Open Agenda

Southwark Council

Healthy Communities Scrutiny Sub-Committee

Wednesday 7 October 2015
7.00 pm
Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Rebecca Lury (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Jasmine Ali
Councillor Paul Fleming
Councillor Lucas Green
Councillor Maria Linforth-Hall
Councillor Bill Williams

Reserves

Councillor Maisie Anderson
Councillor Helen Dennis
Councillor Jon Hartley
Councillor Eliza Mann
Councillor Johnson Situ

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Contact
Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 29 September 2015

Southwark Council

Healthy Communities Scrutiny Sub-Committee

Wednesday 7 October 2015
7.00 pm
Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
4.	**MINUTES** To approve as a correct record the Minutes of the open section of the meeting held on 7 July 2015	1 - 3
5.	**'OUR HEALTHIER SOUTH EAST LONDON': UPDATE FROM CLINICAL COMMISSIONING GROUP (CCG) & SOUTH EAST LONDON PROGRAMME** Andrew Bland, Chief Officer, Southwark CCG & Mark Easton Programme Director for 'Our Healthier South East London' (OHSEL) will present the attached. There will also be a discussion on the forming of a Joint Health Overview and Scrutiny Committee (JHOSC) across South East London.	4 - 57
6.	**REVIEW 2: CARE IN OUR COMMUNITY**	

Item No.	Title	Page No.

This is the first meeting of the review into Care in the Community

- How are we delivering on the Care Home Improvement Strategy?
- How are we delivering on the Southwark Ethical Care Charter?
- What is our approach to Home care and reablement?
- What further things should we be doing as a Council to support care in our community?

There will be a presentation by the :

- CQC
- Cabinet member – with council and CCG officers
- Age Concern Lay inspectors

Papers from the CQC to follow.

7. REVIEW 1: PERSONALISATION REVIEW 58 - 63

The draft report is attached.

8. WORK-PLAN 64 - 67

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 29th September 2015

Healthy Communities Scrutiny Sub-Committee

MINUTES of the OPEN section of the Healthy Communities Scrutiny Sub-Committee held on Tuesday 7 July 2015 at 7.00 pm at Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Jasmine Ali
Councillor Paul Fleming
Councillor Lucas Green
Councillor Maria Linforth-Hall
Councillor Bill Williams

OTHER MEMBERS PRESENT: Councillor Stephanie Cryan, Cabinet Member for Adult Care

OFFICER SUPPORT: Julie Timbrell, Scrutiny Project Manager
Jay Stickland , Director of Adult Social Care
Aarti Gandesha, Healthwatch Southwark Manager

1. APOLOGIES

1.1 There were no apologies for absence.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were no urgent items of business.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. PERSONALISATION REVIEW: MAKING SOUTHWARK PERSONAL

4.1 The chair introduced the review

VIDEO - OPENING, INTRODUCTIONS & PERSONALISATION REVIEW

https://www.youtube.com/watch?v=5j9XCS1smdU&index=1&list=PL_maFEOk7e9hIhNk1BMLC7Sb_iVK7iEAe

5. PERSONALISATION REVIEW - EVIDENCE FROM CAS

5.1 The paper was noted.

6. PERSONALISATION - EVIDENCE FROM HEALTHWATCH

6.1 Aarti Gandesha, Healthwatch Southwark Manager, presented the circulated paper and the committee posed a number of questions – please see the video.

VIDEO - PERSONALISATION, AARTI GANDESHA, HEALTHWATCH SOUTHWARK

https://www.youtube.com/watch?v=he58moD8e50&index=2&list=PL_maFEOk7e9hIhNk1BMLC7Sb_iVK7iEAe

7. PERSONALISATION - GOOD PRACTICE FROM LONDON BOROUGH OF RICHMOND UPON THAMES.

7.1 Councillor David Noakes, who works in Richmond, presented good practice from that borough, with reference to the circulated documentation.

The vice chair then tabled some draft recommendations for the review.

RESOLVED

The committee agree to take into account the draft recommendations tabled by vice chair, Councillor David Noakes. The chair, Councillor Rebecca Lury, will draft the final report, ready for the next meeting, and circulate in advance for comments.

VIDEO - EVIDENCE FROM LONDON BOROUGH OF RICHMOND

https://www.youtube.com/watch?v=Tm08M2rPOgc&list=PL_maFEOk7e9hIhNk1BMLC7Sb_iVK7iEAe&index=4

8. PERSONALISATION - CABINET LEAD

8.1 Councillor Stephanie Cryan, Cabinet Member for Adult Care and Financial Inclusion presented with the Director and the committee posed a number of questions – please see video link.

9. PERSONALISATION - OFFICER REPORT & PRESENTATION

9.1 The Director presented the report, with the cabinet member, and the committee posed a number of questions – please see video.

10. WORK-PLAN

10.1 The committee discussed the circulated work-plan.

RESOLVED

The work-plan was agreed.

VIDEO - WORKPLAN

https://www.youtube.com/watch?v=mtGvpcPk2Hw&list=PL_maFEOk7e9hIhNk1BMLC7Sb_iVK7iEAe&index=3

CHAIR:

DATED:

Agenda Item 5

Our Healthier
South East London
Improving health and care together

NHS

Dear colleagues,

We have previously updated you on *Our Healthier South East London,* which is the five year strategy to improve health and integrated care across south east London. The programme is led by the six NHS Clinical Commissioning Groups (CCGs) in the region, including NHS Southwark CCG, with commissioners from NHS England (London), working in close partnership with local authorities, local providers of care and other partners.

There have been a number of developments in the programme recently, including publication of an 'Issues Paper' for local residents and stakeholders and the publication of an updated version of our draft strategy, which we are calling the 'Consolidated Strategy'. Attached is an update on the progress of the programme, which we hope you'll find useful.

We continue to seek views on the challenges facing the NHS in south east London, explored in detail in *Help us improve your local NHS: Issues Paper*, published earlier this year.

We are publishing a follow up to this paper – *Help us improve your local NHS: Emerging strategy* – to describe the new models of care that have emerged from the programme's six clinical leadership groups. This will be published before the end of September.

If you haven't read the Issues Paper then you can do so by visiting the programme website www.ourhealthiersel.nhs.uk, where you can also read the programme's Consolidated Strategy, which outlines the case for change and new models of care in greatest detail.

We would be very pleased to hear your views on how the strategy, which remains a draft at this stage, is developing or your response to any of the questions we pose in the Issues Paper.

Given the current stage of the programme, we are talking to local authorities about the potential for establishing a joint overview and scrutiny function for south east London and look forward to updating you on that in due course.

If you have any questions about the attached update, or anything else relating to the programme please email ourhealthiersel@nhs.net

Kind regards

Andrew Bland

Chief Officer – NHS Southwark CCG

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

Our Healthier South East London
Improving health and care together

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Our Healthier South East London: update
August 2015

This paper sets out the progress to date of the *Our Healthier South East London* programme, which is led by the six south east London CCGs – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – and NHS England. The programme aims to develop a commissioning strategy to ensure improved, safe and sustainable services across the six boroughs.

1. The case for change and our vision

We published the Case for Change in February 2014. It sets out how the six CCGs and NHS England are working together to address challenges around quality of care, finance and workforce. Commissioners recognise that while some issues can and should be addressed at local borough level by the CCG and its partners, others cross borough boundaries and require a joint response.
We have a shared understanding of the challenges facing south east London. These are outlined in our Case for Change.

Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well

Our collective vision
In south east London we spend £4 billion in the NHS. Over the next five years, commissioners aim to achieve much better outcomes than are achieved now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste

2. Progress of the strategy

Our programme has been built around engagement with stakeholders and the public, with strong involvement of local provider Trusts, local authorities, public and patient voices and the general public (see section 3 below). We have been talking to local people and stakeholders at every stage of the programme and we have taken their feedback into account as our strategy has developed.

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A draft strategy was published in June 2014 and in June 2015, we published an updated version, which we are calling the **Consolidated Strategy**. It will be signed off by commissioners by the end of August. The strategy sets out models of care across all of our clinical workstreams:

- Community-based care
- Urgent and emergency care
- Maternity
- Children's services
- Planned care
- Cancer

These new models of care have been developed by local clinicians, working with senior NHS project managers and public and patient voices. They suggest a number of interventions to improve health outcomes for people in south east London.

Our strategy envisages a transformation in the way care is delivered, with much more care taking place in community settings while hospitals provide specialist care for those who really need it. Community-based care delivered by Local Care Networks in each borough is the foundation of the integrated whole system model that has been developed for south east London (see attached diagram).

While the models of care are far-reaching, we have not at this stage developed any proposals for specific hospital sites. The extent to which services might change at particular sites is being examined over the autumn, after which the potential options will be clearer. Should proposals emerge for major service change, we would formally consult local people on these.

For most interventions, implementation planning can commence immediately. However, there are areas where the impact of the strategy needs further consideration because there is more than one option for delivery, and it could result in significant service change. These interventions will have to undergo a robust options appraisal process.

This option appraisal process aims to identify the best way, or way(s), of delivering the overarching strategy and realising its full benefits. It filters the many potential options for how the interventions can be implemented, and is designed to identify options that are recommended for further work, and, if appropriate, for formal consultation.

Will there be a consultation?
We are currently looking at the likely impact of the strategy in some detail, with a view to considering what changes we need to make in each area to implement it successfully.

Most of the recommendations set out in the strategy can move straight away to detailed design and implementation and some changes are already underway and do not require public consultation. These are mostly community-based care initiatives, designed to deliver more care in the community, which our engagement suggests have widespread clinical, stakeholder and public support.

