Our Healthier South East London
Improving health and care together

NHS

Tell us YOUR views

Help us improve your local NHS

Emerging models and further thinking

A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

September 2015

Introduction

What is Our Healthier South East London?

Our Healthier South East London is a five year strategy which aims to improve health and care services across south east London. The programme is led by the six NHS Clinical Commissioning Groups (CGGs) in the region – Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark – with commissioners from NHS England (London), working in close partnership with local councils, local providers of care and other partners.

We published a draft five year strategy in June 2014 and an updated version of that strategy – the Consolidated Strategy – was approved by each of our CCGs in July 2015. We also published *Help us improve your local NHS: Issues Paper* earlier this year. This set out the challenges that the NHS faces, some of our emerging ideas, and some questions for readers to consider. The next step is to talk to people about the emerging ideas (models) for providing care that are being suggested, before we put forward final recommendations.

This paper builds on *Help us improve your local NHS: Issues Paper*

We are still considering the responses we have received to *Help us improve your local NHS: Issues Paper* (known as the Issues Paper) and are encouraging local people and organisations to respond.

You can download the Issues Paper at www.ourhealthiersel.nhs.uk or write to us requesting a hard copy at: Our Healthier South East London, 160 Tooley Street, London SE1 2TZ.

We are now able to build on the Issues Paper by sharing more information about the 'models of care' being put forward. These models aim to address the challenges set out in the Issues Paper.

Our aim is to improve the NHS in south east London, making services safer, of consistent high quality, financially sustainable and more joined up. We are focusing on supporting health and wellbeing to prevent ill health and helping people with long term conditions to manage their health so that they can keep well for longer. We are building on and learning from the examples of excellence which already exist in south east London and elsewhere.

Most of our ideas remain subject to change. We want to hear your comments on them so that we can take your views into account.

Where are we now?

Some of the ideas set out in this paper, such as those which focus on improving community-based services, are already being implemented in south east London.

For other ideas, we are working in partnership with each local provider trust on how these changes might work to get the best results for patients. If there are proposals that would require major service change, we will carry out a full public consultation before making any changes. But we do not know if such proposals will emerge. We are doing further work to get a clearer picture and are talking to partners, local authorities, patients and the public about the best way forward.

We are publishing our latest thinking to add to the details in our Issues Paper, so that people in south east London are kept up to date on the sort of changes that are being discussed.

What will happen if we make no changes?

Our Issues Paper sets out the challenges currently facing the NHS in south east London (and elsewhere). It reports some of our emerging ideas and some of the new national and London-wide programmes that aim to tackle the problems and deliver a better, more user-friendly and sustainable NHS.

Further work has given us a more detailed idea of the potential impact of the strategy, and the picture if we do nothing.

The NHS in south east London currently spends £4billion annually and has 4,166 acute hospital beds. Over the five years of the strategy, we expect the available money to grow to around £4.8billion per year, but if we continue to provide care as we currently do to our growing population the amount we need to spend will be around £5.9billion.

The need for hospital beds will also grow to 4,866 beds – an extra 700. This is because the demand for health services is increasing; people are living longer but many with long term conditions, such as diabetes, heart disease, high blood pressure and mental illnesses, and the technical advances in diagnostics and treatments mean that the costs of providing care are rising faster than inflation each year.

Our Healthier South East London is about responding better to people's needs by providing an alternative high quality model of care that is focused on improved outcomes for everyone. The care models are focused on prevention, early intervention and keeping people healthy and out of hospital.

This is not about closing a hospital, but about avoiding the need to build a new one – which we could not afford – by improving health and outcomes and delivering services which better meet people's needs.

Productivity is expected to increase and providers will continue to deliver efficiency savings which will help to close the gap.

It is also about creating a legacy for the future as the improvements in prevention and care should result in benefits which will materialise beyond the next five years.

We aim for bed occupancy to meet national guidance and to meet the London Quality Standards (a set of minimum quality and safety standards set by senior clinicians and patient representatives) – neither of which are the case at the moment – which will improve safety, quality and efficiency.

Our current forecasts show that, with the changes put forward in the strategy, at the end of the five years we would still need about the same number of beds as we have in our hospitals now in south east London, though some of them may be used differently, for instance more day cases, fewer inpatient beds and shorter lengths of stay.

Emerging models and developing ideas

Six areas of healthcare have been identified as the priorities for improvement.

