Appendix I
Community Based Care Strategy for South East London

Securing sustainable NHS services
Consultation on the Trust Special Administrator’s draft report for South London Healthcare NHS Trust and the NHS in south east London
Our strategy for coordinated, high quality care closer to your home
1. **The context of healthcare needs of the population in south east London**

1. The demand for healthcare services in south east London has been and is expected to continue increasing. Population growth (figure 1) and an ageing population are putting increasing pressures on the healthcare system (figure 2). Medical advances and improved healthcare provision are supporting people in managing their care and improving their quality of life. However, as more people live longer we are seeing increasing number of people living with long term conditions, or even multiple long term conditions, which require effective management to prevent a deterioration in people’s quality of life. Best practice management of these long term conditions is key to supporting people in effectively managing their own care and enabling them to maintain their quality of life.

![Figure 1: Projected SEL population growth](image1)

![Figure 2: Health spending per head by age group](image2)

2. Despite these improvements there continues to be significant health inequalities across south east London, with a man born in Greenwich having a life expectancy three and half years shorter than a man born in Bromley. There are also significant differences within boroughs – in Greenwich the impact of deprivation means that there is a seven year difference in life expectancy for men.

3. Alongside these health inequalities there is still some variation in the access to and quality of healthcare services provided across south east London. Local commissioners are committed to continue to build on their recent successes, such as the introduction Bromley Intermediate Dermatology Service (see figure 3), in order to further improve the access to, and quality of, care provided, and to reduce health inequalities across south

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1 Greater London Authority (2011) 2011 Round of Demographic Projections
2 Hospital Episode Statistics 2011/12; Office for National Statistics 2011
3 Public Health Observatory analysis; National Centre for Health Outcomes Development
east London. This is something they must do within the financial resources allocated to them.

4. Increases in investment in the NHS are no longer at the levels seen in recent years, but the cost of providing care is projected to continue increasing at rates above national inflation. This puts significant pressure on the whole healthcare system to deliver better care for less money. Commissioners are therefore required to take on the challenge of commissioning high quality care that will meet the increasing needs of their local populations within a tight financial envelope. Within this they have a duty to ensure that every investment made delivers the best outcome possible and that the latest evidence about best practice is adopted so that local residents receive the best possible service from the NHS.

Figure 3: Overview of Bromley Intermediate Dermatology Service

**Bromley Intermediate Dermatology Service** aims to provide assessment, investigation and treatment for a range of skin conditions in one visit.

The service is provided by a team of specialists including consultants, advanced general practitioners and specialist nurses in five clinic settings across Bromley, none of which are in a hospital.

The aim is to divert 50 per cent of patient referrals to intermediate care in a community-based setting and already there has been a 30 per cent reduction in hospital referrals. The service provides good clinical outcomes, a high level of patient satisfaction and swift access to hospital-based care when required.
2. The vision for commissioning care in south east London over the next five years

5. It is within this context that the commissioners in south east London have developed their strategy for the future provision of care across south east London. The recent Commissioning Strategy Plan (CSP) for South East London, Better for You, outlined the vision for the population of SEL in 2015 that:

“More people In South East London will stay healthy, and every patient will experience joined-up healthcare which meets their needs in the most effective way.”

Under this vision all six CCGs aim to meet the following five strategic goals:

- In every contact with the NHS and local public service partners, people are encouraged and enabled to positively manage their own health, in partnership with health professionals and their carers
- Patients experience the NHS as a joined-up personalised service, rather than a disconnected set of services they are required to navigate
- Patients are treated with dignity and the respect due to them at all times.
- Clinical decision-making and healthcare delivery is in line with evidence-based best practice and takes account of value for money
- The logistics of healthcare delivery, within and across different care settings, are designed to meet patient needs, whether long-term or acute, in the most effective way

6. In working to deliver these strategic goals commissioners are looking to ensure a consistent standard of care across the whole of south east London with healthcare services commissioned to enable the prevention and detection of healthcare conditions. Patients should expect to have appropriate access to high quality primary and community care services that meet their everyday and urgent care health needs. Effective early intervention should focus on the needs of the individual and support them in managing their own conditions and receiving care in the most appropriate place, be that at home, in their local GP practice, a local hospital or a specialist centre. Greater integration across all health and social care services will support people in managing any long term conditions they have, preventing unnecessary admissions to hospital. However, to ensure that where hospitals services are required the care provided is of the highest quality, appropriate services will be should be centralised across south east London. This centralisation of specialist services will help drive up the quality of care and the outcomes for patients, but must be supported by integrated services that will enable patients to return home as quickly as possible to receive rehabilitation and follow up care in the community and a speedy return to independence. Such integrated services should also be used to improve the provision of care for those at the end of their life.