For services based in acute hospitals, our strategy is for all our hospitals to meet the London Quality Standards, a series of quality and safety standards designed by clinicians working with patients and the public. All 32 London CCGs have signed up to these standards and are working towards them.

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We are currently carrying out an analysis of where each of our acute hospitals in south east London is in relation to these standards, so that we can determine what the next steps should be. This analysis will form part of the assessment to determine if we need to go through an options appraisal process.

We expect the analysis to be complete by early September.

If an options appraisal process led to proposals for the reconfiguration of hospital services, and major service change, public consultation would be required.

3. Impact of the strategy

We have analysed the likely impact of the strategy, though further analysis will be needed once we have a clearer idea of what may be proposed for specific sites.

The NHS in south east London currently spends £4 billion in total across commissioners and providers and has 4,166 acute hospital beds. Over the five years of the strategy, the available money will grow by £800 million to £4.8 billion. However, if we do nothing, the spend will grow in total by £1.1 billion to £5.9 billion.

The requirement for acute hospital beds will grow because the demand for health services is increasing; people are living longer but many with long term conditions such as diabetes, high blood pressure and mental illnesses. 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 the population we serve. This is because:

- The care models are focused on prevention and early intervention and keeping people healthy and therefore keeping people out of hospital
- Community Based Care is the foundation of the whole system and is intended to keep people closer to home, treating them in the community and enabling people to only visit hospital when they really need to
- Care pathways and professionals will be more integrated
- Productivity is expected to increase and providers will continue to deliver efficiency savings (eg through improved procurement, combined support services, improved rostering of staff) which will help to close the gap
- Our aim will be for bed occupancy to meet the national guidance (which is not the case now) which will improve safety, quality and efficiency
- **Our current modelling therefore shows that at the end of the five years, we shall need about the same number of hospital beds as now - but some of them will be used differently (more day case, fewer inpatient beds; shorter lengths of stay…)**
- This is therefore 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
- 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 current time horizon of the next five years.

4. Engagement

We are committed to involving stakeholders and the public in helping us to develop the strategy. This is reflected in our approach to date and in the programme's governance.

We have held a number of independently facilitated events:

- Two deliberative events in July 2014
- An event in each borough in November/December 2014
- An event for members of patient reference groups to discuss how the programme may make decisions (our draft options appraisal methodology
- An event in each borough in June 2015, for voluntary and community sector stakeholders (30%) and members of the public selected by random sampling to broadly represent their local communities (70%).

These events discussed the emerging case for change and the emerging ideas set out in the draft strategy. Feedback was collated and responded to in 'You Said We Did' reports produced by the programme, available on the programme website www.ourhealthiersel.nhs.uk

Issues Paper
In May 2015, we published an **Issues Paper**, summarising the case for change and the ideas set out in the strategy, together with some questions for local people and stakeholders to respond to. This has been widely distributed across south east London. The publication of Issues Papers is regarded as emerging best practice for programmes considering major service change. **We strongly recommend that all our stakeholders read and respond to the Issues Paper.**

Direct involvement of public and patient voices
Public and patient voices have been represented on all of our Clinical leadership Groups, which make recommendations about our six clinical workstreams - community-based care, urgent and emergency care, maternity, children' services, planned care and cancer. We also have a **Public and Patient Advisory Group (PPAG),**, which meets every six weeks to advise the programme on public engagement.

Equalities
An early, independent Equalities Impact Assessment was carried out in the summer of 2014 and a further Equalities Analysis was carried out in the summer of 2015. This will be published shortly on the programme website.

5. Governance and decision-making

Provider Trusts, local authorities and the public are all embedded in the programme's structures:

- They are represented on our **Clinical Leadership Groups**, which have recommended the new models of care. We also have a **Partnership Group**, drawn from CCGs, patients, local authorities, provider trusts and other stakeholder organisations, which meets on a monthly basis to discuss and feed back on key developments in the programme.
- Our **Clinical Executive Group** includes Medical Directors from local provider Trusts and NHS England and local authority and PPAG representatives.
- Both of these groups report to our **Clinical Commissioning Board**, drawn from the leadership of the local CCGs, which makes recommendations for CCGs governing bodies to consider.

In addition, CCGs have regularly updated **Health and Wellbeing Boards,** discussing the strategy with them at each key milestone.

Ultimately decision-making as to how services are commissioned rests with the Governing Bodies of the six CCGs and NHS England. Earlier this year, the six CCGs agreed that local decision-making would be taken through a **Committee in common** of the six CCGs, with each CCG nominating three representatives to this joint committee.

A full governance chart is attached.

Scrutiny
Up until now, CCGs have reported to their local Overview and Scrutiny Committees as part of business as usual arrangements. However, with the publication of the Consolidated Strategy and Issues Paper, we believe there is now a case for the establishment of a **Joint Overview and Scrutiny Committee** for south east London and we have raised this with local authorities. Our suggestion would be to have a first meeting of a Joint Overview and Scrutiny Committee before the completion of our options appraisal process.

6. Next steps

- We will continue to plan and implement most of the strategy: taking forward the new models of care and interventions that do not need public consultation. We will work with our partners in secondary, primary and community care, mental health trusts and with local authorities to do so.
- By September, we expect to know whether an options appraisal process will be required for some of the care model initiatives. If consultation is needed, we expect it to take place from July-September 2016, with preferred options agreed by December 2016.
- We will shortly publish a summary of the draft models of care and further thinking as a follow-up to the Issues Paper. This will summarise our very latest thinking, as set out the consolidated strategy.

How stakeholders and local people can help

- Respond to our Issues Paper at http://www.ourhealthiersel.nhs.uk/about-us/issues-paper.htm or by writing to Our Healthier South East London, 160 Tooley Street, London SE1 2TZ.
- Invite your local CCG and the programme team to a meeting to brief colleagues or to run a roadshow on your premises for your staff.
- Share this briefing and our Issues Paper with colleagues and stakeholders.

Staying in touch
You can email the programme team at SOUCCG.SELstrategy@nhs.net or follow @ourhealthiersel on Twitter.

Attached for your reference is a diagram of the programme's Whole System Model and a summary programme timeline.

