



Appendix O

The strategy for community-based care in south east London



Bexley Clinical Commissioning Group



Bromley Clinical Commissioning Group



Greenwich Clinical Commissioning Group



Lambeth Clinical Commissioning Group



Lewisham Clinical Commissioning Group



Southwark Clinical Commissioning Group

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 growth¹

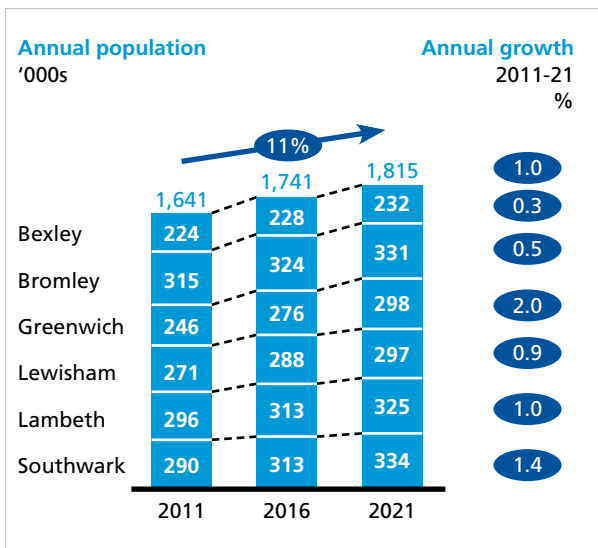
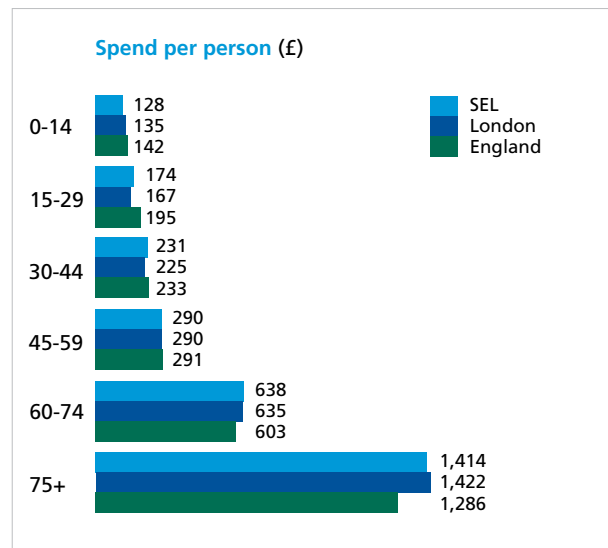


Figure 2: Health spending per head by age group²



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 Bromley³. 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 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 many recent successful initiatives, examples of which are summarised throughout this document. To further improve the access to and quality of care provided in order to reduce health inequalities across south east London CCGs have agreed to work together in collaboration to share experience and resources.
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

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

quality care that will meet the increasing needs of their local populations within a tight financial envelope. 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 services of the highest quality from the NHS.

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 for South East London, Better for You, outlined the vision for the population of SEL that by 2015:

“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 have aligned their aims and agreed 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, pharmacy or health centre, a local hospital or a specialist centre. Greater integration across all health and social care services will support people in managing their long term conditions, preventing unnecessary admissions to hospital. However, to ensure that where hospitals services are required the care provided is of the highest quality, appropriate services 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 can 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

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 Commissioning Strategy Plan and further developed through a series of Community Based Care workshops that have included all six Clinical Commissioning Groups and many 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 Commissioning Strategy Plan, and are focused around three areas of care:
 - **Primary and Community Care:** providing easy access to high quality, responsive primary and 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. This 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 to ensure that the plans for the hospital service are fully aligned with the commissioning intentions of the SOUTH EAST LONDON Clinical Commissioning Groups.
10. The aspirations for community based care and mental health will enable the patients in SEL to:

Easy access to high quality, responsive primary and community care

- Have access to public health programmes that support **prevention and early detection** of diseases by proactively finding people at risk of losing their good health.
 - Be supported to **manage their own health** and any illnesses that they have and given confidence to take **decisions about their own care**, including navigating access to specialist services where needed.
- 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**.

Integrated care for people with long term conditions

- 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.

Timely, convenient and effective planned care

- 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:

Area	As a patient in south east London in the future you will be able to...
Supporting self-management and choice of treatment	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 physical healthcare or mental healthcare 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:

Area	As a patient in south east London with a specific long term healthcare need in the future you will be able to...
Shared information and effective risk stratification	<ul style="list-style-type: none"> • 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 and 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. Patients will be supported in this through the three following approaches:

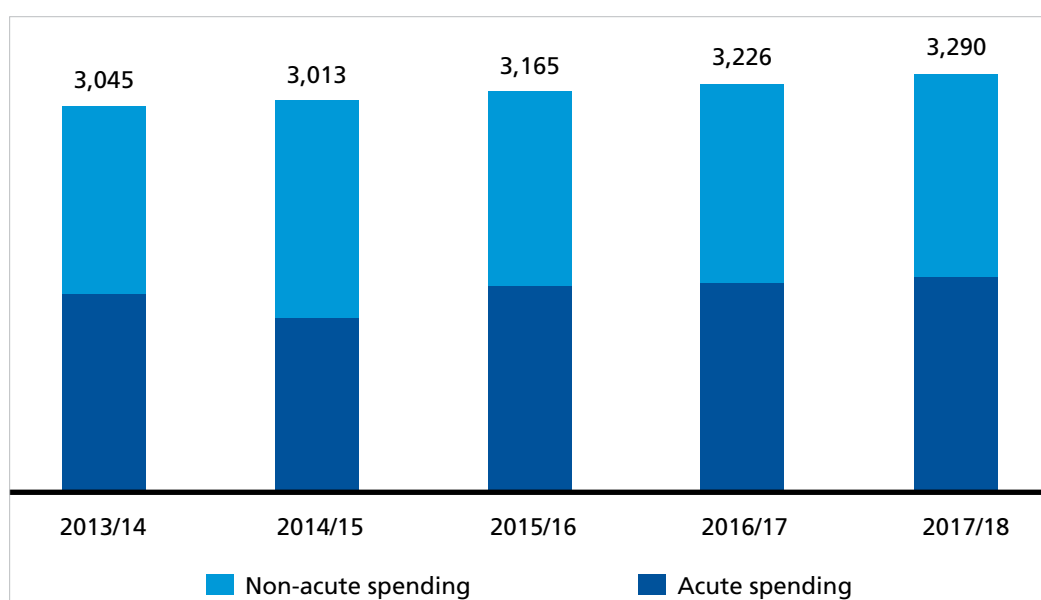
Area	As a patient in south east London with a need to access planned care in the future you will be able to...
Effective patient engagement and information to support choice	<ul style="list-style-type: none"> • get expert support from staff in primary care and outpatient clinics to help you make the 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 been done in a hospital within an enhanced community setting, where this is convenient for you

15. 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, pharmacy or health centre however, those with specific planned and emergency care needs will continue to be treated in hospitals and will benefit from increased specialist cover resulting in a more responsive service better suited to the needs of patients.
16. Successful delivery of these aspirations will see a shift from with patients traditionally seen in hospital being treated in community settings and in their own homes. This shift will enable hospitals to focus on treating the most acute patients and using their specialist skills to best effect and must be accompanied by an associated reduction in activity in hospitals in order to provide the necessary benefit to the wider health system.
17. This transformation of primary and community care will support the wider transformation of clinical services across south east London which is being proposed as part of the TSA process.

