Southwark and Lambeth Integrated Care (SLIC)

Integrating Care in Southwark and Lambeth: What we did and how we did it
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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.
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 lain 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.
How will you know? Planning to deliver Producing the plan and communicating the vision

• Co-create a vision that is meaningful to all

Make sure it is understood at all levels, across all organisations.

• Produce a strong business case

Agree the balance of priorities between cost savings, improved outcomes and improved staff and citizen experience. Be explicit on the required timescales for delivery of benefits. Set achievable targets, with a realistic trajectory for change.

• Create the conditions for change

Ensure there is funding to ‘buy’ people’s time and incentivise collaboration. Build trust and engagement and ensure there is clear ownership from all partners.

• Identify interventions and system enablers

Create high-impact interventions based on evidence – or strong hypotheses that generate evidence – and linked to population need. Adopt a ‘test and learn’ QI approach.

• Facilitate and encourage co-design

Work together to design and test robust interventions and ensure that citizens are able to play a key role as catalysts for change.

• Identify programme support

Be explicit on the functions required, think about a central vs virtual team and identify an independent challenge function.

• Use available expertise

Identify external organisations that can support and accelerate progress on your agenda e.g. voluntary and housing sectors.

• Develop lateral leadership and change skills

Bring together all those tasked with delivering quality improvement and equip them with the skills to bring about transformation.

• Use measurement metrics

Measure at programme and project level and think about how to measure ‘intangibles’ e.g. trust and relationships and citizen engagement.

• Evaluate continuously

Consider how best to collect data – consider a ‘researcher in residence’.

• Learn and adapt as you go along

Encourage a culture of honesty to be able to respond and adapt to learning.

• Have strong governance structures

Pay close attention to ownership and accountability.
About SLIC

Defining SLIC

SLIC is a partnership of commissioners and providers across health and social care, along with citizens, working together to improve the value of care in Southwark and Lambeth to help local people to live healthier and happier lives. But there are two ways that SLIC is defined:

SLIC the partnership.

SLIC as a term to describe a set of interventions – the SLIC programme.

The SLIC programme aims were to:

• join up care around people and across providers;
• identify and manage people’s care needs better and intervene earlier; and
• ensure that care is provided in the most appropriate setting, particularly at times of acute crisis.

Interventions to achieve these aims were designed to relate to and support each other and bring about system-level transformation.

SLIC the partnership worked together on SLIC the programme to design and deliver these interventions, but the partner organisations also worked on their own initiatives, individually and in sub-groups, for example, the Diabetes Modernisation Initiative, the development of GP Federations, Lambeth Living Well Network, and the Southwark Safe and Independent Living (SAIL) project in partnership with Age UK.

SLIC has had a major impact. However, the multitude of projects taking place in Southwark and Lambeth, as part of SLIC and outside it, combined with interdependencies between the projects, means it is very difficult to attribute success solely to either the SLIC partnership or SLIC the programme. This issue will be discussed in more depth later in the report.

The SLIC business case

In considering the impact of SLIC, we must consider progress against the business case submitted to the GST Charity for funding in 2012.

In January 2012, the majority of care for people aged 65 and over in Southwark and Lambeth was not preventative or co-ordinated, resulting in high levels of demand for hospital and institutional care. The business case sought to address this issue and reduce demand.

The business case set out extremely ambitious aims and, four years on, we have achieved many of these. We have tested and implemented new models of care, learned to work together, and had a positive impact on the lives of the people providing care and those receiving it. In short, we have shown it is possible to transform the health and social care systems in Southwark and Lambeth – no small feat.

What was also ambitious in the business case was the trajectory of change and the financial targets – and there is a now consensus among stakeholders that these were unrealistic.

Projected financial savings included a reduction of 14% in emergency bed days (later re-profiled to a 5% reduction) per month for people aged 65 years and over, and an 18% reduction of residential care home placements by 2015.

As discussed later in the report, although the target for emergency bed days was not met, this comes with a caveat: given that the population of Lambeth and Southwark aged 65 years and over has grown by 5% over the period 2012/16, we have succeeded in keeping numbers relatively stable. In addition, the targets to reduce residential care were exceeded in both boroughs.
FIGURE 2.1 SLIC the Partnership

* Transforming Outcomes and Health Economics Through Imaging
FIGURE 2.2 SLIC the Programme
So, although we may not have made the cost savings we set out to, we are still doing well compared to other London boroughs. While we managed to stabilise costs, other boroughs have seen costs rise. Also, SLIC has brought a host of other benefits to those who provide care and the recipients of it – some benefits way beyond the remit of the programme.

**About the report**

This report examines the impact of SLIC, critically considers its successes and achievements and discusses the challenges it faced in achieving its vision of helping people in Southwark and Lambeth to lead happier and healthier lives. It also includes lessons learned and recommendations for the partnership in its next phase, and for those considering undertaking a similar journey.

SLIC has undergone a number of evaluations during its four years, and in drafting this report we have considered a number of reports. These are listed in the references at the end of this report.

As the King’s College London (KCL) report has incorporated evidence from all of these reports, and is the latest and most comprehensive report of SLIC, it will be our main point of reference.

We have also included data from board reports, as well as anecdotal evidence – in particular, patient stories and feedback from those closely involved in the programme.

**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!”

**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 Bella 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 within the normal range. Bella is now far less likely to be admitted to hospital with a stroke, diabetes, or a fall.
Addressing a collective problem with collective action
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.
Enabling transformation – GST Charity support

Today the concept of ‘integrated care’ has a growing profile throughout the health sector, largely due to the publication in October 2014 of the NHS England Five Year Forward View and its focus on developing new models of care. Subsequently, the five-year commissioning strategy Our Healthier South East London was published in July 2015, aimed at providing person-centred care in a proactive and integrated way.

But when SLIC began, linking up services at scale across the local NHS and local authority social care, and working together to deliver preventative, co-ordinated and community-based services was a radical departure from the norm.

As one of the first major schemes of its kind in the UK, there was no blueprint to follow, and so the decision to integrate care was bold. The partnership needed to be able to innovate and test new approaches, while simultaneously continuing to provide and improve care for the people of Southwark and Lambeth.

The GST Charity grant allowed the partnership to fulfil this dual role, creating the space that enabled time and effort to be invested in testing ways to integrate and transform care. In other words, it gave the partnership the opportunity to take more risks, and to experience and come to understand what delivering new models of care and system enablers actually involved, while maintaining current services.

This ‘transformation’ funding symbolised a deal between the Charity and the partnership: one that would bring together the funding, and develop, test and implement successful interventions at scale. Just as importantly, the Charity would provide constructive challenges that triggered important reflections on the partnership’s approach throughout its four years as SLIC.

**FIGURE 3.1** Striving for improvement day-to-day

Care providers only have capacity for day-to-day delivery of care. This includes constantly striving to improve the services they offer.

**FIGURE 3.2** Creating space for transformation

The Charity grant creates time and space to develop and test innovative care provision without impacting on the day-to-day delivery of care.
What were SLIC’s successes?
What were SLIC’s successes?

“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.” — KCL report ‘What worked well?’

In discussing ‘What worked well’ in SLIC, KCL report authors listed 11 areas, briefly summarised in Box 1.

Separately, the KCL report includes another potential benefit arising from the fact that SLIC was an innovative and, in some ways, experimental project, dealing with issues for which there was little or no evidence. The report says that lessons have been learned about how to plan, undertake and evaluate such programmes, as well as about individual initiatives within the programme.

That the partnership and the GST Charity have taken on these important lessons can be illustrated in the development of their approach over the last 12 months to the Children and Young People’s Health Partnership (CYPHP), a local partnership setting out to deliver a new model of healthcare to the 120,000 children and young people of Southwark and Lambeth. The Charity commissioned additional support to ensure that accountability was built into the programme from the outset, along with quality improvement methodology, rigorous measurement and evaluation, and governance. In addition, they funded an extended period for the CYPHP team to co-produce the plan before they would consider an application to fund its implementation.

We will examine the areas of success highlighted by KCL in more detail in the following three sections:

• Our approach to integrating care
• What we did to integrate care
• Did we increase the value of care?

**BOX 1 What worked well in SLIC (KCL report)**

- **Vision** – partners in the care system united to achieve a common goal of integrating care across health and social care.
- **Business case** – the business case mobilised resources to develop a programme of tangible interventions.
- **Range of interventions** – a strong perception of achievement from stakeholders in the range of projects associated with SLIC.
- **Impact on demand for services** – emergency admissions (and discharges) of people aged 65 years and over in Southwark and Lambeth remained broadly stable, while acute admissions from other areas increased. Admissions to care homes reduced significantly.
- **Learning and journey** – the process was adaptive; priorities changed based on experience, for example, from Long Term Conditions to resilience.
- **Citizen engagement** – involvement of local people was championed as one of the successes of SLIC, driving the resilience agenda, and in co-production of interventions.
- **Clinical engagement and leadership** – over time, primary care was increasingly engaged in SLIC and initial mistrust replaced by greater leadership and involvement.
- **Leadership and accountability** – strong leadership was apparent in terms of support leadership (SLIC core team) and system leadership (Board governance structure). Project support was effectively resourced.
- **Structure** – engagement of new clinical directors of GP Federations, trained through the Charity’s GP Emerging Leaders programme.
- **Relationships** – enhanced trust and communication between partners led to improved relationships between partners.
- **Funding** – a shift in investment toward community and primary care demonstrated by investment in ERR and @home.
Our approach to integrating care – how we did things was as important as what we did

“Citizens’ involvement in SLIC is something to be proud of. Working on an equal footing with professionals to co-design projects and being represented at every level of governance meant we could play an important role in improving care for local people, for example, in developing the attributes of care which are to be at the heart of every new intervention and way of working.” — Nicola Kingston, Chair of the SLIC Citizens’ Board

Many of the successful aspects of SLIC highlighted by KCL related to the approach we took to integrating care, under their headings of ‘Learning and adapting’, ‘Citizen engagement’, ‘Clinical engagement and leadership’, ‘Leadership and accountability’; and ‘Trust and relationships’.

We designed and tested a range of interventions to help us reach our vision of improving the value of care for the people of Southwark and Lambeth. Our approach meant we also addressed essential enablers such as: building trust and relationships; investing in strong leadership, governance and a strong central team; and focusing on citizen and clinical engagement. We also introduced a ‘test and learn’ quality improvement methodology and facilitated co-production with stakeholders. With citizens, we co-designed the ‘Attributes of Integrated Care’ stating that people should experience care that is empowering, holistic and preventative, and that all new ways of working should be designed with these attributes at the core. KCL said, “the role of the citizen is a phenomenon of SLIC.”
WHAT WERE SLIC’S SUCCESSES?

BOX 2 Effective measurement of interventions

Although programme-level measurement remains a challenge, we developed an effective way of measuring SLIC interventions. As we developed our methodology, we used a balanced set of measures, plotting data over time using run charts (graphs that display trends over time – a simple and effective way to determine whether the changes we made were leading to improvement) and made good use of qualitative data from patient feedback.