These are:

- Community-based care
- Planned care
- Urgent and emergency care
- Maternity
- Children and young people
- Cancer

Mental health in all its aspects is included within each of these areas as it is relevant to all of them. We are using this integrated approach to make sure that mental health is addressed in all our plans.

Clinical Leadership Groups have been set up for each of these areas, made up of doctors, nurses, therapists, health service managers, social care staff, patients and members of the public. These groups have developed a number of possible solutions and models to address the challenges in these areas. They have also begun assessing and testing these ideas using evidence and outcomes from other areas; and looking ahead to show what kind of effect they might have. The assessments are looking at impacts in the key areas of:

- improved quality
- better and less variable outcomes
- value for money
- providing a sustainable whole system health and care system

Our current ideas are described in this paper in more detail than is set out in the Issues Paper, which was first published in March 2015. This is because work has continued since the document was published. The opinions, ideas and priorities of local people and patients which are being gathered through our engagement will continue to be used in the further development of these ideas and proposals.

Whole System Model

We've developed a model to show how healthcare should work in south east London. The person – you – is always at the centre, supported in the community by Local Care Networks.

These are the foundations of the system, co-ordinating care and providing:

- access to specialist services where required
- support to keep people out of hospital; but with the hospital services always available if needed
- high quality care wherever you are and whenever you need it

Cancer
Earlier detection and diagnosis for cancer patients and support to live with and beyond cancer

Maternity
Mums to be will receive personalised continuous care and will have choice over birthing options

Urgent and emergency care
People who need urgent and emergency care will get the right support at the right time

Planned care
Patients who need planned care across south east London will receive consistently high quality care regardless of setting

Children and young people
Children and young people will have access to more specialised services in the community

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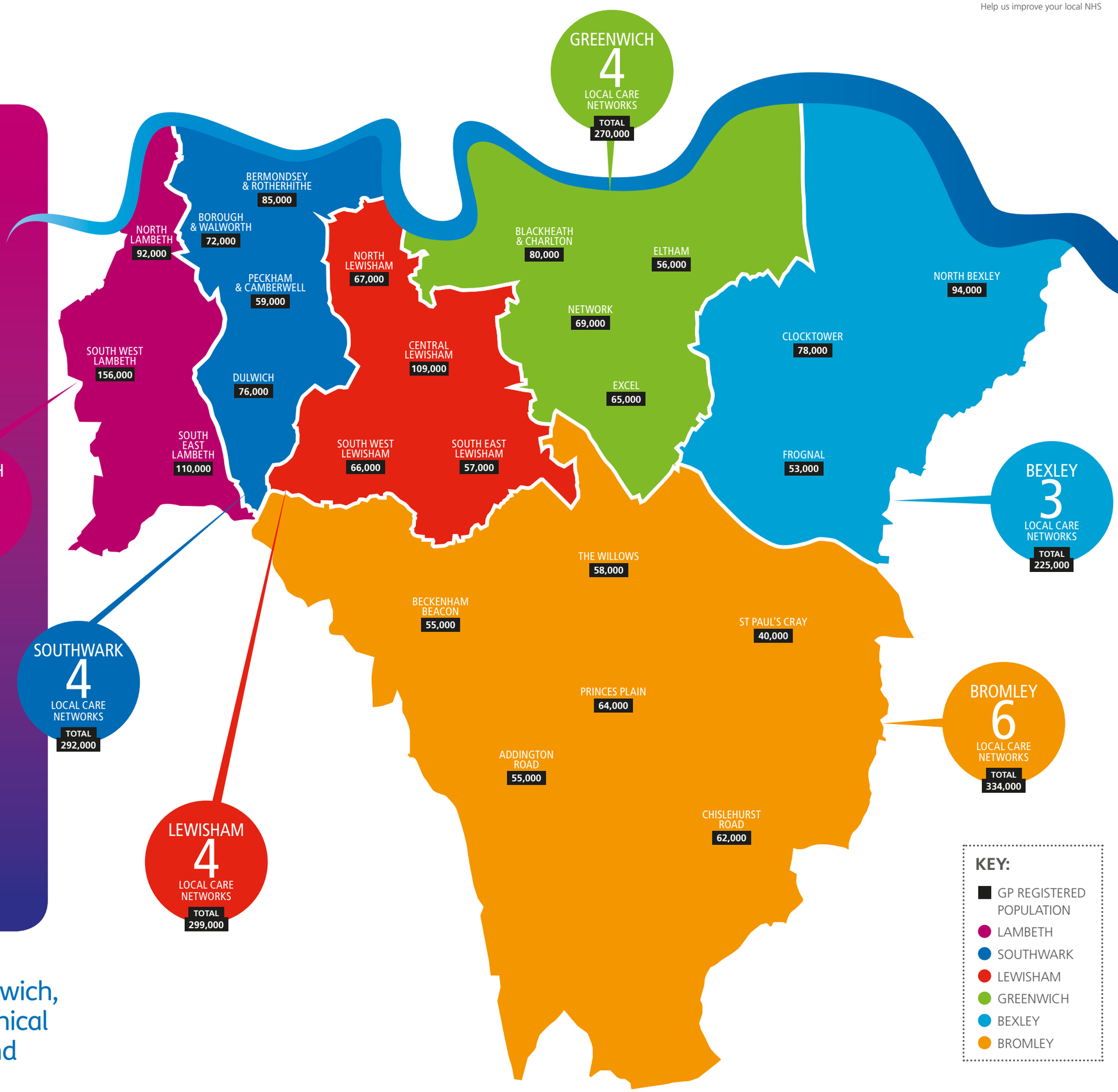
Local Care Networks