5. The programmes that will help deliver the changes

- Commissioners will be required to deliver the aspirations for Community Based Care outlined above within the tight financial envelope available to them in the future. Through the TSA process an assumption on the allocations for the next five years was calculated. The commissioner allocation is expected to increase year-on-year (see figure 3) 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 to meet the needs of a growing and aging population.
- Working on this assumption the CCGs have agreed a QIPP target for the next five years that totals £128.7m. These savings will need to be made across all areas of care and will inform the funding available across the system in the future. As such they have been built into the assumptions being used by the TSA.

Figure 3 – Five year projected allocations across south east London (£m)



- CCGs have all made progress in developing their community-based care services in different ways with success in different areas. In developing the Community Based Care strategy the CCGs have shared their experiences to date and set out a set of common standards for services across south east London. They are also working with the London Regional Office of the NHS Commissioning Board to consider opportunities to drive improvements in primary care services based on local, regional and national best practice. Some examples of progress to date that are now being developed and drawn on by other CCGs are provided in throughout this chapter.
- Using these examples, along with their existing CSPs, the CCGs are developing integrated plans that will deliver improvements in quality in line with the CBC aspirations and productivity and efficiency savings in line with their QIPP requirements over the next five years. These projects will be essential in releasing resources to address increased population demand across the system and will be developed around the three areas of care outlined in the aspirations.

Transforming primary and community based care

22. Underpinning the success of the Community Based Care strategy is the transformation of primary care services as the services that are directly accessed by all patients and support the provision of effective integrated and planned care. High quality primary and community care services also enable secondary care to focus on those services that need to be provided in a hospital setting.
23. South east London is not unique in the challenges it is facing around variation in quality of and access to primary care services – many other health systems in London and nationally are also looking to transform their local services. NHS North West London’s Shaping a Healthier Future programme places strong emphasis on the need for improving access to primary care and ensuring that a greater number of services are centred around patients and provided outwith the traditional hospital environment.
24. London is facing dramatic demographic changes and unprecedented financial pressures and south east London’s CCGs recognise that a strong system of primary and community-based care is more important than ever. In line with this the London Regional Office of the NHS Commissioning Board has recognised that the current model of GP service provision is unlikely to be unsustainable with growing patient needs and expectations, flat funding growth requiring 3% annual productivity gain across the system and variety in cost and value-for-money across the system.
25. This position is also supported by The King’s Fund Improving the Quality of Care (2012) who have advised that major changes are needed to the organisation and delivery of primary care to meet these challenges including:
 - GPs should work more closely with hospitals, community services and social care to improve the co-ordination of care, especially for patients with long term conditions.
 - GPs and commissioners must make better use of data to understand and act on local variations in performance, and exploit the potential of IT to improve the quality of services for patients.
 - GP practices could move more quickly towards different models of service provision e.g. federations or networks – this will enable smaller practices to retain their local focus but provide a wider range of services.
26. The London Regional Office of the NHS Commissioning Board is working with the CCGs in developing a programme to transform primary and community care. This programme will build on the transformation framework the London Regional Office of the NHS Commissioning Board has developed to provide an evolutionary and collaborative provider change programme for primary care that focuses on delivering the aspirations for primary and community care.
27. Two examples where patients are already benefitting from improved access to treatment available within their communities as a result of the CCG adopting an innovative approach to providing urgent care services are outlined below:

Greenwich's Integrated Care System

Office of the Trust Special Administrator

Greenwich CCG is continuing to work towards full integration of all health services to deliver 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.

Benefits 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.

Benefits for the NHS...

- Integrated care allows for various agencies to coordinate 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 a reduction in non-elective admissions to top put them in the top 20% in the country.

Lambeth's Healthy Living Pharmacy

Office of the Trust Special Administrator

The Healthy Living Pharmacies (HLP) initiative, launched in 2012, encourages pharmacies to support health and wellbeing to residents across Lambeth. Each site has a local Healthy Living Champion who has been trained and accredited to keep residents up-to-date with health services in the local community and can sign post residents to further help – including information and advice about alcohol intervention, stopping smoking, sexual health and minor ailments. The Champions are moving ahead with providing health interventions and supporting local residents with making healthier lifestyle choices.

Benefits for patients...

- Easy access to informed advice within the community.
- Support to find the most appropriate service to meet their needs.

Benefits for the NHS...

- Improved coverage and penetration for health promotion campaigns.
- Increased take up of community care offerings.
- Reduced dependence on emergency departments.

28. Further work planned over the next year to transform primary care is explained in the table below.

1. Easy access to high quality, responsive primary and community care		
This work stream brings together projects that will transform primary and community care by focussing on prevention and early detection and ensuring that people can access treatment at the earliest possible stage.		
Focus	Priorities for 2013/14	Example schemes from CCGs
Prevention and early detection	<ul style="list-style-type: none"> • Develop incentives to improve outreach and early detection • Work with Local Authority Public Health team to extend screening initiatives to non-traditional settings 	<ul style="list-style-type: none"> • Bromley are expanding their vascular check programme • Southwark are implementing specialist dementia training to enable GPs to identify early signs of vascular dementia • Lambeth is piloting Healthy Living Pharmacies where community pharmacists offer advice and support to people on stopping smoking, health checks and preventing alcohol related disease
Support people to manage their own health	<ul style="list-style-type: none"> • Further develop discharge support programmes • Extend education programmes to a range of professionals in a variety of settings • Develop use of personal health budgets for appropriate conditions 	<ul style="list-style-type: none"> • Southwark are developing a community mental health pharmacist role that will train carers and families about their medication • Lewisham are extending their minor ailments programme that provides treatment for approx. 2000 interventions in 10 pharmacies to 8000 interventions in 30 pharmacies
24/7 access to primary	<ul style="list-style-type: none"> • Roll out 111 services across SEL • Extend hours in GP surgeries • Commission further home treatment services 	<ul style="list-style-type: none"> • Southwark is commissioning home treatment and crisis teams to 24/7 provision for people in early crisis and to support inpatient admissions • 111 schemes are being developed to include links with local authority and mental health services to provide 24/7 support for patients and health professionals
24/7 access to urgent care	<ul style="list-style-type: none"> • Evaluate and extend UCC offerings 	<ul style="list-style-type: none"> • Southwark and Lambeth are evaluating UCCs at Guy's Hospital and King's Hospital and are beginning the procurement of a UCC at St Thomas' hospital to support the current emergency arrangements
High quality care	<ul style="list-style-type: none"> • Work with Local Education and Training Board, acute providers and National Commissioning Board to develop workforce • Extend outcomes based incentive schemes for long term conditions 	<ul style="list-style-type: none"> • Bromley is working to develop community neuro-rehab and stroke teams to better support patients • Greenwich is supporting ophthalmology and dental services to provide extended pathways in primary care
Support hard to reach groups	<ul style="list-style-type: none"> • Implement Health and Wellbeing Strategies in association with Local Authorities • Develop services and engagement schemes for deprived areas 	<ul style="list-style-type: none"> • Bromley is creating a dedicated travellers service • Lewisham is up-scaling public health programmes and specifically targeting at risk groups and areas. • Lambeth has agreed equalities targets for mental health, diabetes, high blood pressure, childhood obesity, HIV support and alcohol related disease to ensure that those who need the services can benefit from them