For example, the SLIC team supported the Integrated Hospital Discharge Team (IHDT), to conduct a six-month test on Anne Ward, St Thomas’ Hospital. A total of 164 patients were cared for by the IHDT for the test’s duration. Data was collected and updated daily by the IHDT administrator, and shared with SLIC on a weekly basis for data analysis. As part of the testing cycle, reports were regularly circulated and discussed with the IHDT and relevant stakeholders.

A baseline average of 22 days to complete a London Health Needs Assessment (LHNA) was reduced by 16 days to an average of 6 days as a result of this intervention (see Figure 5).

**FIGURE 4** Number of patients through IHDT by borough

**FIGURE 5** Days from LHNA ‘started’ to ‘completion’ by patient

**FIGURE 6** Average length of stay: Southwark and Lambeth

- Southwark  - Lambeth  - Others
KCL researchers assessed SLIC very positively against the Integrated Care Pathways (Greenhalgh). The KCL report reinforced that our main success was our ‘integrated’ approach to integrating care – in other words, how we did things was as important as what we did.

On the basis of the checklists they used, they identified evidence in SLIC that corresponded to each level of integration, as shown in Figure 8.

The KCL report identified the following SLIC attributes and matched to the models on the following page:

- **Co-production** – Catheter Passport, Holistic Assessments (HAs).
- **Learning** – organic adaptation over time, for example, developing the resilience agenda.
- **Collaboration** – a key premise of the SLIC programme and of integrating care.

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### Figure 7 SLIC Attributes of Integrated Care

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<tr>
<th>Empowers and activates people and communities, enabling people to be in control of their health and wellbeing</th>
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<tbody>
<tr>
<td>• Recognises, uses and develops all the assets available in our communities</td>
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<tr>
<td>• Empowers people to be active and in control of their own care, and supports the needs of carers</td>
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<tr>
<td>• Promotes choice for individuals, their families and carers</td>
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<tr>
<td>• Provides more care in people’s homes, or supports them in community settings close to home, which enables them to stay as well and independent as possible</td>
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<th>Offers holistic and co-ordinated care and support</th>
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<tr>
<td>• Works with people holistically across their physical, mental and social dimensions</td>
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<tr>
<td>• Meets the needs of all citizens, is easily understood and navigated by individuals</td>
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<tr>
<td>• Provides continuity of care over time, and co-ordinates care across settings and providers</td>
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<tr>
<td>• Ensures effective transition for individuals between services</td>
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<td>• Removes duplication and feels seamless to individuals</td>
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<table>
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<th>Is proactive, preventative and focused on better outcomes</th>
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<tr>
<td>• Actively promotes good health and wellbeing across communities, enabling people to live healthier, more independent lives, for longer</td>
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<tr>
<td>• Detects problems earlier and intervenes quicker</td>
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<tr>
<td>• Avoids crisis and the need to address avoidable complications</td>
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<tr>
<td>• Aids recovery and a return to independence</td>
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<td>• Provides equitable access</td>
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**WHAT WERE SLIC’S SUCCESSES?**

- **Hard and soft approaches** – monitoring against targets and incentivising take-up, for example, GP sign-up for HAs.
- **Trust** – improvement of relationships has been described as a ‘big win’.

In addition, in considering ‘High Performing Network Components’, the KCL report stated: “It can be argued that the SLIC initiative has made progress in developing each of the three facets of high-performing networks: IT developments are beginning to come on stream; the narrative journey has demonstrated inter-organisational learning and adaptability; and organisations were drawn into a broader, lateral governance arrangement.”

The frameworks demonstrate that success is reliant on the change management approach combined with the delivery of new models of care. Attempting one without the other will not work, and will not bring about sustainable change.

That SLIC has been positively assessed against these frameworks is encouraging. It shows that SLIC has laid the foundations for the future, providing the basis for integrated care to flourish in Southwark and Lambeth.

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**FIGURE 8** High performing network (Ferlie) and integration checklist (Greenhalgh)
What we did to integrate care

“We would have struggled to work together without SLIC. We’ve shifted our thinking and, instead of having polarised opinions, there is a shared view of care. People now understand that the answer to our health and social care pressures isn’t more hospital or community beds, but that more care can be – and needs to be – delivered in the home.” — Cathy Ingram, Head of Local Rehabilitation and Integrated Care, GSTT Community

The KCL report noted in its ‘What’s worked well’ section that there was a strong perception of achievement among stakeholders in the range of projects associated with SLIC, including simplified discharge, dementia, falls pathways, catheter care, nutrition, locality geriatricians, HAs and the Local Care Record.

This perception is borne out by the fact that, of the 27 SLIC projects, 24 (89%) have been mainstreamed or funded for continued testing after SLIC ended.

What should not be overlooked is the sheer scale of what was achieved by clinicians, professionals and citizens from across the partnership. The quantity and quality of projects designed, tested and implemented during SLIC is in itself a significant achievement. SLIC projects were strengthened and unified by partnership working and by being part of the programme. Although funded by the GST Charity separately from SLIC, the GP Emerging Leaders Programme (a development programme to foster strong leadership in general practice and provide the foundation for better integration across the health and social care system) had a symbiotic relationship with SLIC, and so its contribution to system change cannot be separated from it.

When considering the impact of SLIC the programme – and SLIC the partnership – it becomes apparent that no single change in isolation would have ‘moved the needle’ towards increasing the value of care. The sense of interconnectedness that SLIC fostered created value by getting people to think differently and see the value of working together. For example, GPs and Care Navigators carrying out HAs and care management, and GPs and geriatricians working together via the Telephone Advice and Liaison (TALK) helpline. SLIC helped break down barriers and allowed the system to unlock the potential of the expertise and resources that already existed. This provided a fertile ground for innovation and creativity in how care was delivered.

Successful SLIC projects range from high-cost, large-scale system changes that enable new ways of providing care, such as the Local Care Record, to smaller-scale, low-cost projects such as the Integrated Hospital Discharge Team IHDT. Some of the most impactful projects, such as the TALK helpline and Hot Clinics, involved no additional investment.

All projects were aimed at achieving the original vision of supporting people to live healthier and happier lives. They can be categorised under three headings, linked to the original programme aims of:

- joining up care around people and across providers;
- earlier intervention – getting involved earlier to improve lives; and
- providing care in the most appropriate setting – supporting people to feel safe and cared for at home.

There is also another category of ‘enablers’ which support projects under all three headings, such as informatics.

The following examples showcase a number of interventions for each category.
Joining up care around people and across providers

Holistic Assessments (HAs)
“Our frail housebound patients have appreciated someone who has time to have a cup of tea and listen to things that concern them – invaluable things that could not be captured in a 10-minute consultation – but could singly make a life more meaningful in a way that reducing blood pressure might never.” — GP, Southwark

To date, 100% of practices are signed up to cover HAs, and more than 14,500 people have had an HA. GPs came to lead the way in providing HAs, spending time talking to patients about their lives and what mattered to them – as well as their medical conditions – and creating with them a plan to address their needs.

Audits and quality reviews carried out in Southwark and Lambeth revealed that 95% of HAs were judged as being of a good standard and that nearly all led to co-produced care plans. In addition, a number of diagnoses were proactively detected through HAs, including diabetes, dementia and heart failure. Safeguarding issues were also identified, including a patient who had been trapped in their bath being referred to Enhanced Rapid Response (ERR) to prevent such occurrences in the future.

A key factor in the success of HAs was bringing in support from the voluntary and community sector. Traditionally, GPs have struggled to engage with the voluntary sector, in part due to the disparate nature of voluntary and community sector organisations, but the Care Navigation Project overcame that barrier by embedding Age UK SAIL Care Navigators into GP practices in Southwark. Care Navigators worked with practice staff to successfully reduce isolation and manage the social needs of their older patients. They identify support networks and community groups to help people remain as independent as possible.

Community Multi-Disciplinary Teams (CMDTs)
“The voluntary and community sector is more valued and actively involved in the conversations – we can now take our own cases to CMDTs. This means local people aren’t just supported medically, but also helped to live more independently and improve their wellbeing.” — Erin Mee, SAIL Care Navigator at Age UK Lewisham and Southwark

CMDTs see clinicians, carers, social workers and the community and voluntary sector working together to agree care plans for patients, using their collective expertise to identify and promptly put interventions in place. While the implementation of CMDT meetings has not been without issues – in particular, the logistics of getting the right people together at the right time, and in sharing patient information across health and social care systems – the main benefit on which all who took part agreed is that the meetings are a great way of networking with and learning from other professionals, making contacts, breaking down barriers, and ensuring that people

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 she makes clothes to raise money for the club. She has also joined an exercise group and a lunch club.
with complex needs receive the right care, in the right place. Now, with the development of Local Care Networks (LCNs), coupled with the further development of the Local Care Record, there is even more potential for the CMDT networks SLIC has developed to become embedded in the care system.

Local Care Record

“The Local Care Record has been a very gratifying project to work on, both personally and professionally, in large part because it has made so many people happy. Clinicians in general practice and our local hospitals have unanimously been singing its praises and saying what a huge difference it has made to their working lives and the safety, quality and experience of patients. And benefitting from such a successful initiative is motivating them to think about what other improvements could be made.”

— Adrian McLachlan, Chair of Lambeth CCG

Sharing information doesn’t just happen by getting people in the right room; it needs to happen electronically too. A key enabler for the whole programme was the roll-out of the Local Care Record, which is having a positive impact on patient care by allowing ‘real-time’ access to patient records for clinicians in primary and secondary care. This ‘two-way view’ – GPs seeing hospital records and hospital doctors seeing GP records – means that doctors and nurses can see test results, medication and previous treatments and make fast, informed decisions about a patient’s care. Primary care staff can directly access the patient record instantly with no separate log-ins. It is a fast, easy-to-use and intuitive system that allows staff to see test results, x-rays and scans, and copies of hospital letters, saving them valuable time in chasing results. To date we have seen a 75% reduction in calls from GP practices to hospitals chasing information, and a reduction of around 25 unnecessary or duplicate test requests per practice per month. It also allows staff to see upcoming hospital appointments, giving them the chance to advise patients on what will happen, what questions they should ask and how to maximise the value of the appointment more generally.

Described by one GP as, “a truly transformative programme,” with another admitting, “I’m not sure I could live without it now I have it,” the Local Care Record has the distinction of being a UK first – the first patient information-sharing system to receive an official accreditation from EMIS Health, a leader in connected healthcare software. While other systems have attempted something similar, the Local Care Record has been accredited as the first to achieve information-sharing to such a high standard. Other London boroughs are now looking at the Local Care Record as an alternative to the more complex and significantly more expensive systems they are developing. Projected savings for

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.”
the Local Care Record are £9.2m within five years, and early analysis suggests this could be exceeded.

