SLIC Key Messages and Q&A

As of 25 September

WHAT IS SOUTHWARK AND LAMBETH INTEGRATED CARE?

Health and social care organisations and people in Southwark and Lambeth have come together so that local people can lead healthier and happier lives. Southwark and Lambeth Integrated Care is the partnership that brings us together.

This means we can help communities and professionals to work better together to provide pro-active and preventative care that gives local people control of their own health and well-being. For professionals, we need to make the right thing to do the easy thing to do.

Southwark and Lambeth Integrated Care is a network between local GPs, the three local NHS Foundation Hospital Trusts (Guys` & St Thomas` NHS Foundation Trust, South London & Maudsley NHS Foundation Trust and King`s College Hospital NHS Foundation Trust) the Southwark and Lambeth Clinical Commissioning Groups, social care and people in Southwark and Lambeth, supported by Guy's and St Thomas' Charity.

WHY DO WE NEED SOUTHWARK AND LAMBETH INTEGRATED CARE?

Our partnership is based on a very basic premise: people's outcomes and experiences are not good enough in the current system, and care as currently designed is not maintainable within current funding and resources. Despite hosting many of the UK's most talented clinicians, professionals and leaders, we start from a system where we make it difficult for organisations and professionals to work together, where care is mostly focussed on treatment not prevention, and where many people are left feeling bewildered and unable to take control of their own lives. We are confident that this can be improved and we have excellent examples of local people successfully managing their lives with the support of health and social care providers.

We believe that this is a shared problem affecting each partner in Southwark and Lambeth Integrated Care. We are resolute in our commitment to face the challenges and we recognise that our response must bring to bear our collective effort and resources. We believe that this joint approach is the best way to provide the highest quality care for our population, from public health and prevention through to acute provision and recovery, at the same time ensuring that we are getting the best possible value for our collective spend. In short, we have to work together to achieve the greatest outcome; hence the need for Southwark and Lambeth Integrated Care.

If we continue on the current government's basis, the system will become financially unsustainable - demand will outstrip current funding estimates by around £350m by 2019. This presents a huge

threat to the care we can provide to our population. Even in the short term, local authorities will have to make very difficult choices about services: Lambeth Council alone will have its care budget cut by £100m, and consequently by the end of 2014 the councils will face a decision about whether to underwrite investment in integrated services, or to begin to reduce their service contracts. Cutting social care would have a significant impact on the demand for NHS services.

The partnership is supported, in some of its priorities, by a small team – the Southwark and Lambeth Integrated Care Team. This team acts as a catalyst and facilitator for change, coordinating the testing of new ideas and supporting bringing them to scale.

WHAT HAS SOUTHWARK AND LAMBETH INTEGRATED CARE DONE, SO FAR?

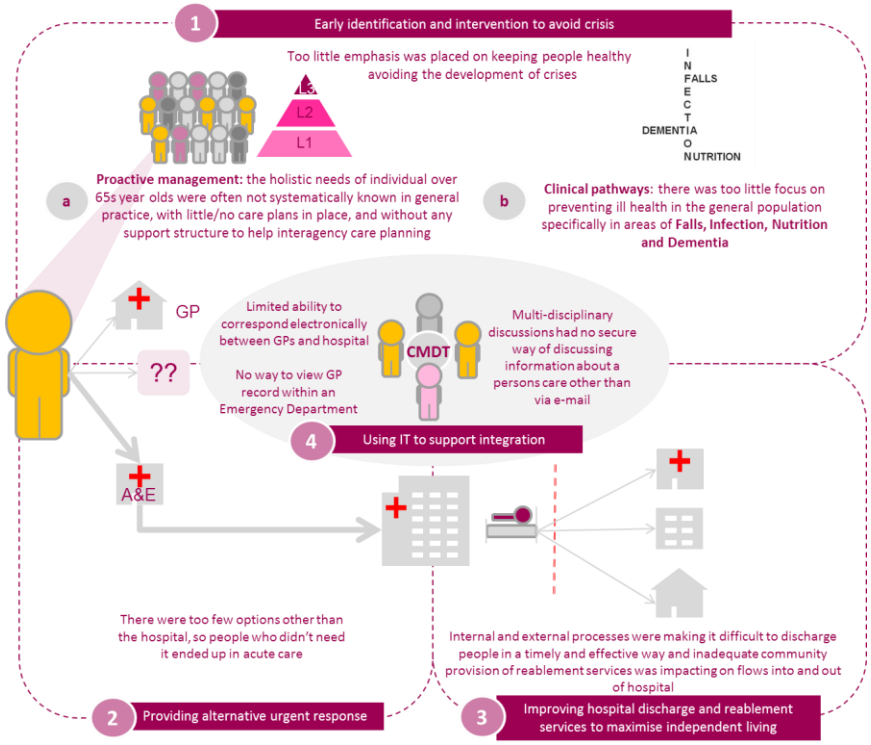
Since 2012, Southwark and Lambeth Integrated Care has been working to improve the system through the Older People`s Programme, to ensure that local older people get the right services, in the right place, at the right time. In some cases, the right care might involve granting people rapid access to specialist opinions. In other cases, appropriate care may call for the support of a care team working proactively to keep people out of hospitals or care homes, or helping people to return to their homes to limit the time spent in institutional care. To achieve this, it is essential that services are personalised and centred on the individual to enable them to spend more time living in their home, with services that support them to do this proactively.