29. These first year activities will have an immediate impact on how primary and community care is delivered, supporting more patients to stay healthy and ensuring they have rapid access to appropriate services when necessary.
30. A south east London-wide approach programme management (see chapter 7 for details) will continually monitor the progress and benefit of each project across the region to allow for high impact schemes to be extended and replicated across the boroughs in years two and three and for appropriate interventions to be put in place where a scheme is not delivering the required benefits. To give an example of what might be required over the next five years, if each GP in south east London prevented a single admission to A&E each week it would reduce both activity and emergency admissions, saving around £6m in total.
31. It has been recognised through this process that a range of additional schemes such as those listed above on their own will not bring about the transformation required in primary care. General practice in particular is under pressure day-by-day and to increase standards, access and continuity of care practices will need to work differently. In order to address this there are examples across the country of CCGs testing out different approaches to delivering primary care, compared with to the more traditional GP practice used in south east London. Examples of what is being tested out across the country include:
- Smaller practices entering into networks of practices to share back office functions, management capability, skills and capacity, freeing up clinical time to be more responsive to the local population
 - Creating networks to share clinical capacity, for example having some practices focus more on direct access while others focus more on long term condition management or more specialised community care
 - Entered into business partnerships with one another backed by more formal agreements which allow practices to remain rooted in their local communities but with the ability to draw on more centralised expertise at scale.
32. South East London GPs have not yet formally considered these models, but through the workshops held have expressed an interest in thinking creatively to improve clinical services and make the best use of the vital workforce in general practice.
33. Going forward the south east London's CCGs and the London Regional Office of the NHS Commissioning Board will embark on a structured programme of engagement with all GP practices and the Local Medical Committee to explore options that could improve patient care and allow general practice to thrive. This will include wide engagement with patients and the public, secondary care providers and local authorities. From this a range of pilots will be shaped to test new ways of working in a safe and protected manner. All practices will benefit from learning from these leaders and also the enablers identified in section 6 will be there to support all practices i.e. not just those participating in pilots.
34. In addition the London Regional Office of the NHS Commissioning Board and the CCGs will work together in order to define what 'core' primary care services are and agree what good looks like for those services – including how improved services will contribute to improved patient experience, delivering the aspirations including reduced reliance on acute services by the population of South East London. The principle of paying once for services will be applied with general practice being the cornerstone for all patient pathways.

35. As with the rest of the Community Based Care Strategy implementing transformation of this scale will require support from a range of enablers (chapter 6) and effective programme management (chapter 7) to make sure it aligns with implementation of the rest of the strategy. This primary and community care programme is the most challenging and requires a partnership between the newly formed CCGs and London Regional Office of the NHS Commissioning Board to support general practice to adopt very different ways of working to enable them to meet the increasing needs of their populations.

Integrated care for people with long term conditions

36. People with long-term conditions now account for about 50% of all GP appointments, 64% of all outpatient appointments, over 70% of all inpatient bed days and around 70% of total health and social care expenditure (The King's Fund, 2012). To better support this cohort of patients, the CCGs in SEL are working in cooperation across geographic and organisational boundaries to develop a consistent approach to coordinated care.

37. Better integration of care services improves patient experience and can significantly reduce duplications and delays in the delivery of treatment. Examples of the work already being done are provided below.



Bexley's Integrated Care for Older People – Case Management

Office of the Trust Special Administrator

A case management approach is already well established in Bexley with practices using a risk stratification tool (combined model) to identify patients with complex needs and holding integrated multi-disciplinary team meetings to proactively plan care and monitor outcomes, so far for 12/13 there have been 3010 patient reviews carried out with the use of Risk Stratification. This joint approach will be further strengthened through joint plans with the Local Authority to integrate rapid response, discharge and community rehabilitation services.

Benefits for patients...

- Keeping their care well managed in a community setting, supporting them to remain healthy.
- Reducing the likelihood of a hospital admission or long-term care.

Benefits for the NHS...

- Fewer people going to hospital requiring costly treatment and care.
- Improved productivity of community teams through less duplication of effort and more coordinated care.

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.

Benefits 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.

Benefits for the NHS...

- Providing that little extra help to patients who are then able to stay at home allows for hospital beds to be used 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.

Lambeth's Living Well Collaborative

Lambeth CCG is aiming to radically transform the outcomes experienced by people with long term mental illness by using "co-production" as the framework for the delivery and commissioning of services in order to deliver our "Big 3" outcomes (Recovery, Improved Physical Health and Quality of Life) plus wider economic and social benefits. It is driving service transformation through the LLWC, a partnership platform comprising the CCG, SLaM, Lambeth Council, VCS providers, Public Health, and users and carers.

Benefits for patients...

- Support will be offered much sooner and before "crisis" occurs.
- Support will be more personal and recovery focused.
- Patients will be involved the design and commissioning of services and in their actual delivery.

Benefits for the NHS...

- Support system transformation toward early intervention, recovery and enablement and away from dependency and crisis.
- Support integrated working across primary care, secondary care, voluntary sector and social care in collaboration with users and carers.