Local Care Networks are at the centre of Our Healthier South East London. These are networks bringing together the different organisations, individuals and agencies involved in the care of a patient.

They will work together in a more co-ordinated way, with the patient's needs at the centre of their services.

The services available will be:

- proactive – supporting and encouraging people to live healthier lives and focussing on prevention
- accessible – for instance, GP services in each area available 8am-8pm, seven days a week
- co-ordinated – making patient care plans available to all relevant health professionals, across all providers and in all areas of care
- providing continuity of care – for instance, offering patients a named care professional at the relevant skill level who is accountable for their care
- based on a flexible, 'whole-person' approach to make sure that every contact that a patient has with a health and care professional counts



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Community-based care

Community-based care is care provided outside hospital. This includes care from GPs, district and community nursing, community health services, voluntary sector services, social care, community pharmacy, and community support services for people with long-term conditions.

We aim to support people to live healthier lives and to reduce the numbers that are exposed to risk factors either through birth (the effect of poverty and deprivation, for instance) or behaviour (such as drinking alcohol, smoking and poor diet).

For people with long-term conditions, we aim to support them to:

- manage their health positively
- stop the conditions getting worse
- reduce risks where possible

For people with multiple and complex long-term conditions or facing the last years of their life, support will be available to enable them to continue to lead as full and active a life as possible.

Much of this work is already starting locally. This means we can begin to support people to live healthier lives as soon as possible.

Twenty-four local care networks are being developed to support everyone across south east London. These involve primary, community and social care colleagues working together and drawing on others from across health, wider community services like housing and schools, and voluntary sectors.

Each borough is developing its own Local Care Networks to respond to the different needs and characteristics of its community, and the details of how they will work is being decided locally.

They will all share a number of core elements:

- involvement of all general practices working at scale within a geographical area, with a single shared IT system
- community pharmacies
- voluntary and community sector involvement
- community nursing for adults and children
- social care
- community mental health teams
- community therapy
- community-based diagnostics
- patient and carer engagement groups
- a leadership team for the whole Local Care Network

The Local Care Networks will ensure that services are joined up and working well together around the needs of the patient, working effectively with:

- accessible hospital outpatient clinics and emergency and urgent care treatment clinics
- clinical specialists
- NHS 111, London Ambulance Service and out-of-hours systems
- housing, education and other council services
- community-based midwifery teams
- private and voluntary sector e.g. care homes and home care teams
- cancer services
- children's integrated community teams and short stay units
- rapid response services
- carers

These Local Care Networks may change over time and may even be called different things, such as neighbourhood or community networks, but their core elements, ways of working and focus on local people will remain the same.

Each Local Care Network will focus on a number of agreed priority initiatives, such as improving access to services and prevention, addressing inequalities, promoting self-management, and the development of strong and confident communities (where people in the community support each other and know how to get help or care when they need it). They will also have a number of other locally-defined priorities based on local needs.

Planned care

Planned care is treatment that is arranged in advance, such as an operation booked on a certain date. We have further developed the ideas which were set out in the Issues Paper.