Citizen involvement was essential to the success of the Local Care Record, as their endorsement provided reassurance to local people about the safety of their data as well as information about the patient benefits. Their involvement, along with the decision to make the record ‘opt out’ instead of ‘opt in’, meant that only 70 people chose not to share their data – and these patients are being contacted by the Guy’s and St. Thomas’ Patient Advice and Liaison Service so they can explain the benefits of opting in and the consequences of opting out.

The Local Care Record has been so successful that we have been able to submit an entry to the Patient Safety Congress Awards. The next step is to link the record with social care and community services, and to develop a patient portal so that citizens will be able to contribute to and view their records.

Simpler online information-sharing platforms are also having a profound effect. Due to the complexity of dementia, the range of services available can be overwhelming and difficult for the public and professionals to navigate. The Digital Directory of Services, created in March 2014, has provided a one-stop-shop online resource showcasing older people’s services in the two boroughs, and has become a key resource for healthcare professionals and local people, with more than one million hits since its launch. Feedback has been extremely positive and has led to the extension from around 100 dementia-related services to more than 1,700 services for older people included on the site.
Earlier intervention – getting involved earlier to improve lives

To help people live healthier and happier lives means providing excellent clinical care when things go wrong, but also working with people to identify potential issues early on, and supporting them to take preventative measures wherever possible.

Citizens told us they wanted to have more control over their health and wellbeing, and so we introduced a range of services to prevent illness and help local people look after themselves better, including identifying older people at risk of falling and those at risk of catheter-related infection.

Across Southwark and Lambeth, falls account for a significant number of fractures, injuries and hospital admissions among people aged 65 and over. In 2012/13 more than 13,000 people had to go to hospital and 3,029 were admitted, at a cost in excess of £8.25m.

Preventing falls

“I really enjoyed the classes and they helped me immensely – they really pushed me. Before the classes I was quite wobbly, but I think about how I walk now and am more steady and sturdy on my feet.” — Irene Brown, Falls Community Class attendee

The Falls Prevention project for those at risk of falling – developed and implemented in partnership with citizens, the voluntary and community sector and primary care – provided a unique telephone self-referral system. People worried about falls could be triaged by physiotherapy assistants and referred to a range of services, such as community exercise classes. More than 500 people were safely triaged through the helpline and 75% of participants reported increased confidence and improved quality of life. The Falls Prevention project was so successful it won the 2016 HSJ award for Value and Improvement in Community Health Service Redesign, and has been funded by commissioners on the basis that it will save a projected £6.5m by the end of 2019.

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.”
Catheter Passport

“My Catheter Passport created a wonderful bridge between staff in different settings, which has allowed us to improve communication and better co-ordinate ourselves, so we can deliver more effective care to people with catheters.” — Gill Downing, Bladder and Bowel Specialist Nurse, GSTT Community

Catheter-associated urinary tract infections are a major cause of hospital-acquired infections and can have a devastating impact on patients. There was poor information-sharing about catheter patients between care settings and patients didn’t feel empowered to manage their catheter at home.

The Catheter Passport was designed with citizens who have a catheter, and has become a useful tool for citizens and professionals in supporting them in catheter management and avoiding unnecessary trips to hospital. Citizen input was so valuable that the project was shortlisted for a GSTT Involvement to Impact Award.

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 hypotrophy. 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.”
Providing care in the most appropriate setting – supporting people to feel safe and cared for at home

Enhanced Rapid Response (ERR) and @home

“I was apprehensive when they told me I could go home, but I really couldn’t fault the @home service. It was like having a hospital at home. They really looked after me, coming in to check my chest and oxygen levels every day. I would describe them as angels.” — Maria, 68, Vauxhall

Despite best efforts to prevent ill health, crises happen, leading to a trip to A&E and then hospital admission – often distressing, and sometimes unnecessary.

Now, thanks to new community-based services, there are alternatives that allow people to be treated at home, or return home from hospital faster – things that citizens told us were very important to them.

The @home Multi-Disciplinary Team provides holistic, integrated care for acutely unwell patients at home which would otherwise be carried out in hospital. ERR teams provide enhanced therapy, nursing and social care to help people become and stay independent in their own homes.

As well as improving the patient experience, these services have benefitted professionals too, by giving them a range of options to provide the best care possible for patients – and to reduce non-essential emergency admissions. For example, the @home team worked with the London Ambulance service to develop a referral pathway so they can assess people in their homes, and then refer them to the @home team where appropriate. The @home team can then treat them, or decide to refer them to a rapid-access Hot Clinic rather than taking them to A&E.

Telephone Advice and Liaison (TALK) helpline

“Being able to speak to a geriatrician to discuss the care of older people is enormously beneficial for GPs – and for specialist – as getting advice at the right time often avoids unnecessary hospital admissions. It’s a great example of how something as simple as a dedicated phone line can help primary and secondary care work well together to improve patient care and support people to be safe at home.” — Dr Femi Osonuga, Southwark GP and CMDT Chair

Providing primary care access to specialist advice is also preventing unnecessary hospital admission. TALK is a direct access specialist hospital phone line at KCHT and GSTT that allows GPs and community staff to speak to hospital geriatricians 24 hours a day, seven days a week to get specialist advice and reassurance. It has been so successful that a similar helpline has been rolled out for Paediatric and Acute Medicine advice.

‘Home’ for some people means care homes. There are an increasing number of elderly residents in care homes who exhibit challenging behaviours related to mental health issues and dementia. The Community Mental Health Team established a new specialist mental health team in Southwark and Lambeth to work with care homes to manage residents exhibiting challenging behaviour, reducing the likelihood of hospital admission.

Over the 12-month test period, there was an increase in the number of referrals to the team from care homes, general practice and social services, as confidence in the team grew. The wellbeing of residents improved by reducing instances of challenging behaviours, and there was a reduction in the use of anti-psychotic medications. Crucially, the intervention improved relationships between mental health teams and care home staff,
who became more confident in managing challenging behaviour in residents.

We have also worked to prevent readmission to hospital and to reduce the amount of time people spend in hospital, supporting them to recover at home.

A significant number of our frailest citizens are discharged from hospital to care homes, and successful care transfers are essential to keep patients safe and to help prevent readmission. We worked with hospital and care home staff to create a ‘transfer of care bundle’ to make sure best practice was embedded at every stage throughout the discharge process and to enable the development of good quality care plans for residents. Evidence shows that 25% of people aged 75 or over are readmitted to hospital within 30 days of being discharged. Evidence during the project showed a marked reduction in 30-day readmission rates to hospital for those residents discharged using the bundle, with a 6% readmission rate compared to 22% for all care home discharges last year. The bundle also led to improved relationships between staff in both settings.

Discharge to Assess (D2A)

“Our Discharge to Assess project put the patient story at the centre and created new insight into how we can better reduce hospital stays and avoidable readmissions.” — Catherine Pearson, CEO Healthwatch Lambeth

Sometimes people no longer require the clinical services provided by a hospital, but need more time to recover and regain their strength before they return home. The Discharge to Assess (D2A) project provided two ‘extra care’ flats to allow medically fit people time to recover away from hospital in an environment similar to being at home, but with 24-hour access to on-site support. This helped them to reduce their dependency on the care system in a safe and supportive environment. Social care and community services team assessments could also be conducted outside the busy hospital setting to identify what support people would need when they returned to their own homes. The test demonstrated the advantages of transferring people from acute care into the community, with envisaged reductions in the number of hospital bed days, along with admissions to residential and nursing care.

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.”
We increased the value of care

In its section on balancing successes and challenges, the KCL report noted: “There is a consensus that the SLIC project has provided a vehicle for strengthening and unifying delivery of care for older people. The funding has created a space that enabled time and effort to be invested in developing integrated care.”

However, as the report also notes, there are two schools of thought among stakeholders when considering benefits and costs. One is that SLIC provided an opportunity to experiment and innovate; it delivered activity and developed relationships that strengthen Southwark and Lambeth, providing a strong foundation for the future. The other is that it did not realise the cost benefits described in the original business case, and that the health gain related to some interventions was unclear. There is also a consensus that the projected benefits were overly ambitious in scale and timing.

Nevertheless, the report says: “…most of the partners have emphasised the counterfactual, namely the proposition that the system is now stronger and better placed than it would have been without the SLIC initiative.”

There are several factors that need to be taken into account in measuring and attributing benefits to SLIC:

- SLIC interventions were tests – we are measuring the effectiveness of prototype interventions, not fully formed programmes. It is too soon to evaluate the impact of some projects, as their effects won’t be fully apparent until further down the line.
- There was no consensus within the partnership of what success looked like. A key question that arose during the Strategic Portfolio Review in 2015 was whether we were basing success on a scale of innovation where a ‘low’ success rate was expected because we were trying something radically different, or whether we were basing success on evidence-based interventions where a ‘high’ success rate was envisaged. In other words, were we creating an evidence base, or adopting an existing one?
- Some results cannot be solely attributed to SLIC. This is either because measurement metrics weren’t in place (the gap before the ‘test and learn’ change model was introduced), or because of the complexity and multiplicity of interventions throughout the partnership, which saw a number of ‘competing’ projects seek to achieve similar benefits.
- Some of the main successes of SLIC were not measured in tangible terms – for example, the trust, relationships and goodwill created.
- During its lifetime, SLIC was subject to a constantly shifting external environment, creating a number of unforeseen factors which have had an impact in a number of ways, including significant financial cuts in social care.

Despite the stated difficulties in measuring value, we will consider – as far as we can – the impact on costs, and the impact SLIC has made on people’s lives.

Impact on costs – measuring success against business case targets

In January 2012, the majority of care for people aged over 65 in Southwark and Lambeth was not proactive or co-ordinated, resulting in high levels of demand for hospital and institutional care. The SLIC business case sought to address this issue and reduce demand.

Projected changes that would lead to financial savings were
a reduction of 14% in emergency bed days (later re-profiled to a 5% reduction) per month for people aged 65 years and over, and an 18% reduction of residential care home placements by 2015.

Based on 44 months’ data (KCL report) we can see that:

• There was a -0.6% reduction in emergency bed days for Southwark and Lambeth but an 18% increase in bed days for other CCGs. The data represents a stabilisation in Southwark and Lambeth hospital activity in contrast to a marked rise elsewhere.

• Care home placements for people aged 65 years and over reduced by 61%. Placements are currently 11.4 per month, which encouragingly is 47% lower than the target of 19.9 per month.

• Emergency discharges rose by 2% across Southwark and Lambeth against the base year 2012 but rose by 23% in other CCGs (please note this data does not include the winter effect for 2015/16 and so may understate the monthly average). In addition, the total number of A&E attendances was stabilised.

There are two scenarios for the emergency bed day figures:

• That Southwark and Lambeth performed well in relation to other CCGs but we did not achieve the success measure set out in the business case. This relates to a footnote that qualifies the business plan target, suggesting that integrated care pathways will provide a bulwark against future demand pressures – if the population increased, then maintaining figures would be a success. Given that the population of Lambeth and Southwark aged 65 years and over has grown by 5% over the period 2012/16, this has proved to be a more realistic ambition, and in this way, we could be said to have succeeded in keeping numbers relatively stable.