38. Beyond these projects, further work being planned within 2013/14 is outlined below:

2. Integrated care for people with Long Term Conditions (LTCs)						
Aim: ensuring that those with long term conditions receive care that is centred around them, tailored to their needs and delivered by the most appropriate, multi-disciplinary health professionals.						
Focus	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Proactively identify and support patients	<ul style="list-style-type: none"> Establish a community geriatrician service 	<ul style="list-style-type: none"> Develop risk stratification tools Expand community matron case finding scheme 	<ul style="list-style-type: none"> Extend Finding the Vulnerable programme 	<ul style="list-style-type: none"> Continue risk stratification, linking to Integrated Care Pilot work and care co-ordination Increase access to vascular health checks including through pharmacies 	<ul style="list-style-type: none"> Further GP training to support understanding of the needs of those with mental health problems Increase engagement with District Nurses/GPs 	<ul style="list-style-type: none"> Enhance health checks Support case finding through practice-based commissioning incentive scheme Specialist dementia training for practices
Co-created care plans	<ul style="list-style-type: none"> Run case management in the community through Multi-Disciplinary Teams in GP practices 	<ul style="list-style-type: none"> Develop care planning, initially for patients with Diabetes, Heart Failure and COPD 	<ul style="list-style-type: none"> Ensure pathways include self-care and support patients ability to cope 	<ul style="list-style-type: none"> Develop patient and clinician education and supporting information tool 	<ul style="list-style-type: none"> Develop patient-specific plans with medical team integrate with community pharmacist 	<ul style="list-style-type: none"> Develop generic approach to care-planning and undertake staff training with resources
Care coordinator role	<ul style="list-style-type: none"> Develop palliative care services 	<ul style="list-style-type: none"> Practice Liaison Officer training programme to support the coordination of patient care, case management and system navigation 		<ul style="list-style-type: none"> Extend primary care case manager role to LTCs Agree protocols and link to integration programme to ensure consistency 	<ul style="list-style-type: none"> Develop Neighbourhood Hubs to support proactive primary care 	<ul style="list-style-type: none"> Extend primary care case manager to LTCs Agree protocols and link to integration programme to ensure consistency
Multi-disciplinary working	<ul style="list-style-type: none"> Create a 7 day, 0800-2000, integrated rapid response team 	<ul style="list-style-type: none"> Develop integrated team to support target 'active' patients and to monitor 'passive' patients to identify trigger points 	<ul style="list-style-type: none"> Work with Bexley and Bromley to commission at scale LTC services Further develop Diabetes into Evidence programme 	<ul style="list-style-type: none"> Review Local Enhanced Services as mechanism for practices engaging in care co-ordination 	<ul style="list-style-type: none"> Scope the inclusion of a mental health occupational therapist in the reablement team 	<ul style="list-style-type: none"> Continue Community Multi-disciplinary teams covering all of Southwark and review and extend practice engagement and coverage
Access to diagnostics, advice and equipment	<ul style="list-style-type: none"> Develop community respiratory service 	<ul style="list-style-type: none"> Reshape rapid response and PACE team 	<ul style="list-style-type: none"> Developing innovative LTC clinics with specialists, GPs and others 	<ul style="list-style-type: none"> Extend use of community geriatrics Review approach for people with multiple LTCs 	<ul style="list-style-type: none"> Expand training to increase interventions delivered in pharmacies 	
Effective discharge and continuing care	<ul style="list-style-type: none"> Expand Step-up/down to handle more complex cases Integrate community rehab and reablement 	<ul style="list-style-type: none"> Develop further the COPD discharge bundle Re-procure intermediate rehab and care service 	<ul style="list-style-type: none"> Continue Intensive Care at home programme Increase step-down and community mental health provision 	<ul style="list-style-type: none"> Roll out HomeWard, integrating reablement/ community nursing with rapid response 	<ul style="list-style-type: none"> Rapid response team integrated with Admissions Avoidance Service 	<ul style="list-style-type: none"> Roll out HomeWard, integrating reablement/ community care

39. The variety of schemes and approaches being taken by the CCGs reflect the diversity of the populations they serve and the partners they work with throughout their geography. It also provides the opportunity by which to measure the benefits of different approaches. With common data available across the south east London it will be possible to readily measure the take up and impact of various initiatives and use this intelligence in years two and three to develop and expand the most effective approached.
40. If, through these projects, each GP in south east London prevents two non-elective inpatient admissions per month there will be a collective reduction in activity and associated savings of around £45m over the next five years.

Timely convenient and effective planned care

41. Successful delivery of the primary and community based care and long term conditions work detailed above will result in more care episodes moving from being unplanned to planned. Within this domain lies the potential for commissioners to exercise the greatest level of control in developing a proactive system built around the needs of patients.
42. Key tenets of the strategy for south east London are all intended to reduce costs whilst improving patient experience and ensuring that choice is strengthened. To do this CCGs are working to offer outpatient clinics in the community and aim to provide diagnostics and further assessment in advance of surgery in an out of hospital setting. In addition, a further shared aim is to improve patient information shared prior to surgery so that patients are fully informed and educated on their procedure as well as the best ways to optimise pre-surgery and recuperate post-surgery. Some examples of the schemes proposed are below.



Office of the Trust Special Administrator

Bromley's Intermediate Dermatology Service

Provided by a team of specialists including consultants, advanced general practitioners and specialist nurses in five out of hospital settings across Bromley, this service aims to provide assessment, investigations and treatment for a range of skin conditions in one visit. The aims of the service is to divert 50 per cent of referrals to intermediate care in a community based setting and already there has been a 30 per cent reduction in hospital referrals.

Benefits for patients...

- Reduced waiting times.
- Increased choice of venue and appointments available in evenings and at weekends.
- Improved patient satisfaction.

Benefits for the NHS...

- Reduced hospital referrals to outpatients.
- Acute service focussed on more specialist cases.

Lewisham's Anti-coagulation service

Already in Lewisham, we commission anti-coagulation monitoring services from a group of local pharmacies providing a number of access points across the borough expanding the number of conditions for which ongoing management can be delivered within the community. The scheme includes more complex care management involving the supply and review of medicines which would otherwise require hospital input.

Benefits for patients...

- Local to patient's home with choice of 6 local pharmacy providers.
- Flexible appointments.
- Increased time with healthcare professional.
- High patient satisfaction levels reported.

Benefits for the NHS...

- Less people having to attend A&E and hospital out-patients.
- Reduced emergency admissions.
- Reduced costs caring for people with long term conditions.
- Collaborative working between local primary care and hospital services.