Standardisation

We aim to make sure that all patients who need planned care across south east London receive the same quality of care and outcomes. This is regardless of where or when they are treated, and relates to all parts of their care – from referral through diagnosis and treatment. It includes discharge from hospital and on-going support from their Local Care Network, if needed.

These standards will be developed in partnership with patients, the public, and clinicians from hospital and from the community.

Diagnostics

Diagnostic services underpin the management of patient care and ensure that decisions can be made as quickly and accurately as possible. We are looking at standardised diagnostic care that is evidence-based and which has been shown to have a number of benefits.

We want to:

- make sure that all GPs have access to the best and most effective methods (including lab tests) for diagnosis – so that all patients in south east London have a consistent, high quality journey ('pathway') to diagnosis
- ensure better shared access to test results for GPs and other professionals so that tests don't have to be repeated
- develop an agreed way to diagnose and treat 'serious but unspecific symptoms' which can be difficult for GPs to diagnose

Elective care centre(s)

We think that developing one or more centre(s) for planned operations such as hip and knee operations and in ophthalmology (eyes) will ensure better quality of care for people in south east London. These will:

- be a partnership between the hospital providers
- help ensure everyone receives the same quality of care
- reduce the number of cancelled operations because the surgical theatres and beds will be used for planned operations only
- achieve better outcomes for patients

Maternity

We want to do more to ensure that women have a safe, personalised and positive experience of pregnancy, including pre-pregnancy health advice, antenatal care and postnatal support.

The ideas are:

- targeted wellness and prevention programmes run by the Local Care Networks, including advice on lifestyle and pre-pregnancy support to improve the health of women before they conceive
- enabling women to access maternity services as soon as possible, ensuring early risk assessment so that women see the most appropriate midwife team at the earliest opportunity
- Local Care Network midwife teams for women at low risk
- specialist condition-focused teams for women with high risks
- continuity of midwife-led care as standard, with a named midwife for each pregnant woman and a personal care plan
- easy access to hospital assessment clinics for unexpected problems during pregnancy
- specialist unit(s) for assessment at the start of labour
- birthing units to encourage straightforward birth and improve the experience for women with low-risk pregnancies
- increased information and communication to enable women to make an informed choice about the best birthing options for them
- increased co-ordination between neonatal and postnatal phases, to improve the mother and baby experience and encourage breastfeeding
- continuing advice and support from Local Care Networks
- all services to meet the London Quality Standards (a set of minimum safety standards set by senior clinicians and patient representatives for maternity services in London)

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“Targeted wellness and prevention programmes run by the Local Care Networks, including advice on lifestyle and pre-pregnancy support to improve the health of women before they conceive”

Children and young people

Our aim is to focus on prevention – keeping our children and young people well. However, when children and young people do need to access care we need to make sure that it is available to them.

Our emerging ideas are:

Supporting families to keep children and young people physically and mentally well. This will be through health, social care and education services working together in a more co-ordinated way. One idea we are exploring is the use of Community Champions, possibly through the voluntary sector, to support healthcare promotion and prevention in a range of different settings.

More joined-up, proactive care in the community, through children's integrated community teams. The teams will:

- bring together a core of paediatric services and improve care co-ordination
- improve links with mental health services – this could be achieved through a 'care co-ordinator' and improved communication
- provide a range of proactive services for children with long-term conditions and care needs
- provide early intervention when a child or young person is ill, support early discharge from hospital and manage short-term conditions
- provide safeguarding services for children at risk

Extended GP hours with closer links to hospitals and specialists.

Specialist children's short-stay units in hospital. These units will be for children needing observation or short-term treatment of up to either 24 or 48 hours. They could be located with or close to the emergency department with rapid access to other specialities and links to the community for on-going treatment. The aim is to prevent unnecessary admissions to wards, to make sure that children are able to return home as soon as possible.

Better planning for when children need to go into hospital, including referral into hospital and for care needed at home when they are discharged. Planning will also take into account the overall wellbeing of the child, for instance the impact on schooling if a young person is in hospital.

Better support when children move on (transition) to adult services through support, information and advice. This is particularly important for young people with complex conditions including mental health needs, but the plans cover all children including those with no on-going health needs. Transition plans will be put into place for those who need it, in collaboration with the young person. This could include a 'transition co-ordinator' who will work with the young person, for instance, take them to adult clinics and organise meetings between paediatric and adult doctors.

"Better support when children move on (transition) to adult services through support, information and advice."