3. The aspirations for Community Based Care in south east London

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4 2012/13 – 2014/15 Commissioning Strategy Plan
7. Across the six boroughs in south east London there has been significant improvement in the quality of care in recent years but there is more to do in order to deliver consistent standards of care across the whole of SEL. To support the drive to deliver consistently high standards of care local commissioners have agreed a set of aspirations to be achieved across south east London.

8. These aspirations have been built up from the existing South East London Cluster of PCT’s Commissioning Strategy Plan, and further developed through a series of community based care workshops that have included all six Shadow Clinical Commissioning Groups and some of their key stakeholders and partners from across primary, community, acute and social care services. These aspirations for Community Based Care support the delivery of the strategic goals outlined in the CSP, and are focused around three areas of care:

- **Primary and Community Care**: providing easy access to high quality, responsive primary & community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy
- **Integrated Care**: ensuring there is high quality integrated care for high risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health and social care) are working together, with the patient at the centre. They will enable people to remain active, well and supported in their own homes wherever possible.
- **Planned Care**: for episodes where people require it they should receive simple, timely, convenient and effective planned care, with seamless transitions across primary and secondary care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics

9. The aspirations outlined below are those that have been developed through the Community Based Care workshops that took place as part of the Trust Special Administrator process to ensure that the plans for the hospital service are fully aligned with the commissioning intentions of the Clinical Commissioning Groups.
10. The aspirations for community based care and mental health will enable the patients in SEL to:

- Have access to high quality, responsive primary and community care

- Have access to telephone advice and triage for all community health and care services 24 hours a day, seven days a week either through their General Practice or through a telephone single point of access

- Have access to primary care service/advice 24hrs, 7 days a week for urgent needs through a combination of appointments and walk in services, telephone appointments, 111/NHS Choices or same day urgent care etc.

- Receive high-quality care that meets agreed quality standards and outcomes, provided through teams working in networks across primary care, community and specialist services that may be based in the hospital

- Know that their local commissioners (CCGs) proactively plan how to meet the health needs for the population they have responsibility for and have confidence they are supporting hard to reach groups of patients

- Receive targeted and more personalised care appropriate to their needs, as a result of systems that allow to proactively identify and support more patients before a crisis.

- Play an active part together with their health professionals and carers in developing a care plan that sets out what they and those involved in delivering their care will do to support them staying as healthy as possible, or what should happen in the event of problems

- Have a named ‘care coordinator’ who will work with them to coordinate their care across health and social care. This role will be clearly defined and clinical accountability for care will be remain with their GP

- Know that their GP is working within a multi-disciplinary group of health professionals to co-ordinate and deliver care, incorporating input from primary, community, social care, mental health and specialists

- Be well supported when they are at risk of being admitted to hospital, receiving the expert advice, tests or access to equipment they need promptly to ensure they will only go to hospital if absolutely necessary

- Be confident that as soon as they are referred to hospital their Community Based Care Team will be working with staff in the hospital and the community to coordinate an individual discharge plan, including intermediate care, reablement and rehabilitation, to support efficient discharge from the hospital within 24 hours of
being declared medically fit, knowing they will receive the right **continuing care** in the community

- Have access to relevant and complete **information**, in the right formats to **inform personal choice** and decisions
- Experience **consistent quality of care and access to services** anywhere is SEL, based on agreed standards, protocols, access times and approaches to referrals and diagnostics such as radiology, phlebotomy, ECG and spirometry
- Receive treatment for planned **specialist diagnostics and care in specialist hospitals**, but be able to access other planned routine outpatient appointment, diagnostics, pre- and post-operative appointments in **settings closer to home** or via telephone / web consultations to reduce unnecessary travel
4. How care will be delivered in the future

11. Delivering care to meet these aspirations will require further change in the way services are currently provided. CCGs have worked with professionals and leaders from across the health service including GPs, nurses and doctors from hospitals to develop an overview of how patients will receive care within each of the three areas of: primary and community based care, integrated care and planned care. In these models, primary and community care services are universal and available to everyone; people with long term conditions will receive integrated services and those with short term needs will receive planned care that they require to address their presenting problem.