3. Timely, convenient and effective planned care						
This work stream focuses on developing the skills and services required to move pre and post-operative activity into the community and closer to minimise time spent in acute care settings.						
Focus	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Information to support choice	<ul style="list-style-type: none"> Procurement of a number of new services specified to improve quality and access and provide information to support choice. These include cardiology and pathology and community offerings in coagulation and Deep Vein Thrombosis, urology, gynaecology, dermatology, general surgery and ophthalmology 	<ul style="list-style-type: none"> Development of Patient Referral Centre to enhance the range of care pathways actively managed 	<ul style="list-style-type: none"> Continue to develop information provided to patients and develop staff to supported informed discussion 	<ul style="list-style-type: none"> Evaluate and re-issue the Choose Well Campaign Review and scope further self-management education opportunities 	<ul style="list-style-type: none"> Improve engagement with district nurses/GPs Evaluate residential care homes "Steps to Success" programme Tele-health rollout 	<ul style="list-style-type: none"> Evaluate and re-issue the Choose Well Campaign Develop materials to support choice for planned care
Consistent quality of care and access		<ul style="list-style-type: none"> Develop shared protocol for acute care across SEL 	<ul style="list-style-type: none"> Continue development of referral management service to support GPs and patients to follow pathways 	<ul style="list-style-type: none"> Develop referral services Test scope for improved decisions support software integrated into existing systems Standardise referral guidelines 	<ul style="list-style-type: none"> Develop neighbourhood hubs to support clinical review of referrals Improve diagnosis and management of Cardiovascular Disease in primary care 	<ul style="list-style-type: none"> Continue to develop referral support services including single point of referral and choose and book Develop diagnostics strategy and implementation programme
Care closer to home with specialist care in appropriate settings		<ul style="list-style-type: none"> Develop and embed care pathways for local access to MSK, gynaecology, oral, dermatology as well as outpatient, diagnostic and minor procedures 	<ul style="list-style-type: none"> Undertake outpatient care audit to identify services with the potential to transfer to community based settings 	<ul style="list-style-type: none"> Re-commission Musculo-skeletal assessment and treatment services Commission optician led ophthalmology services Test non-patient contact approaches Review use of neighbourhood resource centres in Streatham, Brixton and Norwood 	<ul style="list-style-type: none"> Proactive Primary Care Pilot Increase capacity in the psychiatric liaison based at Lewisham Health Centre to ensure appropriate assessment and discharge 	<ul style="list-style-type: none"> Commission new community based services in key specialities; gynaecology, physiotherapy and pain management

43. Years two and three of the planned care work will continue the shift of outpatient and diagnostic services away from hospital settings and into community. This will be supported by the development of local community hubs, such as the development of Queen Mary's Hospital in Bexley, a new Health and Wellbeing Centre in Bromley and Eltham Hospital in Greenwich. The development of these community hubs is already in progress and will provide increased capacity to provide appropriate primary and community care services in community settings, reducing the activity pressures on local hospitals alongside this patient choice will be supported by the provision of appropriate material and approaches to support individuals make decisions about their care.

44. Examples of centres already running include the Akerman Neighbourhood Resource Centre in Lambeth which opened in August this year and integrates local health and social care services for patients under one roof. Clapham One also opened this year and provides Primary and Community Services for patients. Additionally, Lambeth, in collaboration with Lambeth Borough Council and Kings Health Partners will open West Norwood Neighbourhood Resource Centre in Spring 2014.

45. If through these projects each GP in south east London prevents two unnecessary elective spells a month, activity reductions and associated savings of around £40m savings will be delivered over the next five years.

6. The enablers that will help to deliver the changes

46. Successful implementation of transformation on this scale will require the development and implementation of set of key enablers. Building on work undertaken at the Community Based Care workshops the CCGs and the London Regional Office of the NHS Commissioning Board have identified four priority enablers that will support the delivery of the aspirations for Community Based Care in south east London. These are: effective self-management; workforce, information systems, system incentives and contract levers and communications and engagement.

47. The enabler workstreams have been designed to support the work across the three implementer projects. CCG Chief Officers have each taken responsibility for the delivery of an enabler and work is planned to coordinate these activities with relevant external partners such as the London Regional Office of the NHS Commissioning Board, Local Education and Training Board, Local Authorities, SEL Commissioning Support Unit and provider organisations.

Enabler – Workforce		Dr Angela Bhan Chief Officer; NHS Bromley CCG	
Aims/Objectives	1. to proactively seek to address the education needs across primary and community care as part of the process of providing more services outside hospital, and ensure better consistency of care outside CCG boundaries 2. to identify workforce development needs and to support primary, community and social care professionals in developing skills to, using economies of scale in delivery of education and training 3. to secure appropriate additional capacity in primary and secondary care		
Impact	Easy access to high quality, responsive primary and community care To support contractual arrangements and incentives to improve access to primary care Through education ensure consistency in high standards of primary and community services To identify and train new staff to work in primary and community services	Integrated care for people with long term conditions Introduce evidence based practice for the management of long term conditions Support professionals in the community and general practice in developing special interests Ensure consistency of standards Improve health and wellbeing and independence, and reduce hospital admissions by more preventive care and greater support to patients in the community	Timely, convenient and effective planned care Achieve consistency, collaboration and high quality in the delivery of care pathways in each CCG Support for community based care agenda and a greater proportion of health care delivered outside hospitals

Approach – South East London wide

1. Engage with GPs, Practice Nurses and other members of practice teams in educational activities which encourage joint working between primary, community and secondary care, and social care, with the development of working partnerships within and between practices to benefit patient care, using evidence based approach.
2. Work collaboratively with the LETB, the Royal Colleges, AHSN and local professional leads to proactively address education needs across primary, community and social care as part of the process of providing more services outside the acute setting with better consistency of care across CCG boundaries.
3. Identify of workforce development needs, supporting general practice and other community and social care professionals in developing the skills to meet these needs, using economies of scale in delivery of training and education programmes, including the development of practitioners with special interests.

Mechanism

Use a programme delivery approach through the PMO for SE London to deliver a strategy with a workplan. The officer lead co-ordinating and driving this forward will link CCG teams responsible for workforce development and also LETB, AHSN, Royal Colleges and educational institutions

Timetable

Year 1	Year 2	Year 3
Establish programme Implement a number of pilots to commence educational and workforce support to new ways of working Each CCG to have clear strategy Commence training programmes	Implementation starts across CCGs Initiatives and start change in junior hospital doctor training	New workforce in place and further development taking place New training schemes fully implemented

Example



Diabetes: bringing the expert to the community

Office of the Trust Special Administrator

A team of GPs, Nurses and Commissioners from the three boroughs of Bexley, Bromley and Greenwich have been working together to improve services to diabetics. The service model chosen has already been implemented with good auditable results in Derby & Portsmouth and involves Consultants working alongside GP colleagues seeing patients within the community. The Consultant goes into the hospital only for specialist clinics such as obstetrics and in-patients.

Benefits for patients...

- Closer to home access to help with monitoring and control of diabetes.
- Achievement of the four care targets (HbA1C and BP etc.) so they keep healthier for longer.
- The avoidance of life limiting and debilitating complications.

Benefits for the NHS...

- A reduction in patients having to attend secondary care.
- A reduction in the number of patients requiring major operation/ procedures e.g. amputations.
- More independent patients so less spent on caring for patients with complications.