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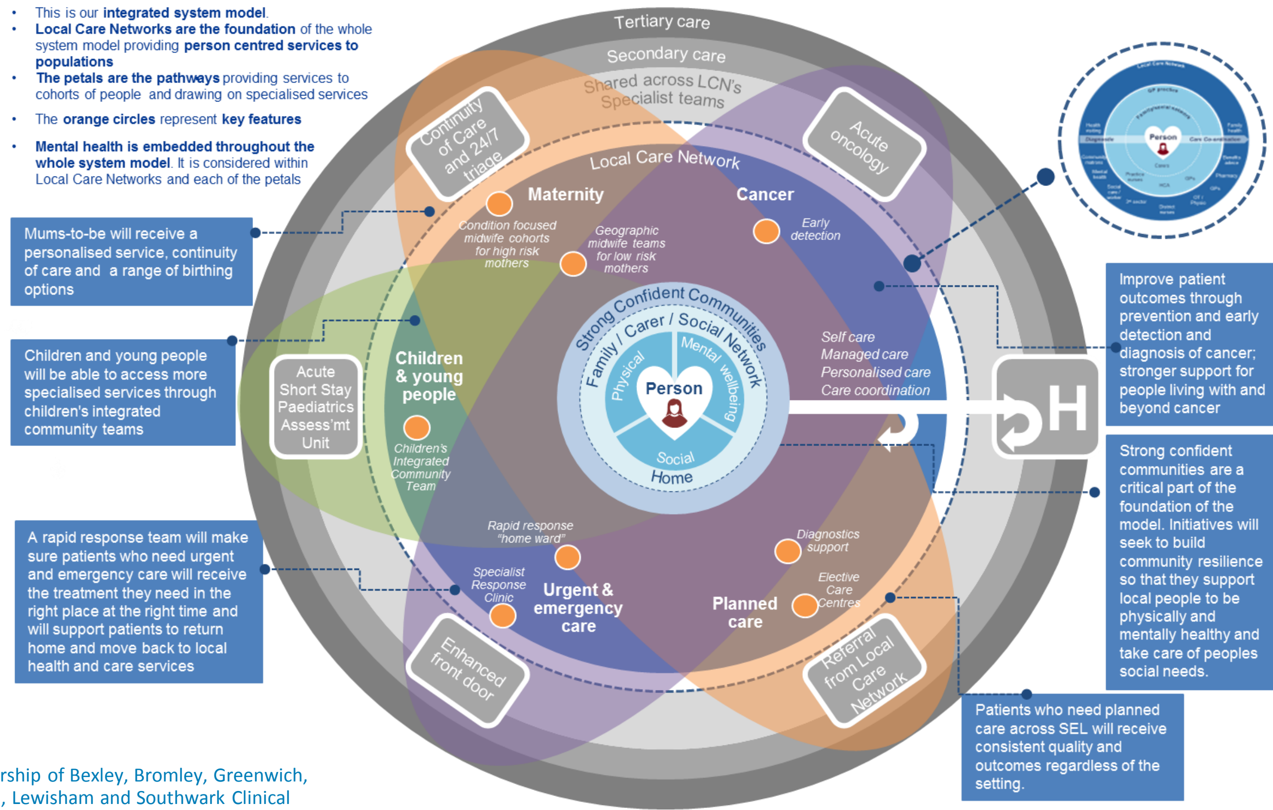
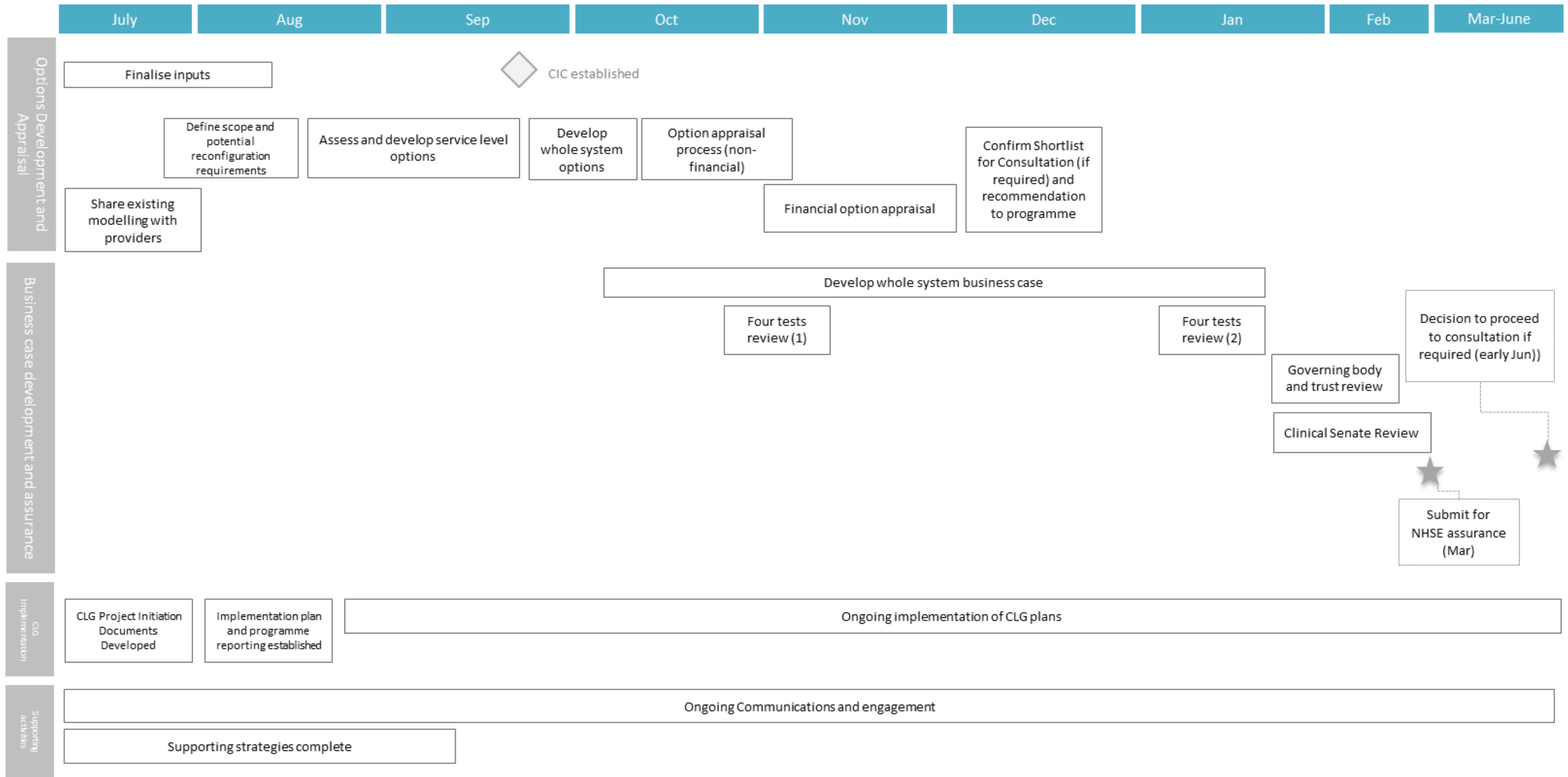
Our integrated whole system model

Community Based Care delivered by Local Care Networks is the foundation of the integrated whole system model that has been developed for south east London. This diagram provides an overview of the whole system model, incorporating initiatives from all 6 Clinical Leadership Groups.

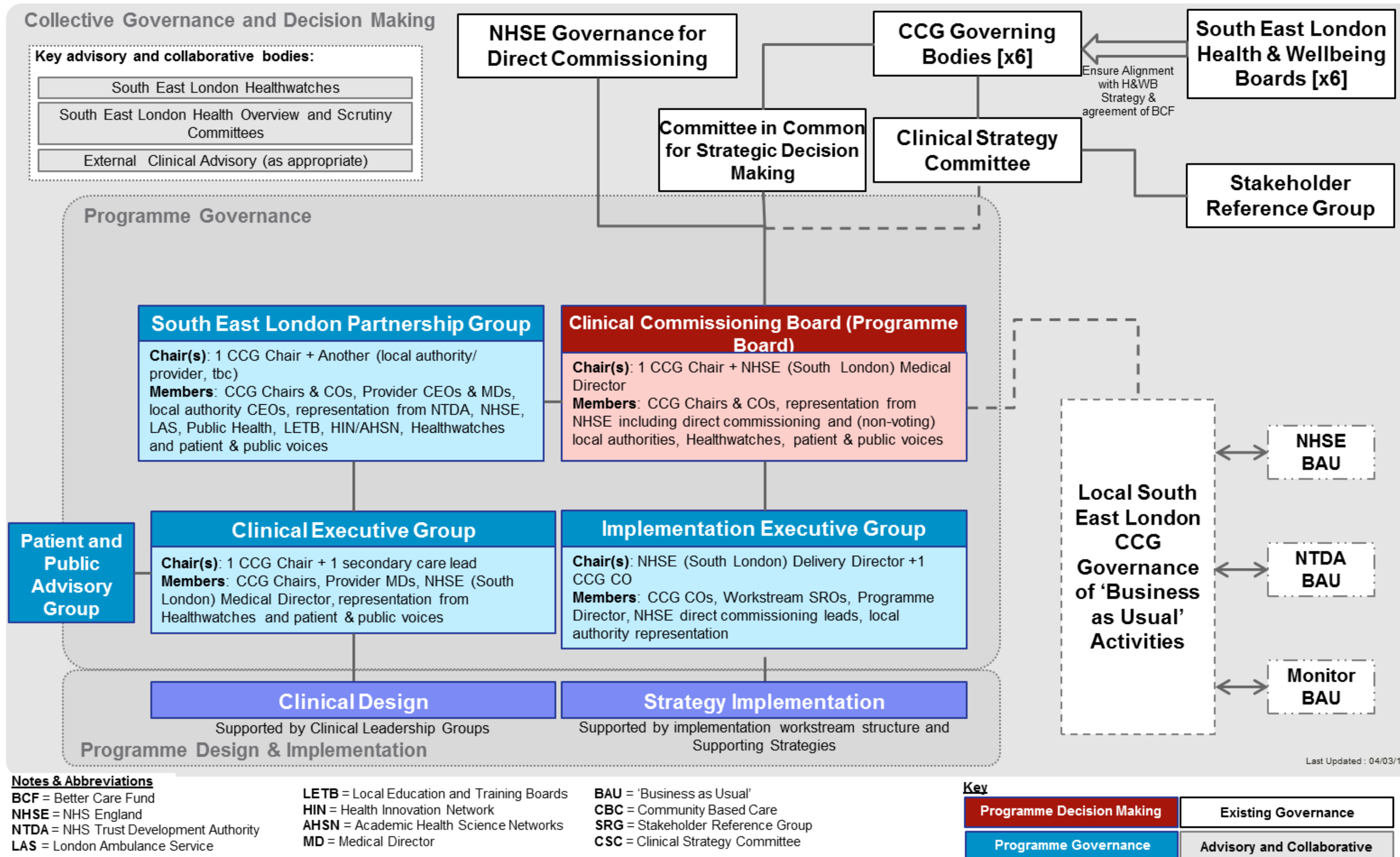


A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Timeline



Governance



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Programme update

September 2015

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

Why are we developing the strategy?

We have a shared understanding of the challenges facing south east London. These are outlined in our **Case for Change**.

Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well

NHS

What are we trying to achieve?

Our collective vision for the south east London:

In south east London we spend £4 billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste

Our Healthier South East London
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Our integrated whole system model

Community Based Care delivered by Local Care Networks is the foundation of the integrated whole system model that has been developed for south east London. This diagram provides an overview of the whole system model, incorporating initiatives from all 6 Clinical Leadership Groups.