12. **Primary and community care:** in the future the population of south east London will have equal access to a consistent standard of primary and community care services. The services that will be provided have been grouped against the following five categories:

<table>
<thead>
<tr>
<th>Area</th>
<th>As a patient in south east London in the future you will be able to...</th>
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| Supporting self-management and choice of treatment | • build your knowledge, confidence and skills about how to manage your health and social care needs through provision of clear information and sign posting  
• get skilled support and advice from a range of staff within your GP practice and wider health community (pharmacies, children’s centres etc.) to help you choose and meet your goals for improving your health, independence and well-being.                                                                                                                                                                                                                                                                                                                                                          |
| Prevention and detection of conditions   | • enjoy opportunities to improve your health within your local community, school, place of worship or workplace, with expert support to prevent ill-health  
• be supported to recognise when you have a specific health need and receive the appropriate support to manage it  
• work with people who understand you, your background and community, who can help you navigate the NHS and social care and understand what services and/or equipment are available to you that can detect problems early and stay well at home.                                                                                                                                                                                                                     |
| Access to 24/7 telephone advice and triage | • get 24/7 health advice by phone and web via 111 and NHS Choices  
• communicate with your GP in more convenient ways, including telephone appointments, text messaging to confirm test results, and email for those with Long Term Conditions  
• see your own health record online, check results, order repeat prescriptions and make appointments  
• contact all community, social care and primary care services (e.g. district nurses) via a single phone number                                                                                                                                                                                                                                                                                                                                                                                   |
| Access to 24/7 urgent primary care services | • get urgent appointments with a GP more easily, either at your own GP or at a nearby GP with whom your GP works closely and provides the same quality of care  
• see a GP or other professional quickly if there is a risk of hospital admission  
• easily make an appointment to see a GP at an Urgent Care Centre at
evenings and weekends by calling the new NHS 111 number

| Receive care across clinical networks with consistent standards | know that you are receiving the same high quality of care as everyone else in south east London and know what you can expect by reading our agreed south east London standards  
| - benefit from a wider range of specialist knowledge amongst local GPs which may mean that you or your family member do not need to go to the hospital |

13. **Integrated care for people with long term conditions:** in the future patients in south east London identified as having a specific healthcare or mental health need will be supported to manage their condition in any integrated way. The services these patients will receive in managing their care have been group into the following six categories:

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<thead>
<tr>
<th>Area</th>
<th>As a patient in south east London with a specific long term healthcare need in the future you will be able to…</th>
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</table>
| Shared information and effective risk stratification | ● be confident that all the health and social care professionals who you come into contact with know what the others are doing and communicate with each other  
| - receive support and services tailored to your individual level of illness, your level of knowledge and confidence about managing your condition & your risk of hospital admission  
| - use simple equipment in your own home to keep track of your health and know that your health professionals are monitoring those results to keep you safe  
| - receive expert support to help you prevent worsening of your condition |
| Effective care planning and risk management | ● play an active part in setting goals for what **you** will do to improve your own health and what professional health and social care support and services you want to receive over the coming year, both on a routine basis and if you have problems with your health  
| - participate in self-management support and patient education programmes  
| - in some situations you may be able to take control of the budget that is used to pay for your health services and decide for yourself how you want to buy the services that you need, with support to make this work best for you |
| Coordinated care delivery | ● have a single person who is responsible for ensuring that all the services you need are delivered on time and that they all work together effectively and smoothly; this may be a GP, nurse, social worker or other health professional |
| Support from multi-disciplinary clinical teams | ● be confident your GP is in touch with the other key health professionals who are involved in your care to discuss your health and ensure that all your needs are being met |
| Prompt assessment for patients at risk of admission | ● speak to a specialist within the hospital by telephone alongside, or be seen at home, in a community clinic, a GP surgery by a community-based specialist or social care professional promptly, when you may need admission to hospital so that alternatives can be considered. Specific response times will be set for different pathways  
| - be provided with any tests, equipment or advice that you need if this would mean you can remain in your own home instead of being admitted to hospital |
- be supported by a multi professional team at home or in a home like setting instead of the hospital if your illness means that it is a safe way of treating you.