Urgent and emergency care

The development of Local Care Networks, with increased access to GP and nurse practitioners, 8am-8pm, seven days a week, is fundamental to helping reduce unnecessary visits to emergency care.

Local Care Networks will have strong links to rapid access services to support the frail elderly, patients with long term conditions as well as people with mental health needs.

Urgent care

Standalone urgent care centres (those that are not on the same site as an Emergency Centre) in south east London should all have the same standards and provide consistent services. This would make it easier for people to understand what services are provided in urgent care and what treatment they will receive there. Urgent care centres could in future include facilities which are currently named walk-in centres and minor injuries units.

Where urgent care and emergency care are available in the same place, they should share governance and management arrangements. A trained professional should triage all patients coming to use either facility and direct them to the right department for their needs.

Emergency Care

Effective triage and referral will ensure that Emergency Centres can do what they are designed to do, which is:

- diagnose and treat life threatening, serious or possibly serious illness or injury
- ensure patients receive effective post Emergency Centre management, with hospital admission only if unavoidable

Improved access to emergency care from GPs and others in the community

There should be a specialist response clinic to provide urgent diagnosis and treatment following a referral from GP or community services. Specialist advice for GPs should be available, including access to senior hospital consultants, to help make decisions and diagnosis.

Rapid response teams in local areas

These would give people the treatment they need in the right place at the right time (including in their own homes or care homes if appropriate) and avoid unnecessary transfer to and/or admission to hospital.

Improving the 111 (non-emergency) service and giving London Ambulance Service (LAS) more information and support

This will ensure that 111 and LAS can refer patients to appropriate services, including rapid response teams and specialist hospital services.

Mental health

A number of changes are being suggested to improve the care of patients with mental health issues in urgent and emergency care.

We want to ensure that mental health patients are seen more quickly in hospital emergency departments, with experts streaming patients at the front door and faster referral to specialities for mental health patients.

There should be rapid access to drug and alcohol services and professionals from within the Emergency Centre to encourage patients to access the specialist service (delays between the Emergency Centre and specialist treatment currently means that a large number of patients will leave before they see a specialist.)

We want to ensure consistent specialist paediatric mental health provision across all emergency centres in and out of hours.

Cancer

We want to improve patient outcomes through earlier detection and diagnosis of cancer.

Increased screening rates, using methods that have been proved to work elsewhere, including:

- face to face health promotion within general practice at every opportunity
- telephone outreach by multi-lingual staff
- challenging and following up with people who do not attend appointments to support and encourage participation
- better and more communication through letters and conversations

Early diagnosis – training for staff; planning how to deal with 'serious but unspecific' symptoms; better access for everyone.

Hospital and other healthcare providers working together to create networked centres of excellence, including integrated IT systems.

More treatment and support closer to home.

Access to appropriate support and information for carers and patients, including:

- a care navigator to help patients access appropriate support and services
- 24/7 advice line
- support to access appropriate online services
- better information to signpost patients to cancer advice and support

Development of an Acute Oncology Service – to ensure that national standards for better and safer treatment are consistently met across south east London. If a patient needs to attend their local Emergency Centre, and this is not at the hospital treating them for cancer, both the treating hospital and the Emergency Centre will be made aware of the patient's cancer treatment and emergency treatment. This will mean joining up IT systems across south east London.

Introduction and routine use of 'Cancer Recovery Package' – a nationally developed set of services which have been shown to improve outcomes, patient experiences and support a co-ordinated transition of the patient from their treating hospital to their GP and community services.

More support for people living with and beyond cancer, including carers. This includes comprehensive psychological support; support and referral to exercise or physical activity; support to return to work, study or volunteering.

Better support for end of life care through Local Care Networks. This will be achieved through earlier advance planning between the patient, carer and care professional to ensure a dignified death, irrespective of setting.

Engagement

Public, patient and stakeholder involvement and engagement is core to the development of our strategy. We have involved people, talked to them, listened to what they think and explored what is important to them ('engaged') throughout the development of our strategy.

We've used a variety of methods, including events, one-to-one interviews, group discussions and outreach work, across south east London to talk to different people and groups.

CLINICAL LEADERSHIP & WORKING GROUPS

FROM OCTOBER 2013 (ON-GOING)

Involvement of approx 500 health and care staff, managers, patients and members of the public from across south east London from the beginning of the strategy.