- This is our **integrated system model**.
- **Local Care Networks are the foundation** of the whole system model providing **person centred services to populations**
- **The petals are the pathways** providing services to cohorts of people and drawing on specialised services
- The **orange circles** represent **key features**
- **Mental health is embedded throughout the whole system model**. It is considered within Local Care Networks and each of the petals

Mums-to-be will receive a personalised service, continuity of care and a range of birthing options

Children and young people will be able to access more specialised services through children's integrated community teams

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services

Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer

Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

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

Progress to date

- **Case for change** published Feb 2015
- **6 Clinical leadership Groups:** Community-based care, Urgent and emergency care, Maternity, Children's services, Planned care and Cancer. Mental Health is an over-arching theme for all 6
- **Governance** : CCGs are decision-makers; Clinical Commissioning Board, Partnership Group, Clinical Executive Group
- **Public and Patient Advisory Group (PPAG) and patient and public voices on each CLG**
- **Draft 5 year Strategy** published June 2014
- **Strong emphasis on community-based care:** Local Care Networks in each borough as the foundation of the integrated whole system model
- **Consolidated Strategy** published in July after CCG Governing Bodies approved the direction of travel.
- **Options appraisal process** under development and informed by engagement event on 6th July.
- **Communications and engagement:** A range of local and south-east London wide events have taken place. The plan for the next phase is being revised to take account of the proposed timetable
- **Issues Paper** published in May; further paper in September sharing models of care – responses to both welcome

Strategy impact analysis (finance and activity): Key messages

- The NHS in south east London currently spends £4 billion in total across commissioners and providers and has 4,166 acute hospital beds. Over the five years of the strategy , the available money will grow by £8oo million to £4.8 billion
- But the spend will grow in total by £1.1 billion to £5.9 billion, if we do nothing
- The requirement for acute beds will grow because the demand for health services is increasing ; people are living longer but many with long term conditions such as diabetes, 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 the population we serve. This is because,
  - The care models are focused on prevention and early intervention and keeping people healthy and therefore keeping people out of hospital
  - Community Based Care is the foundation of the whole system and is intended to keep people closer to home, treating them in the community and enabling people to only visit hospital when they really need to
  - Pathways and professionals will be more integrated
  - Productivity is expected to increase and providers will continue to deliver efficiency savings (eg through improved procurement, combined support services, improved rostering of staff) which will help to close the gap
  - The plan will be for bed occupancy to meet the national guidance (which is not the case now) which will improve safety, quality and efficiency
- Our current modelling therefore shows that at the end of the five years, we shall need about the same number of beds as now
- But some of them will be used differently (more day case, fewer inpatient beds; shorter lengths of stay…)
- This is therefore 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
- 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 current time horizon of the next five years.

Potential scope for option appraisal

Four areas have been identified which potentially require an option appraisal process:

- **Urgent and Emergency Care** (requirement to meet the London Quality Standards and 7 Day Standards)
- **Maternity services** (requirement to meet the London Quality Standards)
- **Children and Young People's services** (impact of implementing a Short Stay Paediatric Assessment Unit and the requirement to meet the London Quality Standards)
- **Planned Care** (implementing elective care centre(s)

During August a process was undertaken to define the scope and make recommendations for how to proceed

Achievement against the London Quality Standards

- Overall for south east London, a large number of standards are being met or are expected to be met within trusts existing plans
- No single site is meeting all the LQS or 7 Day Standards
- A number of key standards such as consultant presence on site are not currently met by any trust in SEL
- Workforce is the main area where additional investment is required to meet the London Quality Standards in SEL with additional consultant cover and MDT the key cost drivers

Recommendations and next steps

At the meeting on 28 August, the Executive Group of the partnership group considered the scope analysis and adopted the following recommendations:

Urgent and emergency care

The urgent and emergency CLG to establish a group to devise a plan and timeline to establish a trajectory towards LQS across the sector taking into account:

- Workforce considerations
- Financial constraints
- Likely future safety, sustainability and quality issues
- The feasibility of network or collaborative arrangements to help meet the standards in an innovative way

The aim being to devise a plan that demonstrates safety and quality, and a trajectory to LQS. We expect this work to report by the end of October.

Maternity

The maternity CLG to establish a group to devise a plan and timeline to meet LQS across the sector taking into account:

- Workforce considerations
- Financial impact given the possible savings from the strategy
- Likely future safety, sustainability and quality issues
- Whether trusts are likely to meet the standards on their own or whether network or collaborative arrangements would be required

The aim being to determine whether it is possible to meet the standards in a reasonable timescale.

Children and young people

The children and young people CLG to establish a group to devise a plan and timeline to implement the agreed clinical model taking into account:

- Workforce considerations
- Financial impact
- The impact of the strategy on our inpatient units and what changes may need to be made to meet safety, sustainability and quality issues in light of the activity projections

Planned Care (Orthopaedic Centre of Excellence/SWLEOC model)

The planned care CLG to establish a Working Group to develop the feasibility and options to deliver the elective orthopaedic centre of excellence model/SWLEOC.

An orthopaedic centre of excellence brings together revision joints, spinal surgery and complex and co-morbid patients.

The SWLEOC model is about consolidation and high throughput of routine cases.

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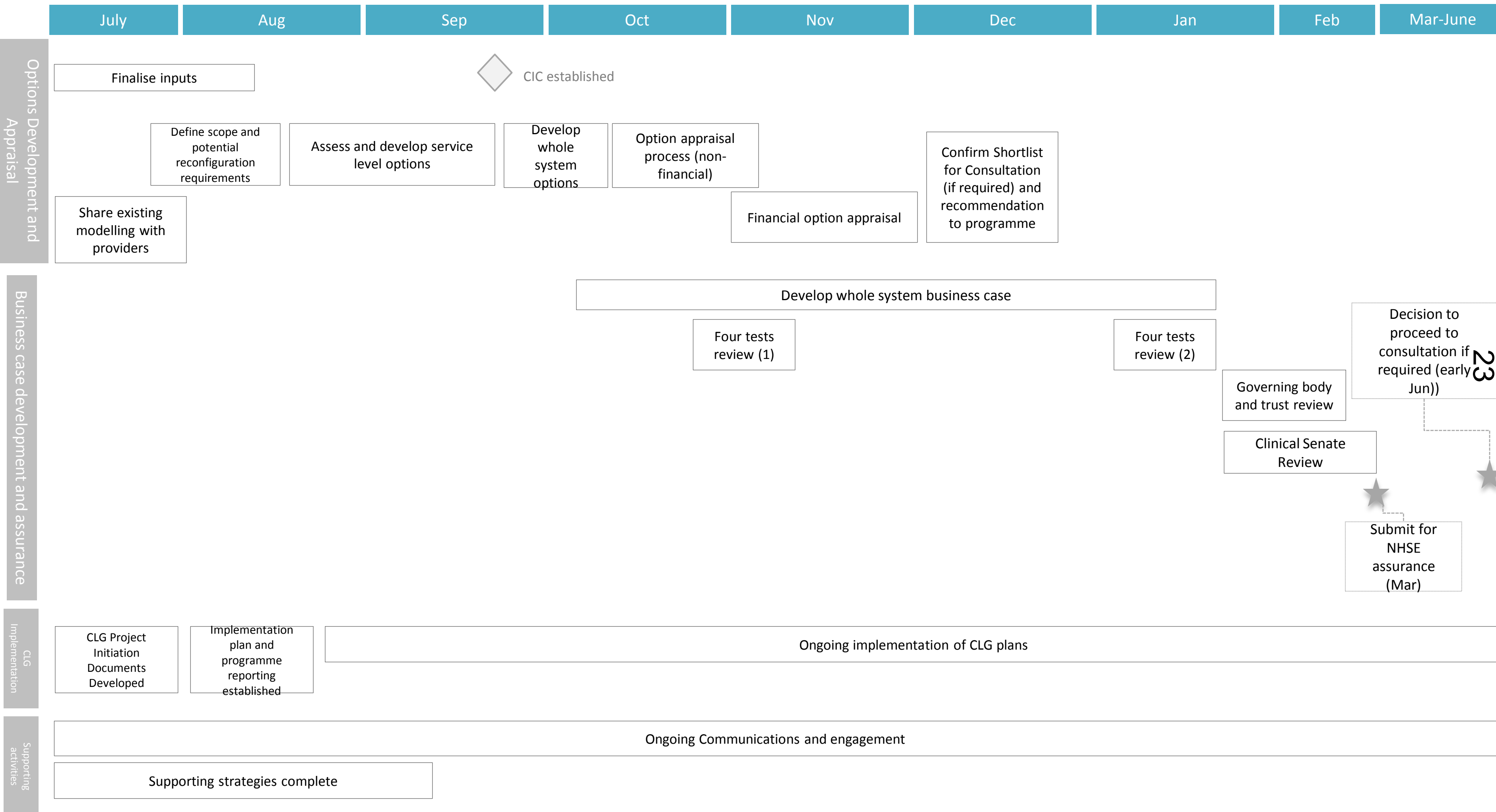
Next steps

- We will continue to plan and implement most of the strategy: taking forward the new models of care and interventions that do not need public consultation. We will work with our partners in secondary, primary and community care, mental health trusts and with local authorities to do so.
- We know where an options appraisal process may be required for some of the care model initiatives. If consultation is needed, we expect it to take place from July-September 2016, with options agreed by December 2016.
- We have published a summary of the draft models of care and further thinking as a follow-up to the Issues Paper. This summarises our very latest thinking, as set out the consolidated strategy.

How stakeholders and local people can help

- Respond to our Issues paper at http://www.ourhealthiersel.nhs.uk/about-us/issues-paper.htm or by writing to Our Healthier South East London, 160 Tooley Street, London SE1 2TZ.
- Invite your local CCG and the programme team to a meeting to brief colleagues or to run a roadshow on your premises for your staff.
- Share this briefing and our Issues paper with colleagues and stakeholders.
- You can email the programme team at SOUCCG.SELstrategy@nhs.net or follow @ourhealthiersel on Twitter.

Summary plan



Our Healthier South East London
Improving health and care together

NHS

Help us improve your local NHS

Issues Paper

This paper sets out a range of issues facing the NHS in south east London. It is not a public consultation document, but shares some of our initial ideas to improve the local NHS. We are encouraging local people to share their thoughts and consider the questions we have set out.