**Proactive discharge planning**
- be confident that if you are admitted to hospital, staff based in the community will be working from the moment you arrive there with your hospital staff to make sure that as soon as you are ready, you can come home, with any equipment or additional services in place, including at weekends

14. **Planned care**: in the future patients in SEL that have a specific planned healthcare need will be supported to make the right choice of treatment and receive high quality care in the right location. The services these patients will receive are grouped into the following three categories:

<table>
<thead>
<tr>
<th>Area</th>
<th>As a patient in south east London with a need to access planned care in the future you will be able to...</th>
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| **Effective patient engagement and information to support choice** | • get expert support from staff in primary care and outpatient clinics to help you make the right decision about how you want to manage your health problem  
  • have access to ‘decision tools’ (such as online information or DVDs) that give you helpful, easily-understandable materials to help you understand what the options are for your condition and make an informed decision about whether you need an outpatient appointment and want to proceed with treatment in the light of your individual clinical circumstances, preferences and values.  
  • get expert support before surgery so that it has the greatest possible benefit for you, including help with weight loss and help with practicing the exercises you may need to do after your operation |
| **Common clinical protocols**                 | • know that you are receiving the same high quality of care as everyone else in south east London and know what you can expect by reading our agreed south east London standards and “patient pathways” for each condition  
  • benefit from a wider range of specialist knowledge amongst local GPs and local health professionals which may mean that you do not need to go to the hospital for specialist advice  
  • be referred for specialist advice by a wider range of primary care professionals, e.g. optometrists, without having to go via your GP |
| **Pre- and post-surgical care in the right location** | • receive much of your care before and after an operation in appropriate local settings, this may include consultant outpatient appointments, some diagnostic tests, pre-assessment before surgery, follow-up outpatient appointments and physiotherapy  
  • have an assessment before you enter hospital of what your needs will be on discharge so that the appropriate health and social care services can be ready  
  • engage with health professionals who provide planned care in the community via telephone appointments or web-based appointments using systems  
  • have some procedures, such as minor surgery, that would traditionally have... |
15. This transformation of primary and community care will support the transformation of clinical services across south east London which is being proposed as part of the TSA process. Effective primary and community services, as described above, will support patients to receive care in the right place for their need. In most circumstances this will mean receiving care at home or at a local GP practice. However, people will continue to have specific planned and emergency care needs that will be most appropriately treated in hospitals.
5. The programmes that will help deliver the changes

16. Commissioners will be required to deliver the aspirations for Community Based Care within the tight financial envelope available to them in the future. As illustrated in figure 3 below, the commissioner allocation will increase year-on-year but, as is the case for all health funding, it will have to be spent more effectively and made to work harder to pay for the increasing cost of care and volumes required.

Figure 4 – Five year projected allocations across south east London (£m)

17. The existing Commissioning Strategy Plans for 2012/13 - 2014/15 are consistent with the assumptions used in the TSA Programme and will continue to be developed in line with these assumptions as the commissioners look to extend their plans out to 2017/18.

18. Detail on the initiatives and programmes that the commissioners have already planned to deliver improved Quality, Innovation, Productivity and Prevention for their local populations can be found in their draft integrated plans. A number of examples of the success commissioners have already had are outlined below:
Lewisham’s Kaleidoscope
Children’s Centre

The award winning LKC centre brings together specialists from a number of agencies including Special Educational Needs, Child and Adolescent Mental Health Services, children’s therapies, audiology, paediatricians, children’s social care and specialist nursing services to act as a resource centre for children with complex needs.