We have identified ways we can improve support for the Older People's Programme team, clinicians and professionals to ensure that their efforts have a greater impact on the lives of local people.

We are looking at the need to focus commissioning around groups of people with similar needs rather than around institutions and professionals. By bringing social and health commissioning together, we are able to shift resources into communities to provide preventative and proactive care, at the same time allowing for the co-design of new models of care for providers, including the voluntary sector and our citizens.

In January 2012, the balance of care for people aged over 65 in Lambeth and Southwark was not preventative or co-ordinated. This was resulting in high levels of demand for hospitals and institutional care. To address these issues, the first phase of work within Southwark and Lambeth Integrated Care comprises of the following (as set out in Figure 1):

Figure 1



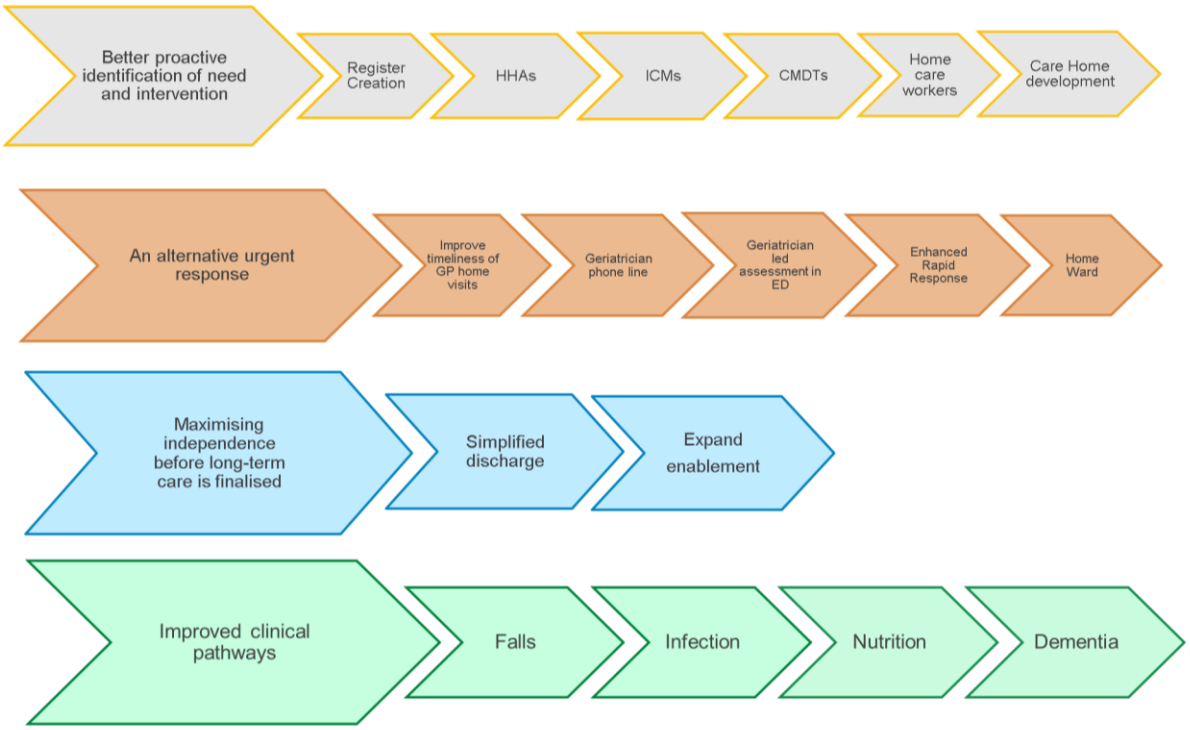
- Identifying need early in a systematic way and intervening proactively to avoid crisis
- Providing alternative urgent responses, so that when people do become unwell or are experiencing a crisis, there are options available for them where they can receive the treatment or care they require, without relying solely on treatment at an Emergency Department
- Improving the hospital discharge process so that people can be discharged in a timely and quality manner, while simultaneously improving and increasing the provision of community reablement services so that people are empowered to live better and more independently in their own home
- Providing an IT infrastructure that enables proactive, co-ordinated care through the real time sharing of information

We are now developing the Older People's Programme further to support self-management in the community, in order to build more resilient individuals and communities.