Enabler – Self Management		Andrew Eyres Chief Officer; NHS Lambeth CCG	
Aims/Objectives	<p>1. To increase the confidence and capability of people with long term conditions (such as diabetes, heart disease, high blood pressure and lung disease) to manage their own condition in partnership with health and social care staff.</p> <p>2. To increase numbers of people self-managing minor illness and injuries.</p>		
Impact	Easy access to high quality, responsive primary and community care	Integrated care for people with long term conditions	Timely, convenient and effective planned care
	<p>Patients working together with GPs, practice nurses and specialist health staff to plan and anticipate the care they require.</p> <p>More patients using their GP, practice nurse and community pharmacy.</p> <p>More patients managing minor illness and injuries with the support of community pharmacies, telephone advice and their GP.</p>	<p>Plans for care and support led by the patient with support from health staff.</p> <p>Written plans agreed and shared with patients.</p> <p>Improved shared information between GPs, nurses, therapists and consultants and the patient.</p>	<p>Better planning of care and support to reduce the need for patients to access care as an emergency.</p> <p>Patient led pathway design</p>
Approach – South East London wide			
	<p>1. Education and publicity programmes for patients</p> <p>2. Joint care planning between the patient and health staff.</p>		
Mechanism	<p>Use a consistent approach to supporting self-care across the cluster that includes:</p> <ul style="list-style-type: none"> • All newly diagnosed patients receiving information and advice on their condition. • All people with a long term conditions engaged in developing a single personal care plan with health staff • All people with long terms conditions being offered an education programme tailored to their needs • Education programmes for people with individual and multiple long term conditions • Development programmes with primary care and community staff to promote care planning in partnership with patients • Simple methods of sharing care plans across organisations being developed and implemented (this could be patient held or web based) • Education and publicity programmes across South east London to promote self-management of minor illness and injuries 		
Timetable	Year 1	Year 2	Year 3
	<p>Test models for education for people with several long terms conditions</p> <p>Test models for care planning</p> <p>Establish clinical and patient champions for the new approach</p> <p>Pilot campaign for minor illness and injury</p>	<p>Refine and roll out model education using clinical and patient champions to support</p> <p>Each CCG to have education programme in place</p> <p>Develop electronic sharing of care plans and records</p> <p>Refine and extend minor illness and injury campaign</p>	<p>Complete implementation of education work</p> <p>Use health staff and patients to evaluate</p> <p>Established model for care planning in place</p> <p>Further refinement of campaign work</p>

Lambeth Diabetes Modernisation Initiative

Office of the Trust Special Administrator

This initiative uses best practice and discussions with service users, providers and commissioners to support self management for patients with diabetes. It has drawn together the various existing services for patients with diabetes and coordinated them centrally to ensure that patients have information about and access to services that best meet their needs. By engaging patients in effective self management programmes, the aim is that there will be a significant reduction in unplanned admissions for this patient cohort.

Benefits for patients...


- Access is more equitable as patients are given information about all available services.
- Information and education is given at the point of diagnosis and then patients are supported through on going clinical care, review, support and education.

Benefits for the NHS...

- Effectiveness of services can be monitored centrally against shared standards ensuring that services commissioned are effective and in line with patient choice.
- Integration is improved, reducing inefficiencies across the system.

Enabler – Information Systems		Martin Wilkinson Managing Director; NHS Lewisham CCG	
Aims/Objectives	<p>1. To support information sharing across primary care, community, secondary (and social care, tertiary over time) with relevant information governance arrangements to enable a shift to new models of care to deliver the CBC Strategy.</p> <p>2. To establish IT solutions that effectively enable sharing of patients records across care settings through interoperability to ensure interface with existing and new IT systems across south east London.</p> <p>3. To increase mobile working for staff in community settings to maximise time spent with patients</p>		
Impact	Easy access to high quality, responsive primary and community care	Integrated care for people with long term conditions	Timely, convenient and effective planned care
	<p>Better clinical management of individual patients with more effective use of scarce clinical resources/time through improved caseload management and increased mobile working for community staff</p> <p>Provide timely risk-predictive tools based on the agreed data flows across care settings</p> <p>Improve patient experience e.g. through introduction of programmes granting patients access to their own records and information about CBC</p>	<p>Effective treatment of patients avoiding unnecessary or duplicated diagnostics tests and other clinical activities</p> <p>Support delivery of integrated joined up care</p> <p>Improve patient confidence in the health system, earlier diagnosis and access to care.</p>	<p>Supporting the move of activity to more appropriate settings and delivery of more effective services at lower unit costs</p> <p>Support targeted productivity improvement of fewer hospital admissions, attendances, referrals and outpatient follow-ups.</p> <p>Enabling more proactive management of long term conditions</p> <p>Potential mitigation to provider reconfiguration as underlying data feed systems may be altered over time.</p>
Approach – Multi-Borough collaboration			
	<p>1. Define new integrated care networks based on post TSA provider configuration.</p> <p>2. Develop common information strategy to support CBC delivery ensuring that shared joint standards are delivered across primary, community, secondary and tertiary providers drawing on existing borough and provider plans. There would need to be borough level work with local Social Care and Voluntary sector organisation where NHS services are delivered, supported by appropriate information sharing and governance arrangements.</p> <p>3. Use of incentives and contract levers to support cultural and behavioural change to support use of information sharing tool as part of clinical practice.</p> <p>4. Investigate options and agree fast-track available approaches with appropriate clinical and organisational engagement, including business case development and pilot and roll-out strategy</p> <p>5. Procure solutions</p> <p>6. Work with preferred IT providers to implement, including suitable training and support for staff</p>		
Mechanism	<p>Delivery will be driven through a single programme to co-ordinate both the significant level of existing work in this area and the new approaches that will be adopted over time.</p> <p>Coordination will be required across all CCGs, the NHS CB, all providers and the CSU with a focus on interoperability.</p>		


	Year 1	Year 2	Year 3
Timetable	Define integrated care systems Agree common information strategy and review existing opportunities to fast-track delivery Agree business case Pilot solution	Complete procurement Roll-out across Integrated Care Systems	Evaluate and modify with contracted supplier

Example	 Office of the Trust Special Administrator
	<p>Lewisham’s Virtual Patient Record Initiative</p> <p>Lewisham CCG is working with Lewisham Healthcare Trust to introduce a virtual electronic patient record for Lewisham patients that will enable primary and secondary care clinicians, and in time social care, to view patient records from across the health system.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Benefits for patients...</p> <ul style="list-style-type: none"> • Improves integration of patient care. • Avoids unnecessary duplication of tests and clinical activities. • Enables clinicians and carers to view relevant patient records from other parts of the health system. • Supports self care and support. </div> <div style="width: 45%;"> <p>Benefits for the NHS...</p> <ul style="list-style-type: none"> • Delivers cash releasing and quality benefit to support the achievement of local QIPP targets. • Provides strategic support for the delivery of integrated care, allowing various agencies to be as effective and responsive as possible, reducing duplication and improving the quality of care. • Supports risk stratification to identify patients at higher risk of requiring future care. </div> </div>