For patients...

• the support they need is coordinated in one place enabling them to reduce or even avoid time spent in hospital.
• care can be readily accessed close to home, reducing the cost and time taken of travelling to and from hospital for multiple appointments.

For the NHS...

• Better integration of these, often expensive, specialist services allows them to be used far more effectively.
• Reducing unnecessary inpatient stays allows resources to be invested in providing care in different ways.
• Referrals to tertiary services have dropped 60% 

Lambeth and Southwark’s
Integrated Care Pilot

The CCGs in Lambeth and Southwark have commissioned services to support people to avoid hospital admission. The Home Ward programme supports those who would otherwise need hospital admission or those who are suitable for early discharge by providing managed care in the patient’s home. They have also set up an Enhanced Rapid response programme that provides a rapid, 2 hour, response time to people who need urgent support to remain in their own homes.

For patients...

• In its first year the programme has enabled over 300 people to be admitted to The Home Ward with a further 700 patients supported at home by Enhanced Rapid Response.

For the NHS...

• Providing that little extra help to patients who are then able to stay at home allows for hospital beds to be taken by those who are most acutely ill and those requiring planned care.
• This allows hospitals to perform more operations and work through their waiting lists.
Greenwich’s Integrated Care System

Greenwich CCG is continuing to work towards full integration of all health services to deliver care community based care and have adopted the principle of ‘in the community when possible, hospital when necessary’. The first stage of development has been expanding the capacity to deliver intermediate care at home.

For patients…

- Patients who are fit to leave hospital are able to return to their home and receive regular support from trained staff in the community.
- Patients who are at risk of requiring admission to hospital can be cared for in their homes and supported to remain healthy

For the NHS…

- Integrated care allows for various agencies to coordinated their efforts to be as effective and responsive as possible. This reduces duplication of work and improves patients’ experiences.
- The intermediate care programme has been in operation since 2011 and has helped Greenwich to achieve the lowest unplanned admission rate in London.

Figure 5 – Unplanned admission rate for all London boroughs
6. The enablers that will help to deliver the changes

19. Successful implementation of transformation on this scale will require a significant investment in a core set of enablers including: IT, organisational development, governance, contracts and incentives and engagement. Effective investment in these enablers will support the delivery of improvements across the whole healthcare system and specifically more effective integration of healthcare services across the whole of south east London.

20. Initial thinking on the enablers required was done at the community based care workshops that helped develop this work. The output of these workshops is outlined in figure 5 below. More work is required in the order to consider which of these should be developed and implemented across both the individual boroughs and the whole of south east London. This will be done through the next phase of the programme and in the development of CCG plans.

Figure 6: Examples of specific activities that might be undertaken against each of the five enablers.

<table>
<thead>
<tr>
<th>Enabler</th>
<th>Activity</th>
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| Engaging patients, carers and users          | • Ensure messages relating to the use of NHS services, including GP and 111 services, are consistent across all local agencies (e.g. NHS, local authorities, schools)  
• Use public campaigns to encourage patients to take responsibility for their care and increase question-asking  
• Recognise patient diversity across south east London and provide appropriate support, such as interpreters  
• Use ‘expert patients’ to encourage and educate others – including providing peer support in hard to reach communities  
• Provide individual training and support for those with long term conditions, and their carers, to help them manage their own care  
• Provide information on access to and use of care to support decision making, examples include decision aids and 111  
• Provide information through appropriate mechanisms, recognising that many older people do not have access to the internet  
• Use key workers to support individuals through a ‘health navigator’ role  
• Routinely capture and act on patient experience data to improve services  
• Provide patients with access to their GP records, ideally before the national goal of 2015 – this could build on the national pilot in Lewisham |
| Information tools and IT                     | • Develop a local solution to the IT challenge that will support access to patient information across the relevant organisations, including social care (e.g. “switch on existing EMIS functionality”)  
• Develop pooled data and data warehousing arrangements to support so that practitioners know in ‘real time’ what services their patients have accessed so that proactive decisions can be made to support people at risk of admission to hospital so that high quality care coordination and case management can be developed  
• Recognising governance is a challenge and can take a long time to solve, a |
A pragmatic solution to making change happen is needed (e.g. allow read only access to notes)