There is a good story to tell on care home placements, but we must bear in mind that the figures are in line with a national trend.

For both targets whether, and to what extent, SLIC has played a role in achieving these figures is a difficult question to answer. We cannot attribute success purely to SLIC, but neither should we disregard its impact.

Regardless of how we interpret the data relating to business case measures, SLIC has achieved much during its four years. The financial targets set out in the business plan were overambitious, yet we feel confident in saying that SLIC has had a positive impact on costs and is on the path to achieving its vision.

Making a difference to people’s lives

“We are very grateful for the tremendous support we have been receiving from the Care Navigator...since my mum has been receiving the service from Age UK, she has been a much happier person.”

The range of patient stories collected during SLIC shows that we have had an impact on people’s lives in a variety of remarkable – and sometimes unexpected – ways. Take, for example, 82-year-old Norman, whose loneliness and isolation were alleviated with the support of an Integrated Care Manager; or Maria who, thanks to the @home service, was able to leave hospital earlier and recover in her own home with the support of daily visits from the specialist @home team.

“Relationship-building is a strength. Before SLIC, the providers didn’t meet; Chief Officers weren’t meeting. We now know each other well.” — Stakeholder, KCL report

But not only citizens have benefitted: The partnership also had a positive impact on the workforce.

For example, an experienced GP leader from Lambeth, Dr Tarek Radwan, has said that being involved in SLIC was a real eye-opener, particularly in terms of the range of people he came into contact with from across health and social care, and that he now takes a far more holistic approach during patient consultations. And Liz Clegg, Assistant Director of Integrated Commissioning for Older Adults, Lambeth, has spoken of how struck she was by seeing
CMDTs in action, witnessing the level of respect each team member had for each other’s opinion.

The role of local people is a phenomenon of SLIC. Stakeholders from every part of the system held up citizen engagement as a success of SLIC. In speaking about their role in designing catheter care, Adrian Hopper, Consultant Geriatrician at GSTT, said: “Their contributions, attendances at meetings, challenges to healthcare professionals and their passion to help has been inspiring.”

When we consider the negativity and scepticism felt in the early days, and the sense of optimism and achievement felt today, we can see that people’s perceptions of SLIC have greatly changed over time.

Staff and clinicians have become increasingly engaged in SLIC. Initial mistrust among GPs has been replaced by great leadership and involvement.

The independent three-year evaluation by The King’s Fund concluded that strong leadership and partnerships created between stakeholder organisations had the biggest impact, stating that, “SLIC partners should be encouraged about what has been achieved – particularly the strengthened relationships at various levels.”

It is this ‘interconnectedness’ – a sense of working together as part of something bigger than an individual organisation, thinking differently and being willing to join up for mutual benefit – that has underpinned the many successes of the SLIC programme. This will be essential in the next phase of the partnership as it seeks to widen the impact of successful interventions.

We can say we have succeeded

“The world has changed dramatically since its instigation. Social services are in a far worse state, general practice is in a difficult situation. Without SLIC, we would have had a series of self-interested organisations because they didn’t have any alternative.” — Stakeholder, KCL report

As we have seen, evaluation of SLIC is not straightforward.

In balancing successes and challenges, the KCL report suggested that evaluation of SLIC is, to an extent, ‘socially negotiated’ noting that, in a large complex system, there will be differences in perception and incomplete knowledge. However, the report did note a “consensus that the SLIC project has provided a vehicle for strengthening and unifying delivery of care for older people. The funding has created a space that enabled time and effort to be invested in developing integrated care.”

When we consider what has been achieved, we feel confident in saying that significant progress has been made in delivering against our vision.

“Despite hosting many of the UK’s most talented clinicians, professionals and leaders, the system made it difficult for them to work together"
Barriers to success

In addition to the areas identified as working well, the KCL report also highlighted areas of challenge for SLIC (or ‘what has worked less well’). The majority of these were under the same headings as successes, demonstrating that there are many areas within SLIC that can be said to be both successes and challenges (see Box 3).

We will consider these, and other, challenges to SLIC’s success under five categories:

- Vision
- Engagement
- Change model
- Measurement
- Leadership churn

These areas relate to issues in the early days of SLIC (pre-2014) and, over time, all were addressed. However, they significantly slowed down progress and, crucially, affected how SLIC and its successes were perceived in the first few years.

Vision

The document which has had the biggest effect on how SLIC has been perceived is the business case submitted to the GST Charity in 2012.

The business case has had both a positive and a negative effect.

Overall it has been extremely positive, because the system leaders came together and set out a trailblazing vision of integration, mobilising resources for a four-year programme to develop and test new interventions and models of care; negative, because some of the timescales and success measures it contained were unrealistic, and weren’t aligned with the vision or with evidence of cost savings. This led to the partnership being seen to ‘fail’ in the early stages.

There was also an issue that people felt there had been insufficient engagement on the business case, and on which interventions would be the most appropriate.

Lastly, the vision outlined by the business case wasn’t effectively communicated throughout the partnership – for example, GPs perceived the business case as secondary-care led, and saw it as an attempt to shift costs and workload into primary care.

Box 3 What are the challenges

Vision – the strategic vision is not universally owned and understood.

Business case – there is a consensus that the financial saving targets were overly ambitious in scale and timing.

Clinical evidence base of interventions – clinicians challenge the underpinning (financial) evidence base, for example, of HAs.

Impact on demand for services – attribution of cause and effect between individual interventions and wider system change is difficult to assess due to lack of measurement.

Learning and journey – SLIC has been adaptive, changing emphasis from a medical to a social care model – with the potential risk of clinical and professional expertise becoming less integrated (although the clinicians on the Sponsor Board, when considering the KCL report, did not agree with this).

Citizens – are aware of tensions around voice, representation and influence.

Clinical leadership and engagement – involvement of clinicians is a continuing challenge.

Leadership and accountability – the price to pay for robust governance is a heavy time commitment related to meetings.
Engagement

“SLIC was a dirty word [in primary care].” — Stakeholder, KCL report

In addition, the partnership made life difficult for itself in its delivery.

Impatient to bring about change, sufficient time wasn’t spent on the fundamentals and corners were cut, particularly around building trust and engagement. Although the intention to work together was there, the execution was rushed, and this meant that, at the beginning, change was seen to be imposed from the top-down, isolating key stakeholder groups — not conducive to partnership working and totally different from the approach to change we later adopted.

This is perhaps most evident in the implementation of HAs, which could be described as a symptom of some fundamental maladies in the early days of SLIC. GPs were asked to begin carrying out HAs, and to follow a very rigid way of doing so. Although financial incentives were offered via the GP sign-up scheme, take-up was very low. GPs felt that change was being done to them, not with them, and as a result very few were engaged. In addition, social services felt excluded as HAs seemed to be very medically orientated.

The poor relationships in this early stage of SLIC were symptomatic of the wider culture in which people were working, where levels of trust were low and relationships often non-existent. For SLIC, this resulted in people passively ‘not doing’ things and also having to deal with real anger, disappointment and a sense of frustration.

Change model

At first, there was no change model — no quality improvement framework to guide or evaluate the implementation of projects, or to allow for flexing and adapting in response to feedback and learning. The expectation was that all GP practices should start to undertake HAs at the same time, without any co-design of the assessment framework, or any small-scale testing. Practices reported extreme frustration when they were told they couldn’t change the approach to assessment.

Measurement

In the early days, there was little systematic measurement within individual projects. For example, recording of HAs was largely based on numbers undertaken, and there was no systematic recording of the benefits of CMDTs. This was demotivating for those involved because the number of HAs carried out was vastly lower than those stated in the business case, and this was interpreted as failing. Also, there were no success stories recorded on the better care some people were receiving as a result of HAs or the ‘softer’ benefits, such as the relationships that were developing as a result of CMDTs.

We didn’t co-design a quality improvement change model until late 2013 so, for too long, there was no way of measuring and communicating good news. However, by the beginning of 2015, resources were only allocated to interventions if they could demonstrate how they would use the change model, and which measures they would use to record success.

Leadership churn

All of these issues were compounded by a lack of stability in the partnership caused by a churn in personnel. This saw two changes to the Chair of SLIC and three changes in team leadership over an 18-month period, with a central team mainly staffed by short-term contractors.
Overcoming barriers to success

“Life now looks very different, in a very positive way.” — Stakeholder, KCL report

The partnership gained traction when the barriers to successfully integrating care began to be addressed:

- A new leader and central team were appointed, bringing different skills and experience and on longer, fixed-term contracts.
- Stronger governance structures were put in place.
- Objectives and timescales were refocused to align with the original vision through a re-profiling exercise. While the business case did not change, this exercise allowed the partnership to revisit its priorities and consider at a strategic level how best to meet those commitments and bring about transformation.
- A number of interventions were successfully co-designed and tested, often with citizens. Through the creation of the Citizens’ Board, citizens were involved at every level of decision-making, and the scope of the programme widened to focus on helping individuals and communities to take control of their own health and wellbeing.
- A ‘test and learn’ change model was introduced to guide the development, implementation and measurement of interventions and to build a body of evidence.

There were four key enablers during this phase that helped the partnership to get back on track: partnership commitment and determination as seen through governance; the SLIC team; effective measurement of interventions; and, most important of all, the relentless focus on building trust and relationships.

BOX 4 Governance

A key milestone in getting the partnership on a solid footing was the strong governance arrangements, developed to provide leadership and rigour to the programme.

SLIC had four main boards:

- **The Sponsor Board**, which met monthly to provide strategic direction and high-level decision-making. The Sponsor Board changed over time to become more strategic, and membership eventually included GPs.
- **The Provider Group**, which dealt with how to turn strategy into action, and acted as a Programme Board.
- **The Operations Board**, which oversaw delivery.
- **The Citizens’ Board**, providing input from patients’ and local citizens’ perspectives. Citizens were represented at every forum.

SLIC governance wasn’t about structures: it was partnership working in action. The boards brought together previously disparate groups of people to discuss issues of collective interest and importance, breaking down barriers and building new relationships across the health and social care system.

By having regular forums in which to take collective decisions and deal with issues as they arose – and crucially, by building trust and relationships – SLIC came to function as a partnership.
BOX 5 SLIC central team

In June 2014 the Sponsor Board agreed that the role of the team was, “to bind us together, acting as a steward of our aspiration, taking the heat out of organisational boundaries, and bringing the citizens’ voice to advocate for change.”

However, six months later, the Deliverability Review for Guy’s & St. Thomas’ Charity by Wragge Lawrence Graham & Co (the Wragge review) identified a further need for the team to have a clear mandate for change, from all stakeholders. The partnership developed an explicit mandate for the team and its priorities, which took it up to its closure in March 2016.

The team included programme managers, change agents, engagement officers, analysts and administrators. They acted as facilitators of change by co-ordinating and testing new interventions and supporting the partners to bring initiatives to scale.