PATIENT AND PUBLIC VOICES

JUNE 2014 (ON-GOING)

34 Patient and Public Voices (including local Healthwatch organisations) involved in all of our groups and workstreams.

EQUALITY IMPACT ASSESSMENT

JUNE 2014

We commissioned a very early Equality Impact Analysis, which set out a number of considerations for the programme and the CCGs. These are being taken forward at local level and monitored via an Equalities Steering Group.

DELIBERATIVE EVENTS

JUNE 2014

Over 100 stakeholders, patients and the public involved in two deliberative events to explore our case for change, draft strategy, and the areas of focus.

MARKET RESEARCH

JULY AND AUGUST 2014

2987 people interviewed.
Market research telephone interviews and focus groups. These were used to get a better understanding of the views of local people, particularly those with protected characteristics, on the priority areas being looked at.

IN-DEPTH CASE STUDIES

NOVEMBER & DECEMBER 2014

6 in-depth case studies with individuals to explore what our planned models might mean for patients.

WORKSHOPS & DROP-IN SESSIONS

NOVEMBER & DECEMBER 2014

59 people involved through workshops and drop-in sessions at local community venues to find out about different experiences of care. These provided rich insights to support the work of our Clinical Leadership Groups.

FEEDBACK

NOVEMBER 2014

You Said, We Did feedback report published.

WORKSHOPS

DECEMBER 2014

60 participants in Implementing the Whole System Model at a Local Level workshop, including clinicians, stakeholders, partners and patient voices from across south east London.

WORKSHOPS

DECEMBER 2014 & FEBRUARY 2015

110 participants in four workshops, held with the aim of listening to people's experiences and thoughts about current services; and to gather feedback to be fed into the further development of the strategy.

ISSUES PAPER

MARCH 2015

Issues Paper published online.

PATIENT CASE STUDIES

MARCH & APRIL 2015

Patient case studies and future journeys developed and tested with local people.

MENTAL HEALTH STRATEGY WORKSHOP

MAY 2015

30 health and care professionals from across secondary and primary care and the third sector, commissioners and patient and public voices attended a mental health strategy workshop to draw in thinking from across southeast London about opportunities and challenges in mental health.

CARE SUMMIT

JUNE 2015

90 clinical and professional staff and patient and public voices attended a Care Summit to review our strategy and proposed models of care, outlined in this paper.

STRONG & CONFIDENT COMMUNITIES CONFERENCE

JUNE 2015

Over 80 health and care staff, GPs, community and patient representatives and patients attended a conference on strong and confident communities to explore how we support the development of a strong and confident south east London.

EQUALITY ANALYSIS

JUNE TO AUGUST 2015

We commissioned an updated Equalities Analysis, looking at potential impacts on groups protected by the Equality Act 2010 of the sorts of changes outlines in our Issues Paper. This report and an action plan will be published in October and will be a key reference point as we develop our proposals for specific sites and services.

ISSUES PAPER ENGAGEMENT

JUNE TO AUGUST 2015

Over 200 events, stalls, roadshows, articles and other activities.
Local engagement through CCGs on the Issues Paper, via local voluntary and community sector organisations, information stalls, newsletters, discussions at local meetings and representation at partner events.

ISSUES PAPER DISTRIBUTION

JUNE TO PRESENT

Distribution of our Issues Paper to over 900 locations.
Our Issues Paper, including a summary version, was distributed to GP surgeries, hospitals, pharmacies, libraries, council buildings, children centres, nursing homes and other locations across south east London to encourage people to let us know their views about our strategy.

WORKFORCE EVENT

JULY 2015

Over 40 people, including community and local education providers, stakeholders and service users attended a community-based care workforce workshop, exploring the potential impacts of the strategy on the wider health and care workforce, and beginning work on how to meet the challenges.

DELIBERATIVE EVENTS

JULY 2015

441 people involved in six deliberative events focussed on the Issues Paper. A representative sample of people from each borough explored the challenges the health service is facing locally; why things need to change; and giving us feedback on our current thinking.

ENGAGEMENT EVENT

JUNE TO AUGUST 2015

Over 30 patient and voluntary sector stakeholders attended an 'option appraisal criteria' (decision-making process) development engagement event. Plans for the option appraisal were shared, and participants explored what principles or values should guide the decision-making (the evaluation criteria); what evidence and information should be used to assess how each option meets these criteria; how decisions will be made; and by whom.