- Reduce red tape around data sharing by asking all south east London patients to give consent for sharing of their data amongst professionals
- Develop a standardised information tools – such as discharge summaries and referral letters
- Develop a ‘paperless south east London e.g. electronic End Of Life Care register
- Implement 111 as a single point of access for patients on how to access services
- Develop a single point of access for clinicians to be clear on what services are available (acute to community and vice versa)
- Ensure effective remote access to IT systems across the whole of south east London (e.g. in patient’s homes)
- Consider utilising new technology such as Microsoft ‘Vault’ to allow patients to access their records
- Scale up remote technology – but risk in addition not instead of face-to-face
- Use GP comparison/benchmarking tool to assess individual GPs performance
- Provide training and support to staff in the behaviour changes needed to make shared information systems effective

| Organisational and workforce development | • Ensure staff and volunteers feel valued
• Support staff to deliver effective customer care, learning from experts such as the ‘games makers’
• Provide training to GP and community staff to build their confidence to provide more care in the community
• Ensure care is provided by the most appropriate member of staff, taking into consideration the most effective skill set to deliver care and ensure an efficient and effective service
• Provide regular communication and training opportunities to support staff through the change – which may take time
• Ensure staff are provided with effective opportunities for career progression
• Support staff to experience working in different settings of care for example rotation of staff through different settings and providers of integrated services
• Undertake effective succession planning for staff across the system
• Provide training in how to provide clinical services through telephone, web and email forms – a big change for clinicians
• Further develop the skills of GPs and Practice Nurses in a range of areas including shared decision making, self-management supporting and also in motivational interviewing techniques to support people in take positive lifestyle choices
• Draw on national and international experience and evidence to develop innovative professional roles in health and care services |
| Governance and performance management | • Develop clinical leadership for change through governance arrangements and ensuring effective joint working between GP and specialist care
• Ensure there is scope within governance arrangements for local innovation and risk-taking to develop new services and new ways of delivering care |
- Simplify governance around data sharing by securing universal consent to data sharing amongst health and social care professionals – on a population basis
- Develop and audit performance targets for key operational communications across providers e.g. discharge summaries, GP referrals
- Develop shared standards of care across SEL as a mechanism for improving quality and reducing variation
- Standardise delegation of professional assessment across integrated teams
- Align senior leaders around shared key goals across organisations through new integrated governance framework
- Ensure there is trust and confidence in colleagues across the system
- Include key voluntary sector providers in governance especially in regard to mental health
- Focus on delivering and supporting people to change
- Consider implementing a joint board that could oversee care – e.g. Children’s Trust Board

### Contracts and incentives
- Align contracts and incentives across all providers to support a coherence of behaviour and spend
- Implement shared KPIs across providers for key metrics, such as admissions avoidance
- Introduce financial risk sharing across all providers, including acute, community and social care
- Ensure contracts are flexible enough to support collaboration across providers
- Use personal budgets, where appropriate and wanted, to drive quality improvement in community services
- Increase incentives for GP practices to improve their patients’ self-management skills and measure this
- Remove dis-incentives from the system – such as those dictating a minimum ratio of face-to-face consultations for GPs
- Discourage unhelpful competition between different parts of the pathway
- Utilise non-financial incentives and approaches, such as professional leadership, peer led improvement programmes and benchmarking, to drive up quality
- Explore using different funding mechanisms – for example commissioning the care pathway or patient budgets
- Implement evidence-based approaches to incentivising patients to change their health behaviors
7. Delivering the community based care aspirations

21. The commissioners across south east London and the NHS Commissioning Board will continue to develop the plans for local service changes and improvements, taking into account the assumptions agreed through the work of the TSA. As they develop their commissioning strategy plans they will develop implementation plans for specific initiatives that will help them deliver the aspirations.

22. The next stage of the TSA programme will also continue to work with those involved in the Community Based Care work in order to consider if there are any specific implementation requirements that will be taken into account in the TSA’s final report.

To download additional appendices please visit www.tsa.nhs.uk/document-downloads