At times, this seemed like an impossible task, with one social care partner noting that the team was expected to “step into a gulf” because of a lack of agreement between partners, only to be criticised for the lack of agreement. However, support for the team grew over time, with a clear sense of improved leadership. As one GP commented in the KCL report: “The team was excellent – irritated us and challenged us” and KCL commented on the strong leadership of the team.

BOX 6 Building trust and relationships

“Within Lambeth we’ve encountered some quite difficult issues with our domiciliary care market, but we managed to sustain our service because GSTT stepped in to support us. Now that wouldn’t have been possible three years ago, because the relationships wouldn’t have existed. But the relationships were there, so people wanted to work for each other to make it happen, and they understood that it was to the benefit of the entirety of the system and local people to make it happen.” — Helen Charlesworth-May, Strategic Director – Children, Adults and Health, Lambeth Council

Building trust and relationships has arguably been SLIC’s biggest challenge – and success.

SLIC initiatives saw disparate groups of professionals and citizens coming together, often for the first time, and initially there was a great deal of mistrust and scepticism to overcome. Trust was built in a number of ways: by the governance structures which provided forums for debate and discussion and to address anxieties; re-profiling of goals and the move to a resilience focus, engaging primary care, social care, and the voluntary and community sector; and by becoming more inclusive, bringing citizens and professionals together to co-design and test approaches.

Now, four years on, it is widely agreed throughout the partnership that a major benefit of SLIC is the trust and relationships it has created. This has provided a stable foundation for testing projects and initiatives, and has been central to the programme and the partnership’s success.
3

The SLIC journey – where are we now?
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:

75% fewer calls from GPs to hospitals chasing information;

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

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

14,500 people have benefitted from an Holistic Assessment (HA) offered by every GP practice

1,500 calls to the TALK service resulted in 720 people avoiding admission to hospital through referral to the Hot Clinic

2,000 people with complex needs have had their care supported by a Community Multi-Disciplinary Team (CMDT)

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

16% reduction of hospital readmissions from care homes

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

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

200 fewer hospital referrals each month; and

2,000 fewer requests for hospital tests each month
Stabilised emergency bed days for over 65s

In contrast to a marked rise elsewhere

Joining up care across providers

14,500 people have benefitted from an Holistic Assessment (HA) offered by every GP practice

1,500 calls to the TALK service resulted in 720 people avoiding admission to hospital through referral to the Hot Clinic

2,000 people with complex needs have had their care supported by a Community Multi-Disciplinary Team meetings (CMDTs)

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

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.
The SLIC journey – where are we now?

“I have been really proud to be part of something so at the cutting-edge of our healthcare. I’ve had the most wonderful experiences working [with] and learning from my colleagues in social care and in the voluntary sector, and other healthcare professionals within secondary care, that I probably would have never come in contact with.” — Brenda Donnelly, former Practice Nurse and former Community Multi-Disciplinary Team Chair

Throughout its journey, the ultimate destination of SLIC remained the same – to improve the way care is provided in Southwark and Lambeth, to maximise value and to improve outcomes and the experience of care for local people.

Similarly, agreement on how this should be done has not changed. From the beginning, the partnership envisioned creating a sustainable integrated system that involved the redesign of services, and redefined the way professionals engaged with each other. We wanted to fundamentally change the way people were able to take charge of their own care and conditions, putting them at the centre of the decision-making process.

We are heartened that we are on the way to achieving this vision.

When we consider that we were coming from a place where there was little or no evidence for the issues we were seeking to address, four years on we can confidently say that we know how to successfully plan, undertake and evaluate system transformation programmes.

During its four years, the SLIC programme brought together staff from across health and social care, alongside citizens and service users, to redesign care for people in Southwark and Lambeth.

The development of a resilience-based approach (supporting individuals and communities to take control and self-manage their health and wellbeing) ensured that projects moved away from a wholly medical approach and are beginning to bring about the changes needed to support people in a more holistic way to take control of their own health and wellbeing.

Staff and citizens have worked together to co-design new services, using evidence of what works, and to test new approaches to care. This has created new knowledge and relationships to improve the quality of care, and also the experience of care.

The programme developed beyond the business case, to incorporate new learning and develop vital infrastructure. Developing a better understanding of the health of our local population meant the focus shifted from addressing the needs of older people to addressing the needs of people with multiple Long Term Conditions. Work streams expanded and additional work was commissioned, such as the development of the voluntary sector.

Evidence that SLIC is making a difference is emerging all the time. The Care Quality Commission (CQC) report for GSTT published in early April 2016 noted: “There was good multi-disciplinary working, with a strong focus within teams and clinics to reduce hospital admission and promote early discharge. Services were commissioned and designed with this purpose,” and, “…there were examples of very responsive and accessible services, such as rapid referral and quick assessment. These were provided by rapid response teams, the ‘@home’ and ‘supported discharge’ teams who worked closely together.”

Only when projects have been mainstreamed in the next phase of the partnership will we truly understand the impact of SLIC. But there is no doubt that SLIC has laid the foundations for integrated care in Southwark and Lambeth, and that some people have experienced better care as a result.
Lessons learned
Lessons learned

“Failure can be a positive. We can’t assume things will happen. Integrating care is not easy.”
— Stakeholder, KCL report

The many successes and achievements of SLIC, along with the barriers that have been overcome, provide a rich seam of information that others can draw from.

These lessons learned build on our experience of SLIC, and are included to support practitioners and investors to assess whether, and to what extent, these elements exist in their own programmes.

Integrating care and working in partnership are very difficult things to achieve, but we are confident we have shown that it is possible. Success requires having a number of elements in place.

During the four years of SLIC, we came to understand that the key to success lay in achieving a balance – reaching the ‘sweet spot’ of stabilising costs, achieving quality outcomes and improving citizen and staff experience.

There are many lessons that can be taken from SLIC, both things we did that were successful and that the next phase of the partnership will keep on doing, for example co-design, as well as the inherently difficult issues that require further consideration, for example, programme-level measurement. We hope these lessons will be relevant to the next phase of the partnership, to others who are seeking to bring about system-wide integration, such as Vanguard Programmes, and for investors too.

We have divided lessons learned into three categories:

- Producing the plan and communicating the vision
- Planning to deliver
- How will you know?
Producing the plan and communicating the vision

Lesson 1 – Set and communicate the vision

Summary: Co-create a vision that is meaningful to all and make sure it is understood at all levels, across all organisations.

- Work together to agree the vision and make a compelling case for change.

A large-scale transformation programme requires a great deal of energy and commitment from stakeholders. They need to understand why change is necessary, what it means for them, and what they are being asked to do differently as a result. If decisions are only understood at a strategic level, those at the frontline will not be equipped – or inclined – to play their part.

The original vision for SLIC was not sufficiently meaningful to some partners. We should have spent time co-producing a vision with more stakeholders – at all levels, across all partner organisations – seeking their views and addressing their concerns. Not doing so cost us dearly and held up progress.

We learned that one vision statement can never be meaningful to everyone, and can lead to confusion and misinterpretation. This is illustrated by the fact that SLIC was interpreted by some as being a medically focused programme aimed at saving bed days (money) and not about supporting wellbeing or resilience. This alienated social care and citizens as well as GPs, who feared that bed day savings were really about ‘dumping’ extra work onto them.

Lesson 2 – Produce a solid business case describing what you will do and the difference it will make

Summary: Agree the balance of benefits and when these should be realised in the short, medium and long term, and establish priorities that will deliver these benefits. Be ambitious but set achievable targets, with a realistic trajectory for change.

- Take a population approach to priority setting.

It is vital to carry out population profiling to understand the needs of local people. Although SLIC started out by focusing on over-65s with complex health needs, the analysis we undertook on our NHS Year of Care data in 2012 told us that interventions needed to be designed for all people with multiple Long Term Conditions rather than only for people aged over 65. We also recognised the connection between mental and physical wellbeing and the need to address people’s needs in a more rounded way. In light of this information, we re-prioritised our interventions to address the needs of people of all ages to move to a more holistic approach, focusing on building resilient individuals and communities. The Strategic Partnership will need to continue to consider how best to address the impact of certain co-morbidities – for example, 20% of people with established psychosis in South London and Maudsley also have diabetes.

- Set clear priorities.

There are difficult decisions to be made about priorities. Given the significant pressures in public services, there is a pull toward priorities that reduce costs in the short term. While the SLIC programme needed to be weighted toward short-term financial gains, we learned that, unless it also addressed benefits which would be delivered over a longer period, supporting people to take control of their lives via prevention and building resilient communities, our vision would never be realised, and stakeholders would lose faith as actions did not match the rhetoric. It is important to assess priorities and check that they are aligned with achieving the vision.
Clear criteria for priorities and investment should be agreed and used as an overriding framework for decision-making. Our experience suggests that system leaders should agree at the outset the weighting of three interrelated considerations:

- **What is the balance of the value proposition between cost saving, improving outcomes and improving patient and staff experience?**

- **What are the relative priorities between new models of care – such as falls prevention and care planning – and the enablers to support them, for example, information sharing and new forms of contracting?**

- **What are the timescales required for the delivery of benefits?**

We also learned that it is vital to specify the ‘attributes of care’ for all new ways of working. We developed these with citizens, agreeing the attributes of integrated care that people should experience are services that are holistic, empowering and preventative. These attributes guided the development of our new ways of working.

From the outset we understood the importance of developing the workforce as an enabler but had limited success. Over time we learned that plans for the workforce should not be developed separately from the interventions that they prioritised. Once we began to work closely with Health Education England South London we made greater progress, and the next phase of the partnership is committed to progressing the workforce in this way.

- **Use evidence to establish priorities.**

We became better at using evidence as the programme progressed. We learned that, when establishing priorities, it is important to be clear on whether you are using existing evidence, or seeking to generate your own evidence. Both are appropriate, but you must be explicit about which it is.

We welcome the GST Charity’s approach of supporting projects that intend to build an evidence base by testing hypotheses. Consideration should also be given to who is best placed to advise on the evidence for determining priorities.

The SLIC business case suggested that there would be cost savings from providing HAs and co-ordinated care. However, KCL’s report said their review of the effectiveness of integrated care interventions did not support some of the interventions in the programme. Looking back, we should have sought more support from health economists at the outset.

- **Define all the benefits – and when they will be realised.**

While the SLIC business case established a detailed set of interventions, it didn’t fully set out the spectrum of benefits we hoped to achieve. With hindsight, it should also have covered outcomes that mattered to local people, along with staff and citizen experience.

We also underestimated the amount of time it takes to bring about change. In particular, we didn’t allow for any time to prepare our people for change or to build an appropriately skilled central change support team. The business case was problematic in that it set out unrealistic milestones and cost savings – and we were then judged as failing against targets that were never achievable.

Looking back, it would have been easy to deal with this by working with partners and the GST Charity to explicitly amend the milestones and cost savings to a more achievable level, and to formally update the business case so that we could be measured against realistic targets.

