local Care Record** – Allows staff in primary and secondary care to view each other's patient records in real time.

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**Locality Geriatricians** – Bringing geriatricians into the community to support the management of frail, elderly patients in primary care.

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**Nutrition** – Testing community-based interventions to reduce malnutrition in older adults.

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**Reablement** – Rehabilitation to enable discharge from hospital.

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**Resilience** – Supporting individuals and communities to take control and self-manage their health and wellbeing, bringing in voluntary and community sector support.

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**Simplified discharge (Discharge2Assess)** – Transferring patients from hospital to a less busy and pressured environment, such as Extra Care accommodation, where they can be fully assessed before returning home.

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**TALK** – See Hot Clinics above.

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**Urinary tract infection (UTI) and cellulitis checklists** – Checklists designed to support healthcare professionals in identifying and treating these infections to avoid A&E admission.

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**Voluntary and Community Sector development** – Designing and testing new models of voluntary and community sector commissioning in Lambeth for health improvement services, and in Southwark for social prescribing around physical activity, Long Term Conditions and mental wellbeing.

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**Workforce** – Developing the integrated workforce by designing a core competency framework to enhance professional skills and leadership behaviours.

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## Annex 4: People stories

### Joe's story

Joe, 95, attended Strength and Balance classes in Bermondsey. They helped him walk better, and gave him a new lease of life.

Many of Joe's friends have passed away and he has found it hard to meet new people – especially when he became unsteady on his feet.

Joe said: "The classes gave me my life back and the resolve to never give up on life. I've started to wear ties and 'proper clothes' to go out in again. I've now got my confidence back and I've made friends too!"

### Mary's story

*Told by Rachel Henry, Southwark Safe and Independent Living (SAIL) Care Navigation Team Leader at Age UK Lewisham and Southwark*

"Mary, 67, was referred to us by her GP, as she had been frequently visiting the GP practice for about a year. She would often be waiting outside the practice for it to open in the morning. The receptionists would have a chat with her and make her a cup of tea.

"A member of our team went to meet Mary at home. The Care Navigator found out that Mary's mother had died a year ago and

she had felt very lonely since then. They also talked about what Mary would like to do to get out of the house more and make new friends. Mary was interested in trying out an arts and crafts group, so they went along to a centre together the next day.

"Mary really enjoyed it and wants to go back regularly as she can see herself making friends there – and she has not been dropping into the surgery since she started to go to the centre."

### William's story

*Told by Irene Karrouze, Continence Nurse Specialist at King's College Hospital*

"William, 79, lives alone in sheltered accommodation and has a urethral catheter due to benign prostate hypertrophy. Between March and September 2014, William presented in A&E eight times due to catheter problems.

"William said that, when he experienced catheter problems, he would ring an ambulance instead of calling his district nurse. So I gave William a Catheter Passport, and explained that his catheter problems could be resolved by his District Nurse, whose contact details were in the passport. We later discharged

William, with the Catheter Passport completed.

"I'm now confident that William will be managed better, because of the passport and an individual care plan that has been put in place to prevent catheter blocking and A&E attendance."

### Mavis' story

*Mavis Adenekan, 74, talks about her experience of the Strength and Balance classes and explains the positive impact they have had on her life*

"I began having difficulties bending my knees – I had to hold on to chairs for support when I was standing up. Then last summer my knees gave up and I had to start using a stick. It was a slippery slope from there, because I started to develop back problems from walking differently. I even changed my sofa, because the old sofa was too low for me to get up from, and I thought I was going to have to move out of my flat, because of all the stairs.

"Last year I moved to a GP in Lambeth and I was referred to the Strength and Balance classes. I've been attending since last September. When I first attended the class I took the walking stick

with me, but the classes have now given me the confidence and strength I need – I don't use my stick anymore!

“I'm getting older, but I've found strength through the classes to prevent injuries.”

### Norman's story

*Norman is 82 years old and lives alone in a warden-controlled flat.*

Norman used to attend A&E regularly, but never required admission to hospital. He was referred to and discussed at a Community Multi-Disciplinary Team meeting. Following the meeting, an integrated care manager (ICM) looked into the pattern of Norman's A&E attendances and found they were always on Sunday afternoons.

The ICM spoke with Norman and found out that Norman had lunchtime Meals on Wheels from Monday to Friday. He had no other cooking facilities in his home, so in the evenings and on a Saturday, Norman would go to his local cafe. However, the cafe was not open on Sundays, and Norman told the ICM that he would go to A&E as he liked the lunch they gave him and the company.

The ICM was able to arrange for Norman to have Meals on Wheels changed so that he received lunch and dinner on a Sunday. The ICM also arranged for a tea gathering to happen on Sunday afternoons in his block of flats to help with his loneliness.

### Edith's story

*Told by Claire Flanagan, Team Leader, Mental Health Care Home Intervention Team*

“Edith, 100 years old, was referred to us by the care home she lived in because she was becoming aggressive at random points during the day, her sleep was increasingly poor and she was experiencing hallucinations and delusions.

“Edith had already been prescribed medication to help with her sleep and aggression. When she was first referred to us, we undertook an initial assessment, including completing the Challenging Behaviour Scale and Cornell Scale for Depression in Dementia scorings. Edith scored highly on them both: 149 out of 400 in the Challenging Behaviour Scale and 17 out of 38 in the Cornell Scale.

“We saw Edith regularly for 12 weeks and, when we reviewed her progress, we found that she had no episodes of aggression and her sleep had become more regular. She still experienced hallucinations and occasional delusional beliefs, but they were more manageable. Our last assessment with Edith showed there was a fantastic improvement. She scored 8 out of 400 in the Challenging Behaviour Scale and 4 out of 38 on the Cornell Scale. I was so pleased we were able to help Edith, as these changes have improved the quality of her life significantly.”

### Bella's story

Bella, an 80-year-old Portuguese lady, has a history of dementia, type 2 diabetes, hypertension and heart disease. A Holistic Assessment identified a history of falls which had never been addressed, that she was unable to comfortably take a bath, and that she had poor diabetic control and very high blood pressure, putting her at significant risk of stroke.

A care plan was put in place and Bella now exercises daily on an exercise bike, takes regular walks and, after a home visit by an Occupational Therapist, can now bathe more comfortably. She has also reduced her blood sugar levels, and has significantly reduced her blood pressure to the normal range. Bella is now far less likely to be admitted to hospital with a stroke, as a result of diabetes, or a fall.

### Violet's story

Violet was very lonely, and the only person she saw was her daughter. She told a nurse during a Holistic Assessment that she loved to sew, but had no-one to sew for. A Care Navigator told Violet about the Blackfriars Sewing Club, and suggested she give it a try. Violet felt very welcomed and she is now thrilled that sews and makes clothes to raise money for the club. She has also joined an exercise group and a lunch club.



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In partnership with:

Guy's and St Thomas'   
NHS Foundation Trust

King's College Hospital   
NHS Foundation Trust

South London and Maudsley   
NHS Foundation Trust

  
**Southwark**  
**Clinical Commissioning Group**

  
**Lambeth**  
**Clinical Commissioning Group**