Enabler – Incentives and contractual levers		Andrew Bland Chief Officer; NHS Southwark CCG	
Aims/Objectives	To incentivise a shift to new models of care to support the delivery of the CBC Strategy, through the utilisation of contractual levers, financial rewards and other incentives.		
Impact	Easy access to high quality, responsive primary and community care	Integrated care for people with long term conditions	Timely, convenient and effective planned care
	<p>Support effective delivery of prevention and health promotion activities in every setting, at every opportunity</p> <p>Support the collaboration of primary and community care teams to provide enhanced levels of service through new delivery models</p> <p>Incentives and contractual levers to reduce variation in the quality of primary and community care</p>	<p>Providers incentivised to work together to deliver seamless care for patients</p> <p>Establish funding mechanisms to ensure care needs are better identified and managed by an integrated multi-disciplinary team that intervenes earlier to address them</p> <p>Incentives that drive more effective community based care by requiring individualised care planning and co-ordination of care</p>	<p>Contractual frameworks will deliver enhanced and common standards and include clear specifications setting out service delivery models</p> <p>Incentivise common and agreed protocols, access policies and approaches to referral and the use of diagnostics</p> <p>Incentivise change to current models of delivery and adequately resource primary and community care to deliver them</p>
Approach – South East London wide with local adjustments			
	<p>Easy access to high quality, responsive primary and community care</p> <ul style="list-style-type: none"> • Consistent performance management of existing contracts • Incentives for the delivery of higher quality care based on patient outcomes and flexible approaches to access to meet the requirements of patients informed by engagement programmes • Procurement of out of hospital care through extended service contracts or AQP mechanisms, focusing on locality or networked models of provision • Incentives for engagement in workforce/ training and development initiatives <p>Integrated care for people with long term conditions</p> <ul style="list-style-type: none"> • Agreement of financial frameworks and risk sharing agreements that transfer funding to where integrated care is delivered. This will include agreement of capacity plans to underpin agreed service change • Support for the consistent adoption of screening, case finding and of risk-stratification in primary care • CQUINS for self management and the delivery of care planning approaches by community and acute providers <p>Timely, convenient and effective planned care</p> <ul style="list-style-type: none"> • Risk sharing agreements with providers which reflect the shift of care to lower cost settings and specify the level of acute care to be commissioned • Use of payment mechanisms that support service transformation, such as non-face to face contacts • Use of CQUINS payments to support delivery, including the provision of advice and guidance / specialist support to community based models of care 		
Mechanism	<p>Delivery across the six CCGs will be driven through a single programme to co-ordinate both the significant level of existing work in this area and the new approaches that will be adopted over time.</p> <p>Delivery will be on the basis of 'Shared Standards, Local Delivery' recognising the degree to which commissioners have already applied new and enhanced incentives and levers locally will be different by borough or group of boroughs.</p>		

	Year 1	Year 2 and 3
Timetable	<p>Consistent / systematic application of existing contractual levers</p> <p>Map, review and align existing incentives</p> <p>Design and application of incentives that support and appropriately remunerate enhanced levels of provision in localities or networks of providers</p> <p>On going development of approaches to integrated care. Sharing of best practice to enhance all borough programmes</p>	<p>Development of new contractual arrangements that support the new models of care required by the transformation of primary and community care delivery and integrated care</p> <p>Development of pathway tariffs / Year of Care arrangements where they will support and secure integration across health and social care</p>

Example



Personal Medical Services Contracting

Office of the Trust Special Administrator

PMS contracting pays GPs on the basis of meeting set quality standards and the particular needs of their local population. The approach has brought a wide range of benefits and is being used to improve health outcomes, access and to develop new service for patients. Two such examples in south east London include:

- i Southwark saw a marked improvements in vaccination rates when incentivised by PMS contracting.
- ii Southwark and Lambeth have used PMS contracting to ensure that a percentage of payment is linked to health outcomes for patients.

Benefits for patients...

- Services are designed to be targeted to the needs and demands of their local population and to reduce inequalities.

Benefits for the NHS...

- Funding can be targeted to encourage very specific behaviours dependent on local need.
- Outcomes based payments are a cost effective mechanism to promote and reward innovation.

Enabler – Communications and engagement		SEL Programme Director	
Aims/Objectives	<p>To develop, with patient input, an approach to communicate effectively the changes taking place in primary and community based care over the duration of the programme.</p> <p>To establish a programme of communication and engagement that reaches all community and acute clinicians, local community and voluntary groups.</p> <p>To develop good quality resources for project teams to complete engagement activities and provide good quality communication material and branding for the Transformation Programme that gives an identity and refers to local CCG work programmes.</p>		
Impact	Easy access to high quality, responsive primary and community care	Integrated care for people with long term conditions	Timely, convenient and effective planned care
	<p>Ensure strong cross disciplinary communication and shared information systems (where possible) and supports the monitoring of performance and accountability</p> <p>To strengthen relationships and understand requirements from individual practices to local groups and across the SEL community</p>	<p>Support and enable each CCG to remain accountable for delivery providing information to all of methods such as making contractual changes, driving improved performance and creating a culture of integration between providers.</p>	<p>Support and ensure expertise is shared and best practice implemented</p> <p>To develop and share collaborative planning and approaches</p> <p>To influence policy and local innovation in delivery</p>
Approach – South East London wide with local adjustments			
	<ul style="list-style-type: none"> • Create and maintain awareness and understanding of the programme, including benefits and processes, among all stakeholders • Identify, build and maintain strong relationships with stakeholders and ensure engagement occurs at the right level, at the right time, in the right way • Identify and manage communications issues to minimise their impact on the project • Support and provide access to detailed information analysis and financial planning function as required across programmes • Provide clear planning, information analysis, facilitation as required • Support and provide information to help incentivise the health and social care system to improve delivery • Make information readily available so that everyone is able to be involved and contribute ideas / views 		
Mechanism	<p>Delivery across the six CCGs will be driven through a single programme to co-ordinate both the significant level of existing work in this area and the new approaches that will be adopted over time.</p> <p>Delivery will be on the basis of 'Shared Standards, Local Delivery' recognising the degree to which commissioners have already applied new and enhanced incentives and levers locally will be different by borough or group of boroughs.</p>		