WHAT IS THE OLDER PEOPLE'S PROGRAMME?

In order to address the themes identified in Figure 1, the Older People's Programme consists of many different projects that are set out in Figure 2:

Figure 2



The Older People's Programme has helped to pro-actively identify the needs of older people within General Practice, through the creation of registers of people aged over 65 and by working with these people to complete Holistic Health Assessments. The Older People's Programme has developed proactive intervention within General Practice through the provision of Integrated Care Managers and the formation of Community Multi-disciplinary meetings, where staffs from across health and social care meet to discuss the care of people being supported by Integrated Care Managers.

The Older People's Programme has shown that proactive identification of care needs can have a real benefit on people's lives. It has shown that there are areas of real unmet need, such as those identified within a Holistic Health Assessment, which often go undetected until they result in emergency presentations at hospitals or care home admissions.

To address the lack of proactive services for people aged over 65 in the areas of Falls, Infection, Nutrition and Dementia, Southwark and Lambeth Integrated Care continues to lead and support the testing of new service models within these 4 areas. The tests that are currently underway are:

- A new fast track, self-referral, community exercise service to provide strength and balance exercises to older people who are at risk of falling. It has already been shown that there are people living in Southwark and Lambeth who will benefit from this service.
- A patient held document to support and empower people in managing their own catheters to limit preventable infections and avoidable trips to hospital.
- A community dietetic team who are working to support citizens, their carers, local communities and professional staff in addressing the growing number of people suffering from malnutrition.
- A digital online directory of dementia services across Southwark and Lambeth to provide a comprehensive list of all services available to support people with dementia and their carers.

To address the lack of urgent care options available to older people who don`t necessarily require hospital care, the Older People's Programme has helped to test and implement new helplines at GSTT, KCH and SLaM. These helplines allow GPs and Community staff to speak to a consultant in geriatric medicine or old age psychiatry 24 hours a day, 7 days a week. An older person can then be seen in clinic within 72 hours of this phone call. The initiation of this service has highlighted a pitfall in the current system where we make it very difficult for professionals in General Practice and Acute Trusts to speak with each other about the care of their patients. The introduction of the TALK lines has helped reduce the need for elderly people to be taken to Emergency Departments.

In addition, Enhanced Rapid Response and the @Home service enables people who would have been previously admitted to hospital, to stay in their own home with the support of enhanced nursing, therapy and social care support.

To address the reasons why people were admitted to residential care previously when they could have been supported at home, and the many causes behind long hospital stays, the Older People's Programme continues to test new approaches to discharging people from hospital promptly, with enhanced support at home to avoid care home admissions.

To address the lack of real time information sharing to support the co-ordination of people's care across the health and social care system, three main IT solutions are being tested.

1. We have made the GP record viewable across the whole of KHP and potentially to other providers e.g. social care.
2. 'Community Collaborator' is being used to upload and share case summaries and hold online discussions, reducing paper-based records and e-mail transfers of information.
3. EDT Hub similarly removes dependency on e-mail for sending electronic correspondence.

Moving forwards, there will be a significant focus placed on ensuring that these tools are widely adopted across Southwark and Lambeth.

WHAT HAS BEEN THE SUCCESS OF THE OLDER PEOPLE'S PROGRAMME SPECIFICALLY?

General Practice: A Proactive and Integrated System for Older People

As per Figure 2, we propose a workstream centred on early identification of health and social care needs for older people across Southwark and Lambeth. People will be offered proactive Holistic Health Assessments by their GP, nurse or HCA and when required, will be supported by a Care Manager in their Practice. In support of this; GPs, practice nurses and care managers in the community will have support from a local Community Multi-Disciplinary Team (CMDT) comprising of hospital, community, mental health and social care specialists.