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

What are the challenges? P4
What are we trying to achieve? P16
What changes might be made by the local NHS? P20
How can we best reach you? P35
What happens next and how can you get involved? P35

This paper sets out a range of issues faced by the NHS in south east London. We are developing plans to tackle these issues over the next five years. Some of the improvements can be made locally in each borough; some need us to work together across south east London. This 'Issues Paper' sets out the challenges and some of our initial ideas. We would welcome your views on it.

We have some very good health services in south east London. People are living longer and many people are healthier than ever before. But there are some things we need to improve on. We have some services that people find hard to access. Some people do not get the help they need to keep themselves and their families in good health.

So the six south east London NHS clinical commissioning groups (CCGs) – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – and the health commissioners from NHS England (London) are working together with local councils, hospitals, mental health, primary and community care services, the six borough Healthwatch organisations, local people and patients on a five year plan to improve health and services for everyone. This five year strategy for the local NHS is now called "Our Healthier South East London". We are seeking to address a number of challenges, many of them common across the NHS and some specific to south east London.

This is likely to mean that the way in which some health services are delivered will change, with more care delivered in community settings outside hospital and a greater focus on helping people to stay well, making services more joined up and making sure that everyone gets the care and outcomes they expect from their NHS.

Our thinking is very much in line with the NHS Five Year Forward View, published by NHS England in October, which starts the move towards a different NHS and is covered in section 2 of this paper. We are also fully supportive of the London Health Commission, also covered in section 2 of this paper, and its recommendations to improve the health of Londoners.

This discussion paper sets out some of the challenges we are facing and why we think we need to change things. It is not a public consultation document, but we would welcome your views on the questions we have raised and any feedback you have on our current thinking.

You do not have to respond to all of the questions – and if you have questions or comments you would like to raise, please do so. You can use the contact details on page 35 to respond to this paper. Your feedback will be used to shape our strategy as it continues to develop.

What are the **challenges?**

Context: let's build on what works

Before we set out the challenges, we should be clear that we have some excellent health services in south east London. Many of our services compare favourably to other areas, many of our patients tell us they are very happy with the NHS and overall, improvements in healthcare mean that people are living much longer lives than they used to.

We would like to hear your views about which services are working well currently, and which we can build upon, as well as what needs to change.

The case for change

Too many people live with preventable ill health or die too early

Premature death and differences in life expectancy are both significant issues in south east London. There is a difference in life expectancy between the wards of 11.8 years for women and 11.4 years for men (data for years 2008-2012). Serious mental illness also reduces a person's life expectancy by 15-20 years.

About 11,000 people died prematurely across south east London between 2009 and 2011, with four of our boroughs being classed in the worst category for premature death in England. The biggest causes of early death are heart disease, cancer and respiratory diseases.

While the mortality rates for these illnesses have decreased significantly in our area in recent years, they are still considerably higher than the London average.

To address this problem, we need to improve the health of people who live in south east London. Keeping well is critically important for people of all ages. Although the UK's health delivery system – the NHS and social care services – is widely regarded as among the best in the world, the health of our population is poor and worse than comparable countries.

Difference in life expectancy between the most and least deprived wards

Our poor health is a major factor in generating the demand for care which is putting the NHS and social care under such well-publicised pressure.

The way in which health services are provided today does not take account of changes in the population since the NHS was created. People are living longer than ever before. This is good news; it means that the NHS is successfully treating many more people than ever before. But many more people are also living with long term conditions such as diabetes, high blood pressure and mental illnesses.

The NHS in south east London urgently needs to change the way it delivers services to support its 1.7 million people.

The task we face is well illustrated by the diagram opposite. A major goal of our work is to change the shape of this diagram – we need to support people so that they do not move up the diagram and help them to become healthier, like the 16% at the bottom. We must support the 50% of the population who are affected by inequalities and who are at risk of developing long term conditions due to inequalities or lifestyle factors. The key issues are smoking, excess alcohol and drug use, not enough exercise and obesity, and poor mental health. These problems are the major causes of 'health inequalities' between people in south east London and elsewhere in the UK.

COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

EXHIBIT ES-1. OVERALL RANKING

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

This diagram breaks the population up into five broad groups: people known to be nearing the end of life (1%), people with three or more long term conditions (LTCs, 9%), people in the early stages of a long term condition (25%), people experiencing inequalities at risk of developing long term conditions (50%) and people who are healthy and well. The higher up the 'tree' a group is, the more money is spent on them. Our aim is to help more people to move towards the trunk of the tree, in the healthy and well group.

The diagram is a helpful way for us to think about our communities. It tells us that only about one in six people are healthy and well without being at risk of poor health. Half of all people are at risk of having a long term condition (a disability or an illness like diabetes, a heart condition or a long term mental illness). As people get older, they are often more likely to develop long term conditions.

The NHS usually pays most attention to the people who already have a long term condition, but we want to help everyone to stay as healthy as possible and to be independent, so we have to think about all the parts of the 'tree' on page 7.

In addition, we must further improve the way our services work to reduce the numbers of patients being admitted to hospital. This means we need to address the problems of the people towards the top of the diagram much more effectively. We need to deliver more of their care outside of hospital, in GP surgeries, community health settings and, where appropriate, in people's homes.

We must also focus much more on preventing people becoming ill and needing to be admitted to hospital. We need effective ways to monitor those who live with long term illnesses, giving them and their carers the confidence to live their lives as fully as possible, to look after themselves and know what to do when issues arise.

This means that we need to ensure much closer working between the NHS and the social care services provided by local councils. It also means that the various parts of the NHS – GPs, district nurses, community services, hospitals and mental health services – need to be much more coordinated, with the patient at the centre of any plans and all that the professionals working in health and social care do.

The outcomes from care in our health services vary significantly and high quality care is not available all the time

Too often, the quality of care that patients receive and the outcome of their treatment depend on when and where they access health services. For example, we do not always provide the recommended level of cover by senior doctors in services dealing with emergency care, maternity or children. People taken ill at weekends or in the evenings are less likely to see a senior doctor in hospital. The London Quality Standards, developed by senior clinicians in partnership with patients, have set out minimum safety guidelines which we want all of our hospitals to meet. However, we also need to bear in mind that there is a shortage of senior doctors in some areas, making it difficult to meet these standards across all our hospitals.

We don't always treat people early enough to have the best results

Our services are often not set up to detect problems soon enough, meaning that people with long term conditions or mental illness often have to be admitted to hospital in crisis. Earlier diagnosis and support could have helped them to get better sooner or prevented their illness becoming so serious.

In this respect, we are not putting enough emphasis or resources into services based in the community, to prevent people becoming ill or encourage them to take responsibilities in managing their own health. This is why some clinicians feel we have become an 'illness service' rather than a health service, as we too often treat illness rather than preventing it.

People's experience of care is very variable and can be much better

While patients are very happy with some services, surveys tell us that their experience of the NHS is inconsistent and that they do not always receive the care they want. Patient satisfaction in south east London is generally low compared to national benchmarks. Four of our boroughs scored in the bottom 25% for patient satisfaction in hospital care and three of four trusts were in the bottom 25% for the 'Friends and Family Test', which tests whether patients would recommend the trust to friends and family.

This does not mean that it is all doom and gloom: many patients express satisfaction with NHS services and highlight excellent care. The issue is that patient experience of care is too variable. We need to provide consistent, high quality services for everyone in south east London.

Examples of the problems that patients have raised with us are:

- Some patients find it difficult to get a GP appointment.
- Many people feel that they have not been told or do not have enough information about their condition.
- Too often, planned operations are cancelled.
- Waiting times for tests and treatment are sometimes far too long; and patients are not always treated with respect and dignity.

Patients tell us that their care is not joined up between different services

Patients and carers find it frustrating to have to continually provide the same information to different people. It is disappointing that different parts of the NHS do not always communicate effectively with each other or with social services. Patients with complex conditions are often passed from one service to another while the services do not always communicate with each other. Patients' treatment is often not joined up. In particular, patients sometimes stay longer in hospital because joined up arrangements for their care in the community on and after discharge have not been put in place.