- **Subject the business case to scrutiny.**

The evidence base, the links between proposed interventions and savings and claims of potential benefits should be carefully scrutinised, without dampening the ambition of the system. This is a lesson for the partnership and for the GST Charity.
There are two issues that must be considered. Firstly, as well as having a strong evidence base for a programme, or a strong hypothesis to develop evidence, assumptions need to be tested. For example, are targets achievable in the context you are working in? Are the stakeholders you are relying on able to commit to what you are proposing? What about external factors?

Secondly, while it is important to be innovative and ambitious, it is essential for those applying for funding and those considering giving grants to be realistic. There is a pervasive culture in health and social services that almost overstates potential benefits subconsciously, and this should be guarded against. While this culture is hard to shift nationally, given the competition for much-needed funds, the Charity could have these conversations with partners and lead the way at a local level.

This is already happening, as evidenced by the CYPHP – the Charity has played an instrumental role in supporting the partnership to build a compelling and solid business case that will guide the development and implementation of the programme.

Lesson 3 – Create the conditions for change

Summary: Make sure there is funding to support transition, recognise the need to incentivise collaboration and create space for change. Build trust and engagement and ensure there is clear commitment from all partner organisations.

- Ensure there are adequate financial resources.

Creating a fertile environment for change to happen is key to any programme of transformation. The change plan cannot happen without money.

Money is particularly important in terms of buying time for clinicians and professionals to be involved in co-design and testing. Transformation funding helps to cover the running costs of the testing process at the same time as the usual costs of day-to-day care. We needed to create space for people to work on SLIC projects, and to find ways of doing this that wouldn’t detract from their usual jobs. We did this in a number of ways:

- Buying up ‘sessions’ of social care and nurse and doctor time so they didn’t have to work on programme projects on top of everything else.
- Backfilling so staff kept on top of their work.
- Seeking leadership support so that staff felt confident working on programme initiatives.

While citizens gave generously of their time, funding was also required to support them to be effective and to reimburse their costs.

It is also important to incentivise collaboration. The financial resources required to mobilise stakeholders was greatly underestimated. Initially only GPs received any payment. GP payment increased over time, as did payment to other stakeholders to enable them to co-design and test new ways of working.

Resource needs to be allocated to free up time for key stakeholders to work on developing new approaches. If this work is seen as an ‘add on’ or something that is expected to be done on top of extremely pressurised day jobs, it won’t happen.

For us, the funding for transformation projects was about enabling a shift of existing investment – in other words, how we spent the £1bn health and social care budget in Southwark and Lambeth to maximise value. For example, shifting resource from hospital to community and primary care realised a host of benefits: better patient experience; increased trust and engagement across the sector; and a reduction in demand for acute services.

There were four sources of funding for SLIC (Local NHS, the GST Charity, NHS England and Health Education England South London), and the success of the programme was partly due to this investment, which supported the design and testing of new interventions.
Consideration should also be given to other sources of funding — for example, we used SLIC funding to leverage NHS England matched funding for the Local Care Record. How to use NHS and GST Charity funding to leverage additional funding is an issue that should be considered further by the next phase of the partnership.

- **Engagement is needed to support successful delivery.**

We learned that success is not just about what you aim to achieve, but the approach you take. SLIC took time to get off the ground because the importance of engagement was underestimated. Instead of taking joint decisions, working collaboratively and seeking to facilitate conversations and constructive challenge, the partnership was perceived as trying to impose a top-down, rigid adherence to a new way of working. This caused ill will among a key stakeholder group that stalled progress on a number of other initiatives — and which confirmed a bias against partnership working held by some groups and individuals within partnership organisations.

We learned the importance of winning hearts and minds and put a lot of effort and resources into building trust and relationships. In this we were successful. As the KCL report said: “A strong theme throughout [stakeholder] interviews was the benefit in terms of improved trust and relationships.”

SLIC built and maintained trust and relationships in a variety of ways, but key to this was the Provider Group. This group explicitly set out to discuss anxieties in a frank and open debate. An example of this is where concerns about a potential move to an Academic Care Organisation were discussed, and a commitment was made to LCNs instead, alleviating anxieties and facilitating joined-up decision-making.

Trust and relationships were also developed through co-design. We learned that people needed to express their anxieties, sometimes about each other’s roles within the system, before they could move on and identify solutions to problems. For example, in our work on hospital discharges, mistrust and misunderstandings were delaying discharges from hospital into the community.

The partnership’s commitment to the McKinsey report recommendation of an 18% shift in resources from hospital to community and primary care was pivotal in building trust and engagement between primary and secondary care, and between primary care and SLIC.

The main thing we learned about trust and relationships is that they are absolutely critical to any programme of transformation. As Adrian Masters, board member of the regulator NHS Improvement, said: “Building and maintaining trusting relationships is absolutely essential across a care system. This isn’t just a ‘nice to have’; I’d go as far as to say that the quality of trust and relationships can be used as a predictor of success, and should play a key factor in assessment of readiness to deliver transformation in care.”

We also came to realise that SLIC suffered from not having a communications and engagement strategy. This meant that there was no regular ‘drum beat’ of communications and no consistency or co-ordination of messaging.

People working hard at the frontline to support the programme often didn’t get a sense of progress or understand the value of their contribution and became demotivated as a result. We needed better communication with key stakeholders to help them understand what was happening and why, to regularly take stock of progress and celebrate successes across the partnership. The SLIC central team helped the partnership communicate with stakeholders, but this arrangement wasn’t fully in place until 2014 so a lot of opportunities were missed. Even by the close of SLIC, there was insufficient communication within each of the partners about the programme. This is an ongoing
issue for the partnership to address in its next phase.

• **Sovereign organisations have to be committed to partnership working.**

Over time we learned that one of the most difficult barriers was for sovereign organisations to overcome the dominant culture and work in the collective interest of local people rather than in the interest of their own organisations. This was made more difficult by the healthcare context we are working in. While the NHS Five Year Forward View and Sustainability and Transformation Plans are encouraging collaboration, we also face increasingly fierce budget cuts, combined with regulation that is, understandably, driving organisations to focus increasingly on meeting their own targets. This issue needs to be addressed head on and commitment must be secured from the major stakeholders.
Lesson 4 – Identify interventions and system enablers

Summary: Create high-impact interventions based on evidence – or strong hypotheses that generate evidence – and linked to population need. Create templates to facilitate this process.

- High-impact interventions based on evidence and need.

We learned that taking shortcuts and rushing headlong into implementation may save time in the short term, but causes a host of problems later on.

Once high-level priorities are set by system leaders, frontline staff and citizens should work together to define a few high-impact interventions linked to population need. Priorities should be either evidence-based or focused on the need to test a hypothesis and generate evidence. A high-level priority for SLIC was prevention and delivery of cost savings within a year, and stakeholders used evidence to prioritise a Falls Prevention class in the community, which proved to be very successful.

We also learned that it is at the funding application stage that stakeholders will often be at their most innovative. To take advantage of this, we developed a business case template that asked partners to demonstrate the evidence base for interventions, to identify success measures and how they would use a ‘test and learn’ approach.

We found that stakeholders will have different views on what constitutes evidence, so programmes will need to come up with ways of prioritising and categorising evidence – and agreeing explicitly when they wish to generate their own evidence.

Lesson 5 – Facilitate and encourage co-design

Summary: Work together to design and test robust interventions and ensure that citizens are able to play a key role as catalysts for change.

- Consider a model of co-design.

One of SLIC’s greatest strengths was that partners and citizens collaborated to design and test new ways of working.

When we moved to a model of co-design, involving citizens and professionals in identifying and testing solutions, the rewards were evident in the outcomes. Co-design built trust and relationships, and enhanced the quality of our projects. Clinicians, patients, carers and citizens view issues through different lenses, so the iterative process of challenge and compromise ultimately led to more innovative and successful approaches, such as the Catheter Passport and HAs.

We also learned that citizens can be catalysts for change – identifying and helping to resolve issues and address gaps in service provision. As a GP quoted in the KCL report said: “Citizen reps on SLIC challenged us to think, ‘What do people want from their doctors?’ so the Holistic Assessment was refocused to asking, ‘What do you want out of this assessment?’”

- Think about how best to harness citizen involvement.

There is still work to do to engage effectively and work with citizens. The King’s Fund evaluation recommended clarifying the role of the Citizens’ Board in the partnership. So did the KCL report, which said that thought should be given to ensuring that the membership represents the local population. The Wragge review also recommended some changes to membership of the Citizens’ Board. There was also a suggestion for elected members, Health and Wellbeing Board chairs and members of local Healthwatch teams to be included in the governance of the citizen engagement programme.
The next phase of the partnership is now considering this.

Lesson 6 – Identify programme support

Summary: Consider the best means of supporting the programme, whether a dedicated or virtual team, and understand the implications of both options.

- Understand the role a central support team can play.

A dedicated central support team can be invaluable, especially in the early days of a partnership. Once the role of the SLIC team had been defined and it had a stable cohort of staff, it strongly supported the partnership in its efforts to integrate care, from supplying expert change managers to oversee projects to providing administrative support for running the Boards and, crucially, keeping the partnership on track to achieve its vision.

The Wragge review highlighted the value of having a central team. There are obvious benefits to having a team able to focus solely on the work of the partnership, rather than a team made up of people simultaneously trying to manage the ongoing operations of individual organisations. Dedicated teams can support and accelerate the change process by being a trusted, honest broker that can break down organisational boundaries to resolve conflict, speaking truth to power as an independent and objective voice.

However, some members of the partnership believe that the serious issue of lack of ownership can only be solved without a central team – that is, the partnership itself must be accountable for bringing about radical, system-wide transformation, individually and as a group. Four years into the partnership, the need for a central team is not as great as when the partnership was in its early days.

Whether there is a central team or a virtual team, where this resource sits and what the team functions are should be made explicit – and they should be given a clear mandate. Of course, not appointing a support team at all is also an option, but this requires a commitment from individual leaders to prioritise the partnership and make it meaningful for their people day-to-day. Also, without a central team, the role of an independent Chair with non-executives performing an independent challenge function is essential. Recruitment is underway for an independent Chair of the next phase of the partnership.

- Make good use of existing resources.

The original plan was for the support team to draw heavily on secondees from across stakeholder organisations to create a dynamic group of ‘change agents’. This was successful in a few cases but, on the whole, organisations found themselves unable to spare leadership resource. However, we suggest that a secondment arrangement for any future central support should be considered again, as it is a good way of accelerating cultural change, successful collaboration and shared ownership of the transformation programme.

Lesson 7 – Use available expertise

Summary: Identify external organisations that can support and accelerate progress on your agenda, and make good use of internal expertise when deciding who should take the lead on various projects.

- Identify external sources of expertise and resource.