Local CMDT Leaders

SOUTHWARK	
Bermondsey and Rotherhithe	louisa.dove@nhs.net **and** catherine.otty@nhs.net
Borough and Walworth	olufemi.osonuga@nhs.net
South Southwark	brenda.donnelly@nhs.net
LAMBETH	
Lambeth South East	mark.chamley@nhs.net **(interim for)** carley.hennah@nhs.net
Lambeth South West	simonhassan@nhs.net
Lambeth North	cilla.mcginn@nhs.net **and** james.may@nhs.net

An Alternative Urgent Response: TALK

A direct access telephone service offers General Practice and Community staff rapid telephone access to specialists at Guys and St Thomas' and Kings College Hospitals', to support admission avoidance for over 65s. This service can also offer professionals and their patients' faster access to diagnostic clinics if needed. The TALK hotlines are currently focused on Older People but are soon to expand into General Medicine for 18-65 year olds and Paediatrics.

Maximising Independence: Simplified Discharge

We have been testing ways of safely discharging patients from hospitals by enhancing existing services and providing additional support to people in their homes. We know that some dependent patients have greatly benefitted from a rapid discharge and rehab support, which they may not have received using standard processes. Through testing, we have identified a requirement for a more simplified, integrated referral and access system to community services. This is something that we will continue to address.

Testing has re-emphasised the importance of early multi-agency intervention and information sharing. We have recently initiated testing of a social workers involvement in sharing information at an early stage of treatment and their inclusion as part of the multi- disciplinary team.

Improved Clinical Pathways: Falls, Infection, Nutrition, Dementia

Falls

A new fast track service into community exercise has been developed and promoted for people in Southwark and Lambeth. The class aims to provide strength and balance exercises to those people at risk of falling but are not currently referred to existing services. These particular classes are targeted at people aged 65+ living in Southwark and Lambeth and currently take place in 8 different locations across the Boroughs.

Infection

Within the infection working group, we have tested a catheter passport, a patient held document to empower patients in managing their catheters while also promoting information sharing between health professionals. A second iteration of testing has just commenced for two months that will inform the final design.

Nutrition

A new community dietetic team will come into post in July to test two models of care to address malnutrition across our local boroughs. This team will also support the CMDTs and provide a referral route from the HHA. The team will work across a number of care settings, from primary care to home care, and help to build both professional and community capacity to address malnutrition.

Dementia

One of the key challenges identified by the dementia working group was that despite a large number of services to support dementia patients, there was no central source for information or sign posting. Not only is this overwhelming for patients, their families and carers, it is also confusing for health and social care staff.

As a result, a digital directory of dementia services across Southwark and Lambeth has been developed and is accessible online. Not only does this directory provide a comprehensive list of services and how to access them, it may also help health and social care professionals to look beyond their immediate sphere of influence and understand how other health, social care, and voluntary sector organisations can support the well-being of our citizens. In partnership with Age UK Lambeth, the directory of services has been developed and tested with user input and is now available for access.

WHAT HAVE YOU LEARNED FROM THE OLDER PEOPLE'S PROGRAMME?

Over the last two years, the Older People's Programme has brought together staff from across health and social care, to work alongside citizens and service users in Southwark and Lambeth to redesign the care for people aged 65 and over.

The Older People's Programme has shone a light on the scale of the challenge we face, and has suggested that the way care is currently organised, does not work well for either our local people or for our professionals. The Holistic Health Assessments show people`s needs often go undetected until it`s too late, leading to preventable admissions to hospitals and care homes. The work of the CMDTs demonstrates the power of good professional relationships and strong communication. In past years, too many professionals have not known each other and haven`t understood how others could contribute to care. Introduction of the TALK hotlines has highlighted problems within our current system, where we have made it difficult for General Practitioners and hospital specialists to communicate. This has resulted in unnecessary hospital visits, when basic specialist advice could have been delivered via a simple phone call.

For this work, our organisations and citizens have invested a significant amount of time and energy. This has been important in building the hard-won trust upon which transformation is built. In turn, this has ignited an enthusiasm amongst professionals and a belief that improving the co-ordination of people's care is possible.

Through the Older People's Programme, we have developed a systematic way of bringing together the various leaders across the health and social care system. This has made it easier for organisational leaders and citizens to come together to share their perspectives and think strategically about the needs of the care economy overall, beyond the more narrowly defined objectives of any of our individual organisations. We will seek to maintain a leadership coalition for change between citizens, commissioners and providers.

Our experience with the Older People's Programme has shown us that whilst hugely important, the testing and delivery of pilot initiatives is not enough on its own to lead to wide-scale adoption of these new ways of working. The Older People's Programme and other change pilots create valuable knowledge, commitment and momentum, but in practice they 'push' integrated working into an un-integrated system.