The social care system is under increasing pressure

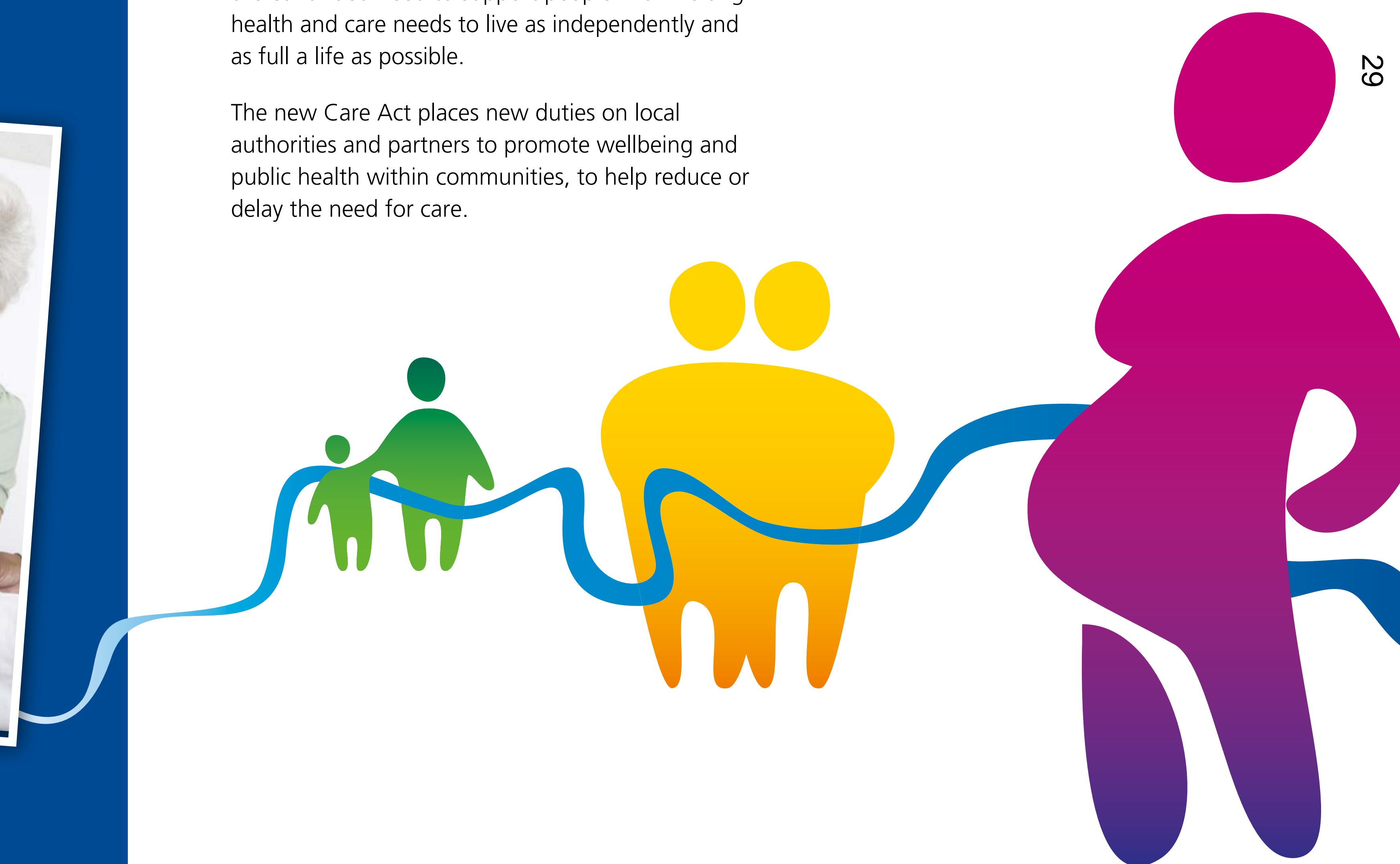
Many local councils face unprecedented pressures on their resources and in some instances are looking to save over 30% of their current expenditure over the next 3-4 years.

Adult social care forms a large percentage of any local authority budget and these services are expected to reduce spending and find more cost-effective ways of working, while maintaining safe, high quality services. Demand is growing in some areas, with increasing numbers of older residents, residents living much longer with complex care and health needs, increased mental health needs and the continued need to support people with lifelong health and care needs to live as independently and as full a life as possible.

The new Care Act places new duties on local authorities and partners to promote wellbeing and public health within communities, to help reduce or delay the need for care.

From April 2016, there will be a cap in place to limit the amount people have to pay towards their care. This is welcome, but it comes without any certainty on the costs to local councils associated with these new duties, nor of the increased demands from people who use services and their carers.

It is clear that the NHS and the social care system need to work better together if we are to deliver the high quality services people need.



> *There have been huge technical advances in diagnostic medicine and in treatments for a wide range of conditions.*

The money to pay for the NHS is limited and need is continually increasing

NHS funding currently increases with the cost of living inflation each year. However, the costs of providing care are rising much faster because the NHS is now treating more people with more complex conditions than ever before and people are living longer. There have been huge technical advances in diagnostic medicine and in treatments for a wide range of conditions, but these new medicines and treatments are often expensive. People also have higher expectations of health services these days. Given the current financial climate, sustained and substantial increases in NHS funding are unlikely for the foreseeable future, which means that we need to do things differently if we are to continue to deliver the best possible care for patients in the years ahead.

Over the next five years the NHS is facing a £30billion financial challenge . The current government has committed to meeting the request in the NHS Five Year Forward View for £8billion of extra funding nationwide by 2020. This will improve the situation, but will not close the financial gap, which is likely to remain significant. Because the costs of healthcare are rising much faster than NHS funding, we know that if we continue in the current way, then we will not have enough money to pay for the services we currently provide by 2019/20. The NHS England Five Year Forward View is consequently based on the assumption that the way in which services are being delivered will change, with more focus on community-based services and supporting people to stay well.

The NHS in south east London faces these same challenges and organisational plans indicate that the forecast gross cost, if we do nothing by 2019/20, would be about £6bn compared to income totaling around £5bn. As a consequence, if we do nothing, then the affordability gap facing the health services across south east London would be about £1bn by 2019/20.

Absolute challenge

Over the period from 2014/15 to 2019/20, the south east London expenditure (without efficiencies) will grow to £1bn more than the projected budget of £4.8bn. This is comparable with the national challenge set out in NHS England's Five Year Forward View.

Annual challenge

On average, the south east London healthcare system will need to make efficiencies of £218m each year (from a budget which will grow to £4.8 bn) between 2014/15 and 2019/20.

An esimated breakdown is shown below.

14/15	15/16	16/17	17/18	18/19	19/20
£251	£228	£154	£162	£141	£156

(millions)

Pecentage challenge

On average, the south east London healthcare system will need to make efficiencies of 4.2% each year between 2014/15 and 2019/20.

An estimated annual breakdown is shown below.

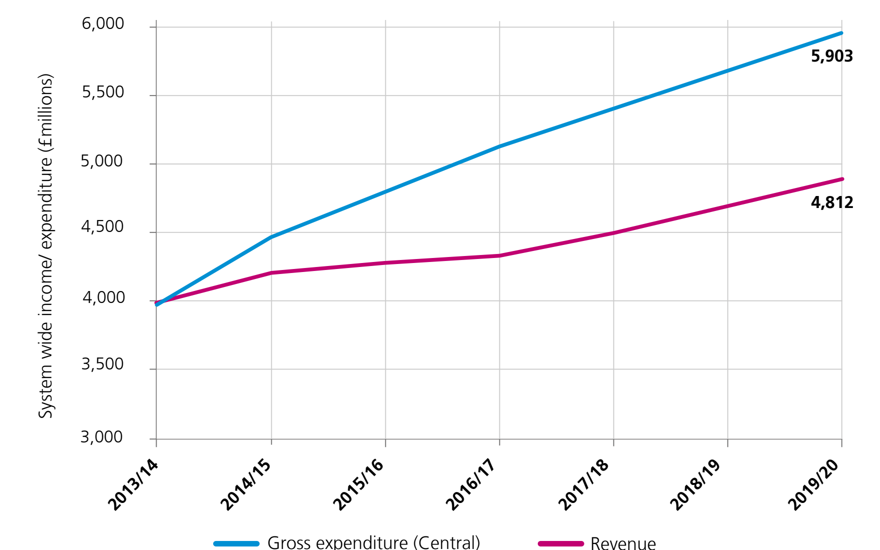
14/15	15/16	16/17	17/18	18/19	19/20
6.0%	5.3%	3.4%	3.5%	3.0%	3.2%

Through year on year improved efficiency within NHS providers of between 2% and 3% this would reduce the remaining challenge to between £400m and £600m. However, hospitals in south east London, as elsewhere across the country, are already facing financial pressures, making the need to do things differently all the more pressing.

To add to this, local councils, who are responsible for social care services, are also experiencing pressures from an ageing population, increased demand for social care and reductions in funding, resulting in them looking to save over 30% of their current expenditure over the next three to four years.

From now on, we need to explore all opportunities and get better value for money for all that is done in the NHS and social care services, in order to operate within the available resources. We need to get the best possible outcomes for patients for every pound available, making the most of resources that are under increasing pressure. This means we need a more integrated approach between different services. Each pound that we spend is spent as part of the whole NHS and social care system.

The chart shows how this challenge is forecast to build up over time through to 2019/20



Every one of us pays for the NHS; we have a responsibility to spend this money well

We face major challenges. We know that by providing services in a different way, it is possible to improve outcomes, to help people to live healthier lives, to deliver services which are consistently of high quality and get more for our money. Changes have been made in the acute treatment of stroke, major trauma and heart attacks in London: services now provided in a small number of specialist centres rather than in every hospital have transformed outcomes. More people survive strokes, major trauma injuries and heart attacks in London than ever before. In bypassing their local hospitals to these centres, the care they receive is much better. These changes have saved money for the NHS so we know that such cost-effective changes are possible.

For example, a study showed that the changes to stroke services saved 12% more lives (around 400 lives a year) and £811 per patient, in spite of the costs of setting up the new system.

Further change is needed: nationally 16 million people attend A&E each year, but 40% needed no treatment or could have been managed by their GP; 2012-13 saw 5.2 million emergency hospital admissions, 1.2 million of which could have been avoided. They add unnecessary costs and create delays in planned hospital care. There are problems of access to GP appointments which can put added pressure on hospitals; in producing meaningful discharge and care plans; and in producing better outcomes after surgery and cancer treatments.

About our population

South east London has a diverse and mobile population, with extremes of deprivation and wealth. A high proportion of our 1.67 million people live in areas that are among the most deprived fifth in England, while a smaller proportion live in the most affluent fifth. Four of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) rank amongst the 15% most deprived local authority areas in the country. The other two boroughs (Bexley and Bromley) are significantly less deprived but have pockets of deprivation in particular geographical areas. The population is very ethnically mixed; ranging from 15.7% of the population of Bromley being from black and minority ethic groups to 46.5% in Lewisham.