REPORT PUBLISHED

JULY 2015

You said, We did feedback report published.

Measuring the impact of the strategy

The main aim of the strategy is to find ways to improve health and care outcomes for people in south east London, so it's important that we clearly determine how to measure its success. We want to reduce the variability we see today, so that people get a more consistent and high quality experience wherever they access services, and improve the overall health and care outcomes for people across south east London.

By working closely with our partners, such as health and care providers, clinicians, patients, members of the public and colleagues in public health, we have set out a framework to monitor the impact of the strategy, focusing on the achievement of better outcomes for patients.

We are developing a set of indicators to provide the evidence that each outcome has been achieved. There will be a number of these for each outcome. These will be published separately to this document once agreed.

'Domain': high-level classifications of the outcomes	Outcome: how the strategy aims to improve people's health and wellbeing
Population health	Prevent people from dying prematurely and help them live longer and healthier lives
	Reduce differences in life expectancy and healthy life expectancy between communities
Quality of life	People are independent, in control of their health, and able to access personalised care to suit their needs
	Health and care services enable people to live a good quality of life with their long-term condition
Effectiveness of care	Treatment is effective and delivers the best results for patients and service users
	Delivering the right care, at the right place, at the right time along the whole cycle of care
Quality of care	Commitment to people having a positive experience of care
	Caring for people in a safe environment and protecting them from avoidable harm

Supporting strategies

Three supporting strategies are being developed to enable the implementation of our strategy.

Infrastructure and estates

We are working to get a full picture of the capacity of NHS buildings, land, estates and facilities across south east London so that we can fully use, change or develop these in the most appropriate way to meet the needs of local people.

This supporting strategy ties in with work being done at a London-wide level by 'Our Healthy London Partnership – Estates Programme', led by London CCGs and NHS England.

Workforce

The *Better Health for London* report, published by the independent London Health Commission, the NHS Five Year Forward View and Our Healthier South East London have all identified the need to focus on developing our workforce to support the delivery of innovative new models of care.

This supporting strategy will help us understand what skills our workforce will need and how differently staff may need to work in the future. This will include new ways of working (for example, flexibility, rotations, different staff groups doing different tasks to today) and different working locations (for example, more staff working in the community).

Work is underway with our partners to understand the make-up of the existing workforce and to define how a future workforce would look and how it might work.

Information management and technology

Using information technology (IT) better can support staff to work in new ways, empower patients to be active participants in their care and, importantly, improve safety and increase quality.

For the success of Our Healthier South East London, it is critical that healthcare IT systems work together within and across organisational boundaries.

There are a number of national and local initiatives in place and each CCG has its own information management and technology strategy and implementation plans, which have been reviewed and initially assessed.

Our work so far shows that progress in primary (GP and community-based care) and secondary (hospital) care is being planned and implemented at various speeds. All CCGs are already moving to IT systems that will enable appropriate sharing of records across GP practices and have plans in place that are in line with key national and London regional guidance.

Case Studies

Here are some examples of innovative new healthcare models in the community that are already making a difference.

Co-ordinated Care – Greenwich

One of 14 schemes named as 'pioneers' by the Government in the development of integrated health and social care, Greenwich Coordinated Care is helping to share best practice among health and social care colleagues nationally. It has won recognition and praise from within the care and health sectors, from Government ministers and from healthcare experts.

It aims to give people time and support to regain their independence, wherever possible, and is helping the elderly population maintain their independence longer. Thanks to the scheme, fewer people require on-going support once care and treatment is complete; there are fewer delayed discharges and reduced length of stay in hospital or care settings; and it has helped reduce A&E attendances and emergency admissions.

Help with medicines – Lewisham

From national evidence we know that 30-50% of patients with long term conditions fail to take their medicines as recommended. However, patients want to stay as independent as possible and still remain in control of their medicines.

The Lewisham Integrated Medicines Optimisation Service (LIMOS), introduced in 2014, works across health and social care to support housebound patients at the highest risk of medicine-related problems, and find it hard to get the support they need to manage their medicines effectively.

The service, which is an example of pharmacy services supporting care for patients with long term conditions, is helping patients to manage their own medicines, get better outcomes from their treatment and remain as independent as possible.

Improving access to GP services – Southwark

Southwark was one of the 20 successful Prime Minister's Challenge Fund sites nationally to pilot new models for accessing primary care services.