Achieving this shift means moving away from some of the practices and behaviours that have been built into our health and social care system for decades. This creates practical challenges because many of the aspects that characterise the existing system – such as separate commissioning between health and social care, the existence of different contracts and payments based on where care is delivered or by whom it is administered, and the process of storing our data separately– act as barriers to the more collaborative approaches that underpin integrated work.

We must work together to overcome the organisational, operational, cultural and professional barriers that can limit care integration so that everyone in the health and social care system is focused on achieving the same thing: better outcomes and experiences for people provided in an affordable way, delivered through services that are empowering, holistic and preventative. In practice, this means bringing our resources together in new ways, organisations collaborating to share responsibility and risk, providers sharing information effectively (between each other and with citizens), new workforce roles and relationships being developed, and better use of the facilities we have access to across the two boroughs.

To take it to scale requires more of our combined resources being focused on supporting people actively at home, despite having a payment system that incentivises treatment in hospitals and a historical focus on treatment not prevention.

We must work with the community to build the resilience required to better enable supported self-management. For this to succeed, we need to acknowledge the important roles of the voluntary sector, housing sector, carers, and other third parties. By looking towards the total resources we allocate on older people, and targeting these resources towards prevention rather than treatment, we have a strong opportunity to make a real difference in the community.

SO WHAT HAVE YOU BEEN DOING TO TACKLE THOSE BARRIERS?

We have conducted a specific piece of work on commissioning, payment systems and the structure of provision to look at the current barriers to delivering integrated care and how we can overcome these barriers.

No decisions have been reached in relation to the specific and detailed changes needed to allow for integrated care to emerge, but there is agreement about the direction of travel we need to embark on if we are going to deliver our ambitions:

- In order to establish a system of integrated care, health and care teams across the boroughs need to be given the freedom to change the way we work together - with one another, and with patients and citizens. This will require a change in the way that services are commissioned and contracted.
- Our approach to integrated services should help us move beyond a model that leaves professionals feeling overwhelmed and practices stretched to their limits. We look towards a system where it is easier for staff to perform their jobs and provide people with care and support when and where they need it.

This change will be led by both citizens and professionals, as we work together to co-design a new future, moving away from a medical model towards a more social model of care. This means focusing on prevention in the home rather than simply treating people in hospitals or care home facilities.

SO WHAT HAPPENS NEXT?

The Southwark and Lambeth Integrated Care Sponsor Board agreed at its May 2014 meeting that the following principles should be used as a basis for taking our work forward. As representatives of their sovereign bodies, Sponsor Board members were asked to take these recommendations back to their decision-making bodies.

Integrated Commissioning:
Support joint commissioning arrangements that bring together budgets across health and social care within each borough, shaping these joint resources around defined segments of the population so that funding is organised around people and their needs rather than institutions.

Shift the focus of resources so that the planned growth in funding allocations is invested in developing primary care, social care and community (physical and mental health), in order to reduce growth in the demand for acute services.

Encourage the development of services that have defined 'attributes of care'. These are services that move beyond a medical model and towards a more social approach which:

- Empowers and activates people and communities, enabling people to be in control of their own health and wellbeing
- Offers holistic and co-ordinated care and support
- Is equitable, proactive, preventative and focused on better outcomes

Move towards an integrated performance management approach that supports all providers to focus on improving 'value'. For example, by using a scorecard of outcome metrics that relate to safety & effectiveness, patient experience and cost.

Prepare and implement specific plans to develop the market, and to identify what procurement routes are most suitable for the task of improving citizen outcomes.

Provision:
We agree that we should work together to design services that are characterised by the 'attributes of care' drafted by the health and social care commissioners (See Appendix 1). This decision was reached with the realisation that all too often the general experience of care at present rarely matches well against these attributes.

This work is not about creating a single vertically integrated system, but rather about developing a genuinely unified system, established through partnership and a united purpose.

These new ways of working must be based on good evidence of the challenges we face and the priorities we set. It should empower healthcare professionals, social care workers and citizens to work together on an equal footing to design services that are effective and sustainable, drawing on the important contributions of other services (e.g. housing) and from the voluntary sector. We will therefore use our collective work to bring information, professionals and citizens together so that they lead the design of services. This will augment existing work, within both primary care and community services. Serious consideration is also being given to the development of neighbourhood and locality working, indicating that more detail is still to be finalised.