The age profile of the population includes a relatively high proportion of younger people, especially 0-9 years, and a slowly increasing older population, with more females than males living into older age.

The local population is highly mobile. In Southwark and Lambeth, the equivalent of roughly 9% and 10% respectively of the current population moved in and out over a 12 month period mid-2011 to mid-2012. Even in Bexley, the borough which has the most settled population, the equivalent figure was around 5%, compared with approximately 3% in London as a whole.

All of these factors need to be taken into account when we plan health and social care services. The six CCGs in south east London also each carry out an annual assessment of how effectively the services they commission engage with and meet the needs of nine groups with 'protected characteristics' outlined in the Equality Act 2010. The protected groups are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) and sexual orientation.

What are we trying to achieve?

The Our Healthier South East London programme is led by six clinical commissioning groups (CCGs) Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. The six CCGs are working with NHS England on a future strategy to meet the health needs of the area.

The CCGs have agreed that some of the issues we face cut across borough boundaries and that they need to work together to address them. CCGs continue to be individually responsible for the health of their local populations; their agreement is to work together on those issues where they need to collaborate to improve the health and care system, while continuing to develop their own local borough plans.

We have been discussing with local people and our partner organisations the best way of tackling the challenges set out above and we will continue to do so.

Our outline strategy puts forward a vision for south east London which we hope to build on further with local people.

Our collective vision for south east London:

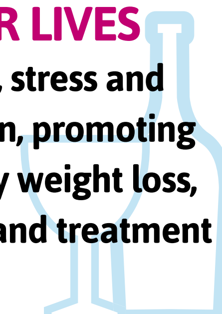
IN THE NHS IN SOUTH EAST LONDON, WE SPEND

£2.3 billion PER YEAR

5yrs Over the next five years we aim to achieve much better outcomes than we do now by:

Giving our CHILDREN the best start in life

SUPPORTING PEOPLE TO LIVE HEALTHIER LIVES – reducing smoking, stress and alcohol consumption, promoting exercise and healthy weight loss, early identification and treatment of mental ill health



Helping communities to support each other

Helping people to live independently and know what to do when things go wrong

Making sure primary care services are consistently excellent and with an increased focus on prevention

Supporting people to be more in control of their health and have a **GREATER SAY** in their own care

Delivering services that meet the same high quality standards whenever and wherever care is provided

REDUCING VARIATION IN HEALTHCARE OUTCOMES AND ADDRESSING INEQUALITIES BY RAISING THE STANDARDS IN OUR HEALTH SERVICES TO MATCH THE BEST

Spending our money wisely, to deliver better outcomes that matter to patients, avoid waste and increase value

Developing joined up care so that people receive the support they need when they need it

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A new national plan for the NHS

The NHS Five Year Forward View was published in October 2014. It sets out a vision for the future of the NHS. It has been developed by the bodies that deliver and oversee health and care services nationally, including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. Some of the key points are:

- **The NHS has dramatically improved over the past fifteen years.** Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted.
- **Our patients' needs are changing,** new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients.
- **There is now broad consensus on what a better future should be.** The Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions will need explicit support from the next government.
- The future health of millions of children, the NHS and the economic prosperity of the country all depend on a **radical upgrade in prevention and public health.** The NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks.
- **When people do need health services, patients will gain far greater control of their own care –** including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.
- **The NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

While we know that a 'one size fits all' model will not work for the NHS and we are responding to local needs, our vision for the future is in line with the key points set out in the Five year Forward View.

Childhood obesity
levels in children aged 10/11 (Year 6) are
significantly above
the England average
in 5 of our 6 boroughs

What is the London Health Commission?

In December 2013, the Mayor of London launched an independent London Health Commission to look at how healthcare could be improved for Londoners. The Commission reported in November 2014 and set out 10 aspirations for the capital:

- Give all London's children a healthy, happy start to life
- Get London fitter with better food, more exercise and healthier living
- Make work a healthy place to be in London
- Help Londoners to kick unhealthy habits
- Care for the most mentally ill in London so they live longer, healthier lives
- Enable Londoners to do more to look after themselves
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them
- Create the best health and care services of any world city, throughout London and on every day
- Fully engage and involve Londoners in the future health of their city
- Put London at the centre of the global revolution in digital health

The Commission engaged widely across London, including over 50 events, polls, roadshows and focus groups, involving more than 15,000 Londoners. A report, Better Health for London, was published in October 2014.

The report made a series of recommendations, including measures to tackle childhood obesity, get people living healthier lives, better support for people with mental illness, improving GP access and more support in the community for people with long term conditions.

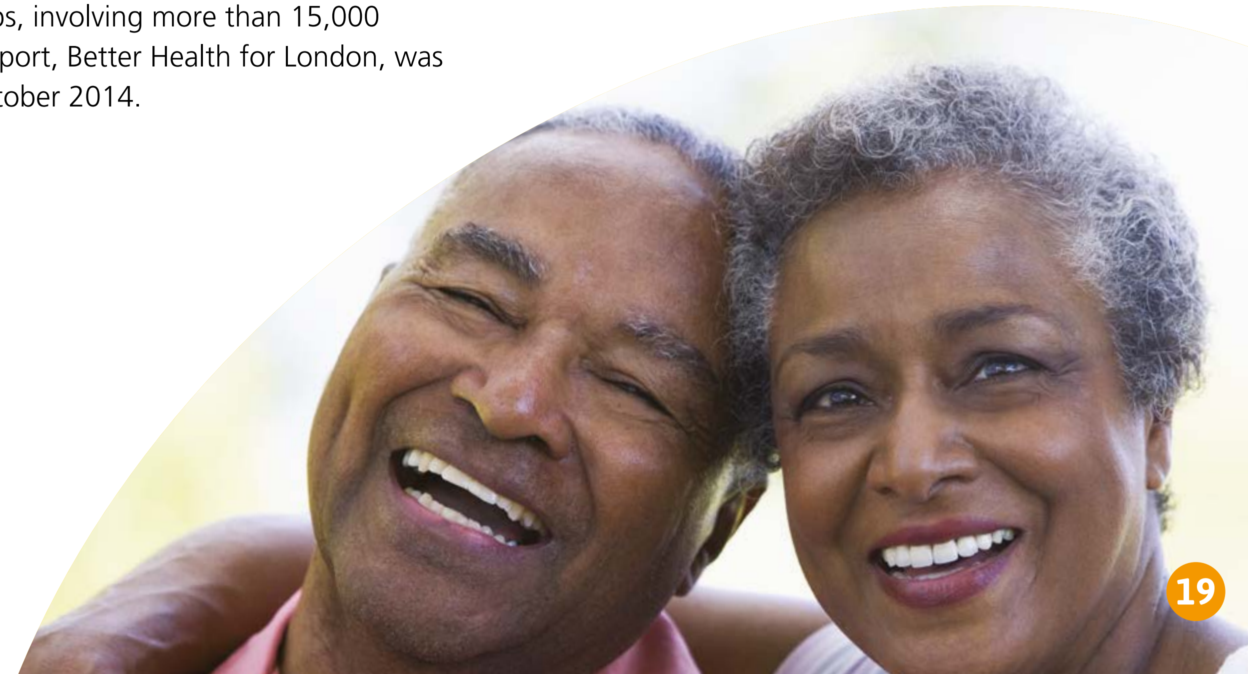
You can read the report and find out more online:
www.londonhealthcommission.org.uk

All of the recommendations and aspirations in the London Health Commission report are in line with those set out in our strategy and in the NHS Five Year Forward View.

Transforming London's Health and Care Together

Our six CCGs, in common with the 32 CCGs across London, working with NHS England, have developed local plans to support the recommendations of the London Health Commission. This is set out in a joint report, Transforming London's Health and Care Together. Links to this and other useful documents are available on our website at **www.ourhealthiersel.nhs.uk**

This includes the launch of 13 transformation programmes, including the development of a commissioning model for primary care, that will help achieve the vision set out in both the NHS Five Year Forward View and Better Health for London.



What changes might be made by the local NHS?

We have identified challenges in all of the following areas of healthcare that we need to address.

- Community-based care
- Maternity
- Children's and young people's services
- Cancer
- Planned care (treatment that is arranged in advance)
- Urgent and emergency care

Six clinical leadership groups, made up of doctors, nurses and therapists from the local NHS, health service managers, social care leaders working for local councils, patients and members of the public, have been set up to come up with possible solutions in these areas. Mental health is covered by all six groups, as we are taking an integrated approach to mental health so it is relevant to all of the groups.

These clinical leadership groups have met several times and discussed the issues in detail. We have also started to discuss some of the emerging issues with local people. A very first draft of a five year strategy was published in June 2014, and the strategy is continuing to be developed as we talk to all those involved about the issues. We need to work out how each part of the local NHS can contribute to shaping our plan and what changes it might mean for local services. We are publishing this paper so that we can further discuss these issues with NHS staff, patients and local people.

We have set out below why we think changes are needed and what sort of changes we are thinking about, under each of our clinical headings.

Community-based care

Community-Based Care covers services that are provided outside hospital. There will also be new services established in the community where we know this will benefit patients' health and their experience. The services will include those provided by:

- All General Practices
- District and community nursing
- Community health services (delivering care to those with both physical and mental health needs)
- Voluntary sector services
- Social care
- Community pharmacy
- Community-based diagnostics
- Community services supporting those with long term conditions

These services impact on all areas of health and care, so getting them right is important – without getting community-based care right, it would not be possible to deliver the improvements needed elsewhere in the system.