Bringing in the expertise of the voluntary and community sector was a milestone for SLIC, and helped to push forward the resilience agenda. We understood that a large proportion of need in Southwark and Lambeth related to social, rather than medical, issues but joined-up services between health and social care was the exception rather than the rule. Making those links, by embedding Age UK Care Navigators into GP practices, demonstrated the positive effect of addressing people’s social and medical needs. Although it is early in the process, the results are very promising, for example, in the delivery of care planning.
We identified a number of other organisations to link up with, including housing, other public services and private sector social care providers. This is something the next phase of the partnership will consider taking forward.

We should also consider making better links with those responsible for supporting change across the partnership – for example, the Wragge review recommended bringing in the Health Innovation Network South London and King’s Improvement Science as sources of additional change support.

• **Identify internal sources of expertise and resource.**

Aside from bringing in external expertise, another lesson we learned was to identify internally who was best placed in terms of capacity to lead change. We realised that large teaching hospitals can play an important role in providing the capacity for testing and implementing new models of care. For example, GSTT took the lead on the Local Care Record, @home, ERR, Nutrition and Falls Prevention initiatives.

**Lesson 8 – Develop lateral leadership and change skills**

**Summary:** Equip those tasked with delivering quality improvement with the necessary skills to design and implement change and to bring about transformation.

• **Support the development of leadership skills at all levels.**

The GP Emerging Leaders Programme was very successful at addressing leadership skills for primary care. As the KCL report noted: “Funding of the Emerging Leaders Programme by the Charity made a big difference... one programme helping to stimulate the other.”

However, it is important that leadership skills are supported across all stakeholder groups. Clinical and frontline leadership are of vital importance – to play a role in transformation, and also to act as advocates for change. As identified in the KCL report, inter-organisational learning is key and consideration should be given to expanding the scope of the GP Emerging Leaders Programme to other stakeholders.
How will you know?

Lesson 9 – Use measurement metrics

Summary: Decide on project and project metrics, think about how best to measure the ‘intangibles’ and ensure that value can be assessed.

“Much stress has been placed on value, resilience and wellbeing and programmes cannot afford to hide behind these laudable terms but specify what they mean, how they will be judged/ measured and that they have been co-produced by stakeholders… with respect to value, the report from King’s Health Partners illustrates the complexities of defining, cleaning and processing the outcome, activity and cost data generated and the considerable resource required to do so.” — KCL report

- Understand what success looks like.

The importance of using measurement metrics is perhaps the most important lesson. In 2012 when the programme was set up, the ideas around value and measurement of value were far more embryonic than they are now, and this is reflected in the measurement we undertook. We learned that there is a need to set up a relationship between elements of the budget and specific activities, enabling costs and value to be assessed.

As the KCL report made clear, SLIC suffered from not articulating what success looked like and how it should be measured. We learned that it is crucial to know whether you are on track, and to be able to continuously measure system progress. To do this, measurement metrics should be agreed with stakeholders at the outset.

Metrics are needed on two levels – programme and project. Programme metrics are needed to ensure that individual projects are coherent and that the interdependencies between them contribute to the overall value. Project metrics are needed to drive improvement and guide problem-solving when things are not going to plan, to enable future commissioning decisions, and to motivate people by communicating progress and success.

SLIC interventions became much better at measurement, especially when it became a condition of funding through our business planning templates. Quarterly performance reports ensured that each project team measured benefits and boards regularly reviewed these, for example, with the IHDT project. Measuring project progress was something we became very good at.

However, programme-level measurement is still something we are grappling with. RAND was commissioned from the outset to measure programme impact and to contrast the impact of SLIC with a ‘counterfactual’ – similar systems who were not implementing a similar programme of transformation – but barriers to national data sharing posed a difficulty. We will receive the RAND final report in summer 2016 and this will inform our future approach to programme-level measurement.

Partners will also need to consider the value of data collection and the degree to which the costs of programme data collection outweigh the benefits. Attribution of success in a complex environment, hosting many interventions with similar benefits, may not be possible.

- Think about how to measure the ‘intangibles’.

Another issue is quantifying things that are inherently difficult to measure. For example, one programme win for SLIC was the building of trust, but it is hard to pin this down in a tangible way. Thought needs to be given to how to measure ‘hard’ and ‘soft’ targets – for example, the strength and effectiveness of partnership and joint working, and the degree of co-production.
Lesson 10 – Evaluate continuously

Summary: Prioritise evaluation, consider how best this is done and who should play a role.

- Consider how to collect hard and soft data – and how to maximise its benefit.

We identified the need for evaluation from the outset of SLIC, and evaluation was commissioned as early as 2012. However, it was beset with difficulties: for example, external evaluators being unable to respond flexibly to the evolving nature of SLIC and to changes in our timescales. Looking forward, we have considered creating a ‘researcher in residence’ role. This would allow for continual tracking of lessons learned, which would help to identify effective interventions in a timely way, allowing for rapid diffusion and scaling up. It would also allow for the collection of ‘softer’ data, such as how people across the partnership are feeling and their views on how various interventions and projects are working.

Lesson 11 – Learn and adapt as you go along

Summary: Be prepared to respond and adapt to learning – don’t be afraid to fail.

- Change in response to learning is positive.

SLIC is a story of learning. During its four years we re-profiled and re-prioritised as we learned and this was a necessary and positive outcome. For example, it led to moving to a resilience model, widening our scope and ambition, and it allowed us to act to address emerging issues, such as initial scepticism and mistrust early on in the programme. It was a necessary part of our ‘test and learn’ approach, where we tested things, some which didn’t work, and then tried again – for example, we trialled a data-sharing system as part of CMDTs.

What we learned is that flexibility is needed. The way of achieving the vision may not be the way originally envisaged, but it can still be right.

A good example of this is the realisation that there is no point integrating something that is not working well. For example, we invested money to support the development of district nursing with a view to later integration.

Lesson 12 – Have strong governance structures

Summary: Recognise the need for strong governance and accountability – and acknowledge the difficulties inherent in achieving them.

- Accountability can be more difficult to implement than governance.

KCL reported that there has been strong system leadership throughout the SLIC governance structure and a clear commitment to governance. However, they also highlight that the price of robust governance is a heavy time commitment for meetings – and noted the disconnect observed by some between strategy and delivery.

While governance was one of SLIC’s main strengths, accountability was a different issue. Wragge reported at the beginning of 2015 that there was confusion between governance and accountability, and an absence of a clear programme of work with detailed implementation plans and agreed priorities. Our experience was that we had good governance and this greatly supported us in moving forward but securing ownership and accountability for all programmes of work remained elusive. Developing accountability and ownership in a network as opposed to individual organisations is difficult. In SLIC, effective accountability for delivery was much more difficult to implement than governance. There were some good examples, such as when CCGs and GP Federations took ownership and control of HAs, but overall this is something that the partnership recognises needs to be addressed in its next phase.

How will you know?
It may seem blindingly obvious that any programme of transformation should create a compelling case for change, produce a strong business case, develop leadership and change skills, measure and evaluate success and have strong governance structures in place.

Despite this, it is rarely done from the outset. This could be due to a number of reasons, for example impatience to get started, or responding to external pressures to get results fast.

As we have shown in the report, this can be detrimental. Bringing about sustainable change requires significant preparation and time spent on these areas that are so fundamental to success. While a less thorough approach may be a more attractive and faster option in the short-term, it will cause problems further down the line.

With this in mind, we have tried to steer away from talking about what we did, and to focus instead on how we did it. This is where we feel our learning will be of most value.

The SLIC Framework for Success on page 6 condenses our learning into 12 key principles, and our hope is that it will be of interest to those undertaking a similar journey of transformation. SLIC learning may not contain ‘eureka’ moments, but what we have tried to show is that it is the cumulative sum of these elements that lead to success.

As we have said earlier in the report, to integrate care requires an integrated approach. The SLIC journey has shown how important it is for all 12 elements to be addressed together for a programme of integrated care to succeed.

Without building trust and relationships, new ways of working can’t be introduced. Without making best use of existing resources – internally and externally, not just relying on the usual suspects – value can’t be realised. And without strong governance, priorities can’t be agreed on and followed through.

Recognising this interdependence is important. Doing good work in one area won’t have impact unless it’s connected with everything else. And these principles are not linear – the process of learning and adapting during a major transformation programme is essential and ensures interventions are high-impact. For example, looking again at emerging data from a project may highlight that it is not targeted at the right group of people or that it’s not aligned with the overall programme vision, and so needs to be re-profiled.

The framework must be underpinned by honesty and the willingness to self-challenge at every stage. It takes courage to say when something is not working, but this is a necessary part of the change journey. It is not a symptom of failure; rather one of success.
FIGURE 9 An integrated approach to transformation
5

Moving to the next phase
During its time as SLIC, the partnership gained a deeper understanding of what needs to be done to successfully integrate care across the two boroughs, and it has now moved into a second phase – the Southwark and Lambeth Strategic Partnership – which will build on the successes and lessons learned in SLIC to continue working to achieve the vision of a system that increases the value of care provided to local people, and that empowers them to take control of their health and wellbeing.

While the vision will stay the same, the Strategic Partnership will go about achieving its aims in a different way. Partner organisations will take on accountability for bringing about system-wide transformation, individually and as a partnership.

In its simplest form, this is about each of the partners saying what they mean to do, doing what they’ve said they would, supporting each other to succeed, and holding themselves (and each other) to account for delivering on their commitments. Everyone will drive success by being involved and taking ownership.

The Strategic Partnership has agreed to focus on a limited number of system-wide priorities, and four of these have already been agreed – Local Care Networks (LCNs), data and analytics to support population health management, further system interoperability, and the Southwark and Lambeth CYPHP.

The Strategic Partnership’s approach to change will be grounded in LCNs that are led by staff and citizens, ensuring that clinicians and professionals work together effectively to create much more co-ordinated care, in the first instance, for people with complex needs. Many of the SLIC interventions, such as HAs, CMDTs and care management, will be mainstreamed into the LCNs.

Data and analytics are fundamental to improving the value of care to citizens. The Strategic Partnership will develop secure systems that allow information to be viewed, recorded and shared at the point of care. They will use data to identify people who need additional support, allowing for early intervention and preventative action rather than waiting until their health deteriorates or reaches crisis point. Organisations in the Strategic Partnership will need to share and link their data, acting as a powerful tool to identify patterns and trends across the whole population and helping them to improve the safety, effectiveness and efficiency of the care they provide.

And the CYPHP, a local partnership of commissioners and providers, will deliver a new model of world-class healthcare to the 120,000 children and young people of Southwark and Lambeth.

However, there is no room for complacency. For example, although our resilience work has provided impressive results in a short space of time, our work in this area is embryonic and we need to ensure that there are concrete plans to further embed this approach and support self-management for individuals and communities.

In this and in other areas, the Strategic Partnership will need to work hard to ensure it makes good use of the solid foundation SLIC has built. It will also have to think carefully about how to overcome barriers – for example, external factors such as continued reduction in funding, and maintaining engagement and momentum in the absence of a central team. In addition, aside from the Charity grant to the CYPHP, there is as yet no central pool of transformation funding to draw from.