New service design should build upon the work that we have already undertaken- including Lambeth Living Well, the Diabetes Management Initiative and the Older People's Programme. These projects were supported by co-design between professionals, citizens and voluntary organisations, and are

good representations of how unified work can be used to successfully improve the lives of our population. We will ensure that we utilise these approaches more systematically in our future work.

We will work together to co-design platforms that support real-time sharing of information between all parties, including primary and community staff, social care organisations and citizens. We will ensure that systems support the emergence of shared records, which citizens and their carers can use to manage their health and care needs. We will look to KHP to provide specific and dedicated support to help us make rapid progress in this area.

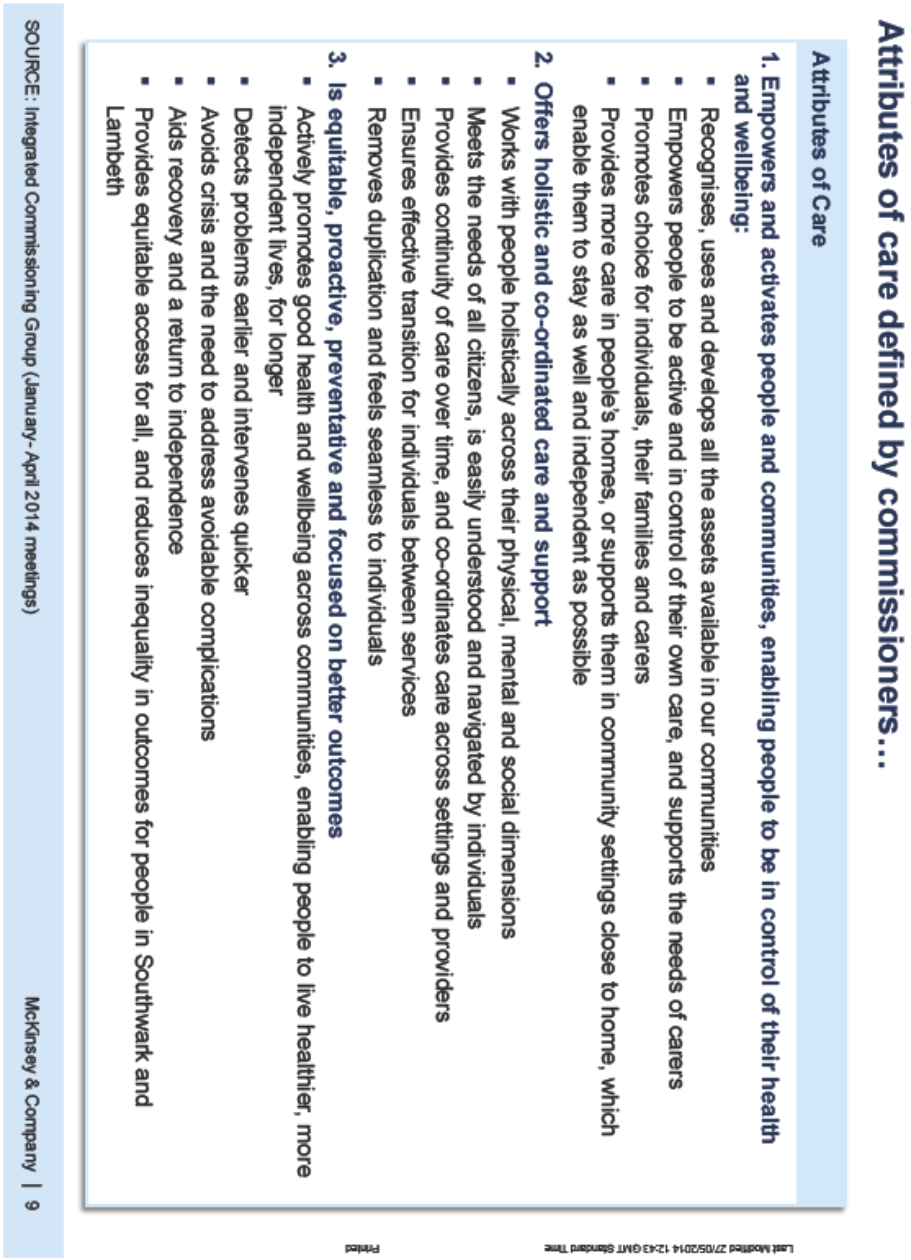
We will make sure that the facilities used across Southwark and Lambeth support professionals and communities to deliver services appropriately, enabling the production of empowering, holistic and proactive care. We will build upon and combine the work already done across Lambeth and Southwark, and we will identify the best use for our estate with all partners and stakeholders in mind.