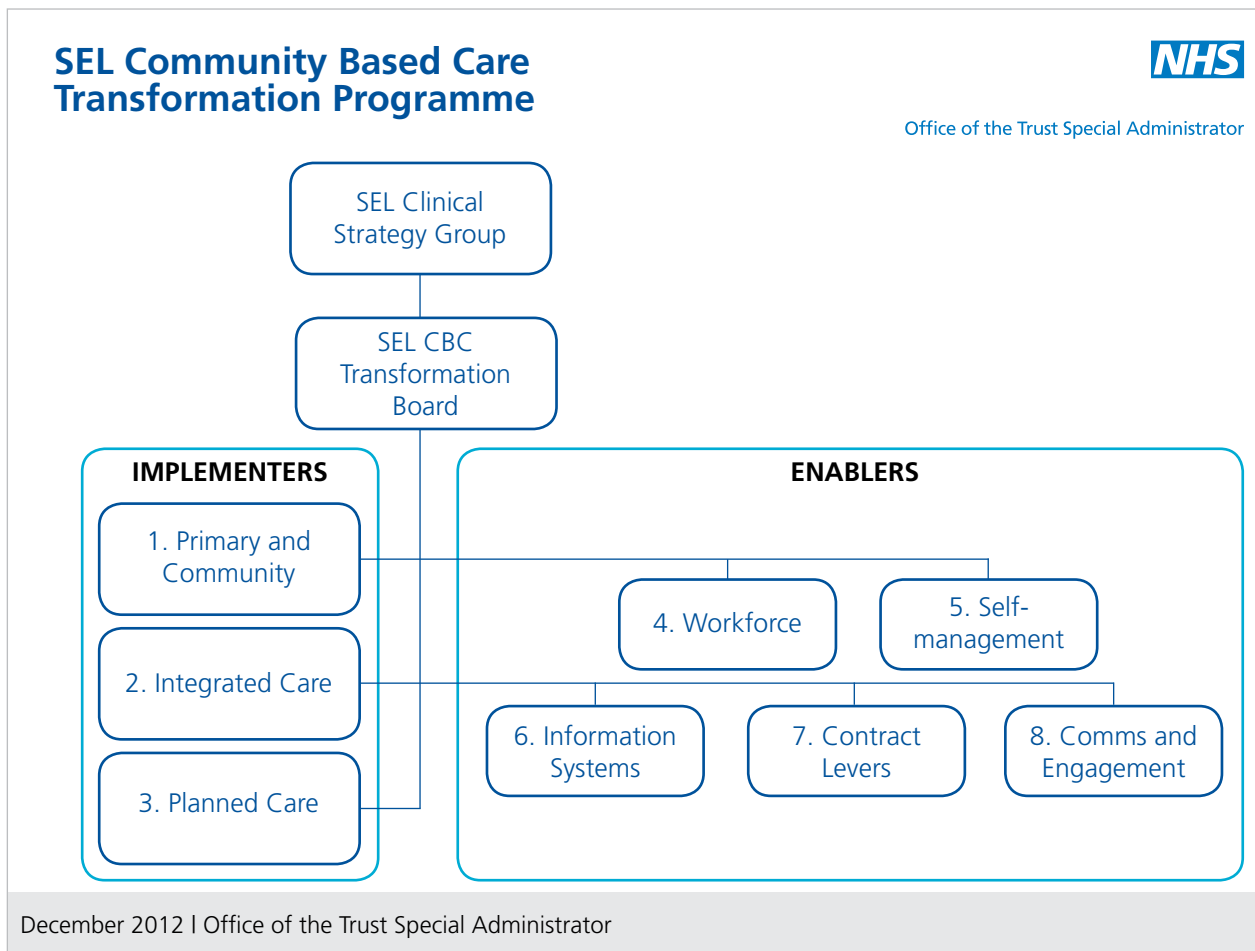
	Year 1	Year 2 and 3
Timetable	Identify and manage issues	Agreed and implement knowledge sharing platform across all programmes
	Test title to check comprehension; strap lines; key messages	Share good practice and support economies of scale (what can we do once)
	Design branding for the SEL CBC Transformation Programme which gives an identity and refers to local CCG work programmes.	Receive and analyse feedback/input
	draft and distribute the regular stakeholder e newsletter	Continue to manage groups critical to further engagement planning
	Develop and maintain local website	Support and provide data on project and programme prioritisation support information analysis and costing
	Develop corporate materials	Clear change management approach operational and implements
	Develop and maintain the contact database	Continue to provide credible facilitation expertise at regular points throughout the projects

7. Delivering the community based care aspirations

48. As outlined throughout this document delivering the Community Based Care aspirations will not only improve the quality of and access to core primary and community based care services for the population of south east London, it will also be central to delivering continuously improving healthcare services within an environment of increasing financial challenge.
49. South east London CCGs consider the strategy to be central to the successful implementation of the Trust Special Administrator’s recommendations to secure clinically and financially secure services, if they are supported by the Secretary of State for Health.
50. Accordingly, it is essential that there is a strong programme to support its continuing development and implementation, including ensuring there is clear oversight and assurance of progress in order to hold all parties to account for delivering improvements. The SEL CBC Transformation Programme (CBCTP) has been designed to provide this function and provide a link into the overall TSA implementation programme, being developed by the TSA and his team.
51. A Programme Board for the CBCTP will be formed as a sub-group of SEL Clinical Strategy Group (CSG), a group that is governed by the Framework for Collaboration which clearly sets out that CCGs remain accountable for their own areas of work and have committed to working in collaboration with one another. The group will report directly to the CSG and will be chaired by a clinician drawn from one of the CCGs and have a Programme Director as the Executive Lead. In addition to this they will have representation from each CCG, each Local Authority, the London Regional Office of the NHS Commissioning Board and the Local Education and Training Board for South London. Members will fully represent their organisations so that the Programme Board can fulfil its function to ensure delivery of the Community Based Care Strategy

52. The CBC Transformation Programme Director will be responsible for ensuring delivery against the implementation projects for the three areas of care and the five enabling projects of work, outlined in figure 4:

Figure 4: primary care transformation programme overview:



53. To ensure there is continued visibility and leadership engagement in the delivery of the programme each enabler has a CCG Chief Officer lead. Individual CCGs will be responsible for developing their local integrated and planned care projects, and the CCGs will work with the London Regional Office of the NHS Commissioning Board to develop the primary care transformation programme as well as their own local primary and community care projects. The Programme Director will then be responsible for monitoring progress on all of these areas and hold the CCGs and London Regional Office of the NHS Commissioning Board to account for delivering to the agreed timetables. The Programme Director will, though the Communications and Engagement work, also be mindful of patient feedback in providing information to the 6 CCGs in order that informed decision can be taken.

54. To support the Programme Director in this there will be some programme management support working at the individual CCG level, but also at the programme level on programmes that run across multiple CCGs. The current proposal is, in addition to the Programme Director, to have a SEL team of three programme managers and additional support team (covering enabling functions).

55. Delivering this scale of transformation at the pace required for the TSA recommendations will require investment to support programme management arrangements. This is expected to be in the region of £690,000 per year, and will supplement the significant planned CCG investment in local QIPP schemes. In addition to this it is expected that CCGs will need to pump-prime their investment to deliver at pace and to ensure that primary care and community based care in south east London is transformed.
56. The CCGs have identified the requirements for this pump priming and start-up costs of £42m over 3 years in order to achieve the commissioner savings, as identified by the TSA, of £128.7m. In order to deliver this will require funding from non-recurrent sources across south east London.
57. In addition to the start-up costs and pump priming, there will be on-going recurrent costs of the redesigned services. Once the programme is fully implemented these costs are estimated to be £30m per annum. These will build up throughout the implementation period and will, in part be funded from reinvestments of QIPP savings.