Although our vision remains the same, the SLIC of 2012 is very different to the Strategic Partnership of today, but we think this is right – a key element of our success is that we have continually
learned and adapted. We’re under even more financial pressure, but the fact that in our boroughs people are still working together in partnership – no retrenching – is a great sign of success.

Transforming systems across health and social care is difficult. We know this first-hand. But we are on our way and will continue to work together to make a real difference to the people of Southwark and Lambeth.
Communications around the closure of SLIC provided an opportunity to highlight the programme's successes and key achievements, and signal the next stage of the partnership. This has provided a foundation for the next stage in communications – sharing lessons learned.

This report will be used constructively in the partnership, and we hope it will be of interest more widely, for example for NHS Vanguard Programmes looking to develop new models of care, and in health and social care policy development.

There are a variety of lessons to be learned and issues to be considered that are relevant to different groups. We have a plan for internal and external communications and engagement activity for before and after the report’s publication to maximise opportunities for the partnership to share lessons learned, promote its work to date and share what’s coming next.

Internally, this includes communicating through partner channels and running a series of ‘lessons learned’ workshops with partner organisations. We will also identify local events, such as annual conferences, where we can present the key report findings.

Externally, this includes attending national events and conferences, and working with the Partnership Communications Group to identify and agree activities to promote the report overall, and highlight the various findings to specific, targeted audience groups.

This work has already begun – we presented lessons learned to a number of partner organisations while the report was being produced. In June we will begin a series of workshops, team meetings and events at all levels throughout the partnership.

Sharing what we’ve learned
Annex 1: SLIC funding

The total funding for SLIC from 2012 to 2016 was £39.7m. The major NHS partners each contributed significantly to the programme and the GST Charity generously contributed £10.6m (27% of the overall total).

£24.7m was spent on three specific projects which have now been scaled across Southwark and Lambeth: Enhanced Rapid Response; @home; and Reablement. This was not new money – we successfully shifted money from acute to community, with funding from Guy’s and St. Thomas’ NHS Foundation Trust (GSTT), King’s College Hospital NHS Foundation Trust (KCHT) and the Clinical Commissioning Groups (CCGs).

In this section, we will focus on the £15m spent on the rest of the SLIC Programme. While the Charity was the major contributor, some NHS partners also contributed and this leveraged some additional resource, including £0.5m from the NHS England Integrated Digital Care Technology Fund to part-fund the Local Care Record, and £0.1m from Health Education England South London.

The total funding for the SLIC Programme was originally intended to cover a three-year period but, after a slower-than-expected start, the programme was extended by a year and so the £39.7m actually funded SLIC for four years.

The extension of the programme increased the delivery support needed. We also underestimated the extent of the support needed to deliver major transformation.

In autumn 2014, the decision was made to allocate resources to the partnership to support delivery and allow us to move faster. Resources were used to backfill staff, to enable them to participate in the design and testing of interventions, and to take part in governance meetings. In addition, changes were made to the amount paid to primary care to deliver interventions.

The SLIC central team was expanded during the course of the programme as it was recognised that experienced change managers and administrative support for the programme would be essential. Resources were also needed to ensure that the boards were properly run. As engagement was highlighted as a key issue, a Citizens Engagement Team was recruited, alongside specialist communications personnel.

Spend on the SLIC programme

SLIC formally ended in March 2016, and the expenditure for the programme to the end of March 2016 was £13.8m, divided between two categories: interventions and infrastructure.

GST Charity funding was not attached to specific schemes, which allowed the partnership, together with Charity executives, to allocate funding flexibly as the programme evolved. This also meant that we could not consider the impact of Charity funding in isolation from the rest of the programme. We need to consider its overall value and impact.

Spend on interventions

The total spent on interventions was £7.4m.

The 27 SLIC interventions were aimed at achieving the three programme aims of: joining up care across providers; getting involved earlier to improve lives; and supporting people to feel safe and cared for at home. These three aims are supported by a fourth heading of intervention ‘enablers’ such as IT and evaluation.
£39.7m
2012–16

27%
GST Charity funded

£24.7m
2012–16

100%
NHS funded

Funded projects:
ERR
@home
Reablement

£15m
SLIC Programme
2012–16

6%
Other (leverage)

23%
NHS funded

71%
GST Charity funded

FIGURE 10 SLIC sources of funding
**Breakdown of the total spend on the SLIC programme**

- **£6.4m** Infrastructure
- **£15m** SLIC Programme 2012–16
- **£1.2m** Outstanding SLIC costs 2016–17
- **£7.4m** Interventions

**£1.07m**
14.5%
Supporting people to feel safe and cared for at home

- **£0.45m** Integrated Hospital Discharge Team (IDHT)
- **£0.33m** Dementia Care Home Intervention Team
- **£0.16m** Locality Geriatricians
- **£0.05m** End of life care
- **£0.05m** Care homes
- **£0.03m** District nurses

**£2.9m**
39%
Enablers of interventions

- **£1.2m** IT/informatics
- **£0.51m** External consultancy
- **£0.38m** Partner resourcing
- **£0.32m** Evaluation
- **£0.18m** NHS Year of Care
- **£0.15m** Local Care Networks (LCNs)
- **£0.11m** Digital Directory
- **£0.07m** Voluntary and community sector (resilience)

**£2.49m**
34%
Joining up care across providers

- **£1.02m** HAs
- **£0.77m** CMDTs
- **£0.51m** ICMs
- **£0.19m** Care Navigators

**£0.92m**
12.5%
Getting involved earlier to improve lives

- **£0.52m** Falls
- **£0.32m** Nutrition
- **£0.07m** Dementia: Psychiatric Liaison
- **£0.01m** Infection
Spend on SLIC infrastructure

The total spend on infrastructure was £6.4m. Infrastructure costs included the SLIC team and associated overheads such as rent, all SLIC governance and design meetings, and engagement and communication costs.

Initially, infrastructure costs dominated expenditure as the programme became established, rising in the second year and then remaining constant. Intervention expenditure continued to rise as the momentum for participation increased, and became the largest element of spend in the latter two years.

Funding for 2016/17

The balance of the funding (£1.2m) was committed to contractual payments prior to closure of the programme, including final payments for evaluation, workforce, voluntary and community sector and associated SLIC closure costs.

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**FIGURE 12 Breakdown between intervention and infrastructure spend**

- **£7.4m** Interventions
  - £2.3m Interventions
    - £1.02m HAs
    - £0.77m CMDTs
    - £0.51m ICMs
  - £5.51m SLIC team
  - £136k SLIC governance and design meetings
  - £138k Communication and engagement
  - £290k Consultancy delivery support
  - £316k Overheads

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**FIGURE 13 SLIC controlled expenditure by broad category over time**

- Infrastructure
- Interventions
Annex 2: SLIC turning points and milestones

The boards agreed a number of turning points and milestones during the four years of SLIC.

2011
Sowing the seeds
The partnership begins as the Integrated Care Pilot (ICP).

2012
United and funded but we learn how hard it is
Charity funding is granted to the ICP and the Older People’s Programme (OPP) is established to improve the quality of care for over-65s with complex needs and Long Term Conditions.

Enhanced Rapid Response (ERR) and @home services are piloted.

Community Multi-Disciplinary Teams (CMDTs) begin – implementation is difficult but seen to be successful in breaking down professional barriers.

The partnership undergoes changes in Chair and team leadership.

Relations with GPs are strained through the initial implementation of Holistic Assessments (HAs).

2013
Gaining traction
The partnership changes its name to Southwark and Lambeth Integrated Care (SLIC).

Strengthened governance arrangements are agreed, the Sponsor Board becomes more strategic and a third – and final – programme leader is recruited.

A ‘test and learn’ change model is introduced.

A benefits re-profiling exercise is undertaken, recalibrating targets, for example, to take account of slow uptake of HA and CMDT activity.

Southwark and Lambeth are two out of only six boroughs approved by the NHS Better Care Fund, set up “to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people” – evidence that we are on the right track.

The Guy’s and St. Thomas’ (GST) Charity funds the GP Emerging Leaders Programme.

Primary Care Trusts become Clinical Commissioning Groups, losing responsibility for commissioning primary care and affecting the implementation of GP sign-up for HAs.

2014
Moving to a social care and population-based model
The McKinsey report identifies a £339m funding gap by 2018, and recommends a structure for shared sovereignty, collaboration and team working. An Academic Care Organisation is considered but not supported by primary care, and SLIC moves instead to a Local Care Network (LCN) structure. The report also recommends an 18% resource shift from secondary to primary care, which improves relations with GPs.

In light of the McKinsey report, there is a reiteration of priorities by the Sponsor Board, which agrees that SLIC should move from a medical to a ‘social’ model and a focus on resilience. This is informed by the knowledge that clinical pathways were being pursued in separate initiatives outside SLIC, and the recognition that common mental health problems, such as depression and anxiety, drove much demand for health and social care.

Relationships are developed with the voluntary and community sector to support the move to a resilient system.
The SLIC Citizens Board is set up to put the voice of local people and service users at the heart of SLIC decision-making, and sees citizens become partners in co-design and testing.

The Sponsor Board agrees a role for the central SLIC team to act as ‘stewards of aspiration’ and to help mobilise change.

GPs trained via the Emerging Leaders Programme lead the way in designing and implementing HAs.

Realising that services needing improvement cannot be integrated, SLIC funds a project to support and improve Guy’s and St. Thomas’ NHS Foundation Trust (GSTT) district nursing.

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### 2014 cont.

### 2015

**Deciding future priorities**

The Local Care Record is developed – for the first time allowing outwark and Lambeth clinicians in primary and secondary care to view each other’s patient records in real-time.

A Strategic Portfolio Review takes place and programme scope is extended to adult populations in general, and business case templates are used for the first time.

The Wragge review (commissioned by the GST Charity) is published. It notes that a ‘step change’ is needed to deliver the ‘required system transformation’ and highlights: confusion around accountability; the role of the Charity, SLIC team and governance structures; and the need for a co-ordinated approach to communications. It recommends an alliance relationship company, which is not accepted – however, work to form the next phase of the partnership commences.

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### 2016

**Moving to the next phase and celebrating success**

The Catheter Passport is shortlisted for GSTT Involvement to Impact Award.

Falls prevention initiative is shortlisted for the Health Service Journal (HSJ) Value in Healthcare Award.

In March, SLIC closes to make way for the next phase – the Southwark and Lambeth Strategic Partnership.

In April, the Local Care Record is used by 100% of Southwark and Lambeth GPs.

In May, the King’s College London report – Southwark & Lambeth Integrated Care Programme Evaluation – is produced.

In the summer, the final report from RAND on value will be produced.
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.
Local Care Networks – Networks led by staff and citizens, ensuring professionals work together effectively to create much more co-ordinated care.

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

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

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

Reablement – Rehabilitation to enable discharge from hospital.

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

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.

TALK – See Hot Clinics above.

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

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.

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

NHS Southwark Clinical Commissioning Group

NHS Lambeth Clinical Commissioning Group

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