Working together:

We will work together, both with commissioners and with providers, to manage financial risk. This will be done with an understanding between providers that a proportion of payment will be based on the achievement of measures, which have been co-designed, collectively agreed and which form the basis of a shared 'value scorecard'.

APPENDIX 1: ATTRIBUTES OF CARE

We have agreed upon a series of attributes of care and new models for their delivery to improve the patient experience for our citizens:



Attributes of care defined by commissioners...

Attributes of Care

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

Last Modified 27/05/2014 12:43 GMT Standard Time

Printed

SOURCE: Integrated Commissioning Group (January- April 2014 meetings)

McKinsey & Company | 9

Q&A

Who is Southwark and Lambeth Integrated Care?

Health and social care organisations and citizens in Southwark and Lambeth have come together so that local people can lead healthier and happier lives. Southwark and Lambeth Integrated Care is the partnership that brings us together.

Southwark and Lambeth Integrated Care is a network between local GPs, the three local NHS Foundation Hospital Trusts (Guys` & St Thomas` NHS Foundation Trust, South London & Maudsley NHS Foundation Trust and King`s College Hospital NHS Foundation Trust) the Southwark and Lambeth Clinical Commissioning Groups, social care and people in Southwark and Lambeth, supported by Guy's and St Thomas' Charity.

What does Southwark and Lambeth Integrated Care exist to do?

At Southwark and Lambeth Integrated Care, our work starts from a very basic premise: people's outcomes and experiences are not good enough in the current system, and care as currently designed is not maintainable within current funding and resources.

Our aim is to drive the delivery of pro-active and preventative care in Southwark and Lambeth to ensure our citizens have access to the right care, in the right place, at the right time. We help communities and professionals to work better together to provide care that gives local people control of their own health and well-being. For professionals, we need to make the right thing to do the easy thing to do.

What is Southwark and Lambeth Integrated Care wanting to change about how health and social care works?

Central to our work and building on the lessons of the Older People's Programme, we have worked with citizens, clinicians, healthcare providers and social care workers to develop a list of what we believe are the attributes of care that we strive to deliver. These attributes aim to:

- Empower and activate people and communities, enabling people to be in control of their own health and well-being
- Offer holistic and coordinated care and support
- Are equitable, proactive, preventative and focused on better outcomes

(See Appendix 1 for full list)

How do you know that this is change people even want?

Citizens have been saying for some time that the status quo doesn't work: their experience of care is fragmented and episodic. Citizens tell us they want more control over their care and its location, so they can live independently, spending less time in either hospital or care homes. Citizens want us to connect services because they wish to be treated as a whole person. We will work with citizens to co-design our ideas for the future.

Why are you looking at locality working?

Primary and community services are already looking at developing neighbourhood and locality working. Developing this further is currently under consideration. This will see strong working relationships emerge with the voluntary sector, other council services (e.g. housing) and communities.

I thought everyone agreed we have had enough of top down change?

This change must be citizen and professionally led and designed. We know better integrated care will ensure that people feel more in control of their lives and will be designed to support improved outcomes and experiences, leading to more resilient communities.

The role of system leaders must be to reject incremental fixes to the system that put specialty, service and organisational interests before the experience and outcomes of our citizens. System leaders will help to create the conditions under which professionals and citizens co-design and implement how care is provided.

What does co-design mean in reality?

It's vital that we are making changes with citizens not to citizens. Co-design means working with citizens to design provision alongside health and social services, housing, the voluntary sector and private sector social care. For professionals, co-design means working with those on the frontline, not just imposing top down solutions.

What has Southwark and Lambeth Integrated Care been doing up until this point?

We started with rapid testing and implementation of connected health and social care interventions, aimed at improving the value of care received by frail and elderly people via the Older People's Programme.

A lot has already been achieved. We are maintaining our focus on providing holistic care by addressing mental health, physical health and social care needs in a unified manner. We have built a strong commitment to action and gained a greater understanding of the options available for reducing avoidable emergency admissions, speeding up delays in discharge, and reducing residential care stays.

At its core, we focus on the needs and wants of older people registered with General Practice. We plan peoples care across organisations and ensure that the right care is being delivered reliably, in the right place, at the right time. In order to achieve the scale and pace of change we need to make a real difference, we need to look at the fundamental way services are organised and paid for.

Don't we want a medical model of care? What does a social model of care mean?

Working towards a social model of care means we are focusing on prevention in the community rather than waiting to deliver treatment in a reactive manner. A social model of care requires working with the community proactively, as opposed to simply treating people in hospital or care homes as problems arise.