Engagement with Southwark residents showed that sometimes they find it difficult to get an appointment with a GP or practice nurse and find the health system hard to navigate. In response, over £2 million has been invested in developing the Extended Primary Care Service, which aims to make it easier for people to see or speak to a GP or nurse. Additional appointments are available from two sites across the borough, which operate 8am – 8pm, seven days a week. Patients access the service by calling their usual GP practice or the GP out-of-hours service. A doctor or nurse will assess them over the telephone and provide advice, refer to another service or book an appointment at the Extended Primary Care Service. With patient consent, doctors and nurses can access their healthcare record to ensure they can offer the right treatment.

The service is being delivered by local groups of practices working together in GP federations and so far over 14,000 appointments have been delivered. This is a new way of working and a full evaluation will be completed at the end of the first year to assess the local impact. Patients have welcomed the service, with 95% of those who have used it saying they would be extremely likely or likely to recommend it to friends and family.

Empowering people with diabetes – Lambeth

Previously ranked 19th in London, Lambeth is now ninth on blood glucose control for their diabetic patients. The significant improvement is thanks to schemes like the Diabetes Modernisation Initiative. This project supports community-based interventions for people living with diabetes, such as telephone and email support from diabetes specialist nurses, in-practice and virtual diabetes clinics and patient education and self-management support. As a result, GP initiated referrals to hospital continue to decline and there has been a sharp fall in emergency admissions for diabetes in the under 65s.

The initiative has proved popular with patients and work is underway to build on community-based diabetes care through a review of blood glucose monitoring and improved insulin initiation in Lambeth GP practices. The work of the Diabetes Modernisation Initiative was also recognised at the annual Care Quality Awards in 2014.

Patient centred end of life care – Bromley

St Christopher's Bromley Care Coordination Service is rising to the challenge of making sure patients can spend their final days in the place of their choice, which is usually at home.

They will formulate care plans for patients and help support family members and carers in the community, so they can make decisions that reflect patients' preferences. They will also engage with other community services to ensure that patients benefit from a wide range of services and specialties spanning heart failure, dementia, respiratory disease, personal care services and palliative care.

Users of the service have given it high praise and it recently won a Hospice UK Innovation award.

Joined up care for frail elderly people – Bexley

Health and social care professionals from a range of disciplines have come together in Bexley to improve the way care is planned for older people with complex health needs. Multi-disciplinary teams meet to discuss patients they are most concerned about who could be at risk of being admitted to hospital or a care home. Co-ordinated care plans are created that involve a range of relevant local health and social care services and better management of patient medicines. This approach opens up communication channels between the professionals and services needed to give patients care that improves their overall health and wellbeing.

This way of working is supporting more people to stay healthy at home by reducing admissions and cutting down the length of time people need to stay in hospital if they are admitted.

Next steps

We have outlined a number of ideas that will help us prevent people becoming so unwell that they need hospital care, to intervene earlier when people need help, and to increase services and support in the community.

Option appraisal

For each of our ideas, there may be different options for how these changes could happen. These options will need to undergo an appraisal process to identify which ones offer the best way (or ways) to deliver the strategy and realise its full benefits.

Option appraisal is crucial to ensure that any potential changes are based on robust evidence. It is also essential in ensuring that changes are assessed carefully against things that are most important to people.

The purpose is to filter potential options in order to identify those that offer the most efficient and effective delivery of the strategy. To do this effectively we are working with our partners, including patients, clinicians and members of the public, to establish criteria which they will be measured against. An event with stakeholders, including patient representatives and members of the public, was held in July 2015 to help develop these discussions.

Development of outcomes and indicators

We also need to refine and agree the indicators that will be used to measure the success of the strategy and continue the development of the supporting strategies.

We would like you to get more involved

We will continue to seek and listen to comments and ideas from people on the direction of the strategy and invite you to tell us your opinions on the ideas that have been put forward in this document and the Issues Paper, first published in March 2015.

You can find out more on our website www.ourhealthiersel.nhs.uk

If you have questions, comments or observations on this discussion paper, please email ourhealthiersel@nhs.net

If you want to keep in touch with our plans as they develop, please email your details to the above address or write to us at:

Our Healthier South East London, 160 Tooley Street, London SE1 2HZ.

Alternatively, you can also fill out a contact form on our website.

To request this document in other formats or languages, or for more information, email ourhealthiersel@nhs.net

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