To achieve a social model of care, we must transform behaviours and relationships between citizens, carers and professionals. In support of this transformation, we are now planning to do the following:

- Refocus commissioning so that it is genuinely organised around groups of people with similar needs, rather than institutions and professionals.
- Establish joint commissioning arrangements to combine health and social care budgets within each borough.
- Shift resources to invest in primary and community services in order to effectively manage demand growth.
- Set out clear attributes of care that we expect services to deliver.
- Develop performance metrics that encourage providers to focus on delivering 'value'.
- Work together to co-design new local models, giving serious consideration to the development of neighbourhood and locality working, whilst recognising that much detail is still to be finalised.
- Reach an agreement on how we will develop real-time information sharing between providers and with citizens; and determine how we will collect and use data to support measurement, testing new approaches and the generation of new evidence.
- Form an agreement on how to make best use of our collective estates so that professionals and communities are able to deliver services which enable empowering, holistic and proactive care.
- Establish how we will manage system-wide financial risk, between commissioners and providers, and across provider groups, by developing detailed plans around new payment approaches.

When will we see any actual change?

We've already seen change through the Older People's Programme. Providers have further committed to working together to co-design services with voluntary sector and private sector social care, housing services and citizens, in order to have different services on the ground by April 2015.

How does this fit in with local strategy?

We have been clear about our intention to align with with Health and Well Being Strategies and we believe that our proposals will better help these strategies be delivered. Through our partnership, this work is also aligned with primary care strategies, hospital strategies and social care strategies.

Are these changes being driven by cuts in funding?

These changes are being driven by our commitment towards better outcomes for people in Southwark and Lambeth. There are big challenges to match increasing demand for our resources, but these are changes that should be made regardless of the financial situation.

I thought that you were facing cuts? Is there any evidence that this work will help with the cuts we are facing?

There is an urgent need to make real change happen on the ground. If we continue on the current basis the system will become unsustainable - demand will outstrip funding by around £350m by 2019. This presents a huge threat to the care we can provide to our population. Even in the short term, local authorities will have to make very difficult choices about services: Lambeth Council alone will have its care budget cut by £100m, and consequently by the end of 2014 the councils will face a

decision about whether to underwrite investment in integrated services, or to begin to reduce their service contracts. Cutting social care would have a significant impact on the demand for NHS services but we will need to develop credible plans to help councils justify investment in integrated services.

Are resilient communities code for older people having to rely on volunteers rather than healthcare professionals?

No but our recent work across Southwark and Lambeth has shown a strong commitment towards providing better support for people to live well in their communities. We do think there is a greater role that the third party sectors can play in building community assets, particularly in supporting people when they would prefer to remain in their own home rather than in hospital or a care home.

What is wrong with commissioning at the moment?

Commissioning is currently based on an organising principle of sectors, professionals and institutions. We group the population by geography, illness, body part, service, etc. If we want to organise care so that it deals with real people and their various interrelated needs, we must develop a connected way of commissioning service that supports providers to work together to provide preventative and pro-active care.

So how do the commissioners intend to group people under the new model?

Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care; a one size fits all approach is inadequate and different sets of people have different needs. The idea of grouping the population is to ensure that the model of care addresses the needs of individuals holistically, rather than being structured around different services and organisations.

Will grouping based on needs enable us to put people at the centre of care?

We already group the population but these groups are centred on services or medical conditions (e.g. health and social, primary and secondary care, mental- and physical-health care). Grouping based on needs rather than organisational boundaries will allow for new models of care to emerge that respond holistically to the totality of people's personal needs.

Will grouping help us tailor services to specific needs?

International examples show that models of care differentiated by need have the greatest impact. However, it is not practical to have two million individual models of care across North West London. Grouping the population around similar sets of holistic needs is a practical way to tailor services to specific needs.

Why are you trying to keep people out of hospital?

We're trying to ensure that local people receive the right care, at the right time, in the right place. For some people, hospital is the right option but this is not always the case. At present, there are too many hospital admissions and people are staying longer in hospital than is desirable. Excessive demand is stretching our available resources and threatening our ability to provide suitable care. This is why we need to improve preventative care and build community assets to support it.

How do you know any of this will actually work?
Provision is building fast on what works in Southwark and Lambeth Integrated Care's Older People's Programme. Other local projects including Lambeth Living Well, 4DfD, Troubled Families, as well as relevant national work, support what we are aiming to achieve.

So has this all been agreed or are you still in the `thinking` stage?
We have decided on the way forward. Now the detailed work of co-design will begin.