What we think works well

We have many first class community-based services and all six CCGs have plans to increase the number and quality of services based in the community, so that people only go to hospital when they really need to.

All boroughs are already driving forward integrated care programmes for people with long term conditions. For instance:

- Greenwich: The national 'Pioneer Project' will build upon the existing integrated care system which is delivering coordinated services for older people and people with physical disabilities in Greenwich.
- Lambeth and Southwark: Integrated Care (SLIC) is a well established partnership between local GPs, King's College Hospital, Guy's and St Thomas' Hospitals, the South London and Maudsley Mental Health Trust, social care in both local councils, and Lambeth and Southwark CCGs. The partnership is already focusing on improving community care.
- Lewisham: A population-based programme integrates services to create a single service to reduce unnecessary hospital admissions.
- Bexley: A case management approach is being taken forward to identify patients with complex needs, in combination with integrated care services for older people across health and social care.
- Bromley: A local pilot is underway with community service providers and GP practices identifying complex patients in order to support them to get the best possible, well managed care.

The case for change:

- Patients and carers often tell us that care is not joined up between different services.
- Older people often have more than one health problem and need support and treatment from a number of different services and professions.
- Barriers exist between the current arrangement of service providers in health and social care which can lead to disjointed service provision for those who need it.
- Many people would like to have greater involvement and control of their own care and be supported to do more to care for themselves.
- Some patients find it hard to get a GP appointment when needed, reverting to accessing other urgent and emergency services or deterioration in their health.
- Patients do not always understand where to get help when or how the system works. This includes people who are new to the UK and its health and social care system.

rate their overall experience of their GP surgery as good or very good. *(GP Patient Survey, July 2014)*

We can improve this, but it is a good starting point.

Some of the ideas we are considering:

- Prevention of illness and supporting people to live healthier lives should be much more central to future health services.
- We need to make sure everyone has equal access to consistently high quality, joined up care, addressing the concerns patients have expressed about services not working closely enough together and the variation in quality between different services.
- Community-based care should be more coordinated, with improved communication between services that inter-link or are integrated. We are currently developing future joined up services in each borough that we are calling 'Local Care Networks' to support this.
- New (or improved) Local Care Networks are intended to bring together general practice, primary, community (physical and mental health), social care and voluntary sector colleagues to provide holistic, patient-centred care in each area.
- Local Care Networks will need to be proactive, supporting people to live healthier lives and focusing on prevention, as well as advice and treatment, to empower people to look after their own health and reduce the possible onset of future health conditions.
- The services available need to respond to the varied needs and characteristics of the population they serve with the flexibility to meet the needs of individuals.
- We would like access to GP services and other community-based services to be available 8am-8pm in each area, with additional local access to more specialised care and expertise outside of hospital. To support this, we would need GP surgeries and other community services to work closely together in their Local Care Networks.
- Services should be more proactive, accessible, coordinated and provide continuity of care; with a flexible, holistic approach to make sure that every contact a member of the public makes with NHS or social care services is made to count.
- We should have a more rehabilitation-based approach to supporting people with long term conditions, enabling people to take control of their own care, avoiding deterioration and episodes of crisis, with a focus on getting better.
- We should improve communication with patients so that they know where to go for help when they need it – our draft strategy suggests that we employ more 'care navigators' to guide and support people through the various services.

Questions to consider on community-based care:

- How might this new system work for you? What might stop it from working properly?
- What do you need from services based in your community, such as GPs, pharmacists, community health services (mental and physical) and district nurses?
- What works well now that we could build on? What needs to get better?
- How can we support you and your family to live healthier lives?

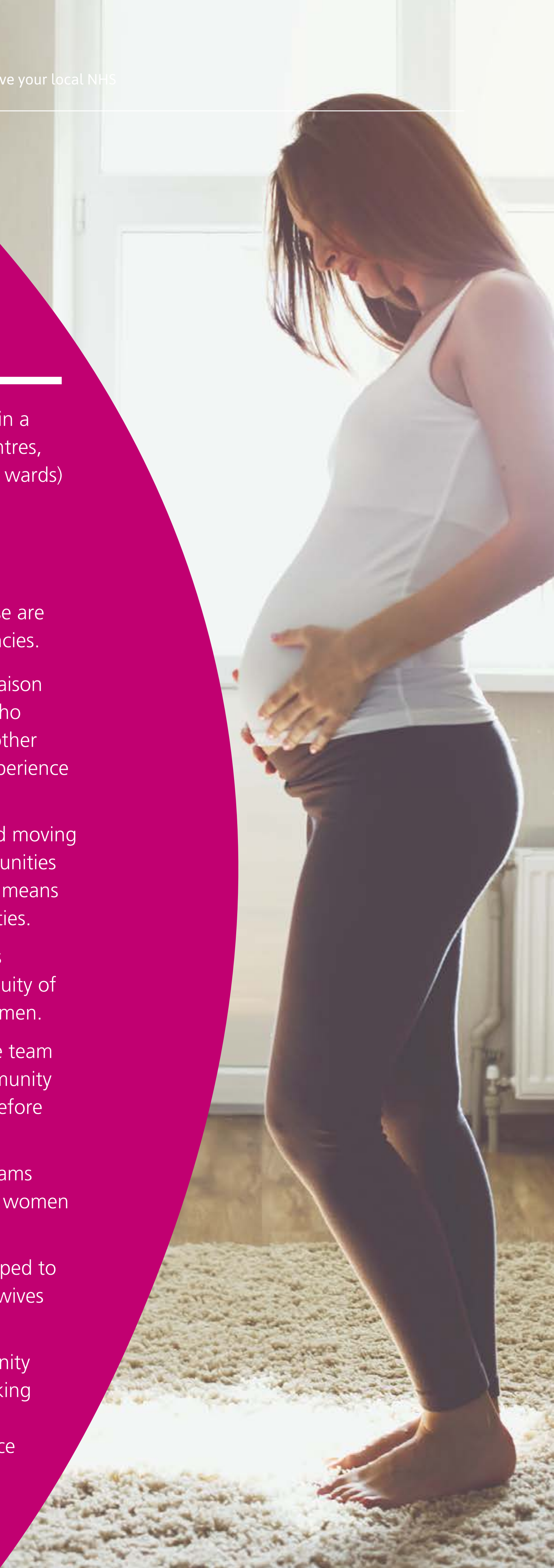
Maternity services

Maternity services support women and their families in a variety of settings (in the community, in children's centres, in midwife-led birth centres and in hospital maternity wards) before, during and after they give birth.

What we think works well

Most hospitals have a midwife-led birth unit and these are very popular with women who have low risk pregnancies.

- Each maternity service has a Maternity Services Liaison Committee - which is made up of service users who undertake spot checks, raise issues on behalf of other users and routinely talk to women about their experience of maternity services.
- Lewisham Hospital is in the process of finding and moving its community teams into premises in local communities - children's centres and other facilities. This move means that these teams will be rooted in local communities.
- Kings College Hospital have two midwifery teams based in the local community who provide continuity of midwifery care. This is very popular with local women.
- Guys and St Thomas's Hospital have very effective team based midwives in health centres and other community settings, providing continuity of midwifery care before and after birth.
- All maternity services have specialist midwifery teams providing support to women at high risk (such as women with mental health problems or teenage mums).
- The appointment of Consultant Midwives has helped to improve the quality of midwifery care. These midwives provide leadership to the midwives in their units.
- The recently developed South East London Maternity Network is working to develop collaborative working across all units, to drive up quality and make sure that women have the same high quality experience at whichever maternity service they access.



The case for change:

- Not all maternity services meet the needs of our population. The employment and retention of the highly skilled workforce required to deliver a service across all health settings is a challenge.
- There are increasing numbers of women with more complicated health and social care needs who require more support.
- Our maternity services are not meeting all of the standards agreed by the 32 London CCGs and the London Clinical Senate - the London Quality Standards. These include 24/7 consultant presence in labour wards.
- Although maternity service users are mostly satisfied with their care, recent surveys have highlighted areas for improvement in areas such as postnatal care and the provision of information and advice once they are at home after the birth – for example breastfeeding advice and support.

Some of the ideas we are considering:

- We want to ensure that all women will have a safe and positive experience from antenatal care through to postnatal support, delivered by a committed and dedicated workforce.
- Mums to be should receive a more personalised service, with better continuity of midwife support and care with the right information to enable them to make an informed choice for their birthing options. This may include home birth or birth in a maternity unit.
- We want to provide better support for women to have a healthy straight forward birth in a setting of their choice where possible.
- We should encourage women to book earlier and they should have better, more consistent support throughout their pregnancy.
- We need to get better at addressing any mental or physical health issues faced by women before, during or after childbirth.
- We want all our services to meet the London Quality Standards, which are the minimum safety standards set by senior clinicians and patient representatives for maternity services in London, to help improve the overall quality of maternity services in south east London.

Questions to consider on maternity services:

- How might this new system work for you? What might stop it from working properly?
- What support would you expect if you were giving birth (1) in hospital or (2) at home?
- What works well in maternity services now that we could build on? What needs to improve?
- What support would you need before and after giving birth?

Children and young people

Services provided for children include specialist services in hospital and in the community. Children and young people access all services, not just those provided by specialist children's doctors, so it is important to remember their needs when considering other services, such as community-based care, planned care, mental health or urgent and emergency care.

What we think works well

- South east London has some of the best specialist children's hospitals in the country.
- There are strong community children's health models in place around south east London.
- We have first class services for children with asthma, sickle cell, epilepsy, and diabetes.
- There are good examples of teams working together across different disciplines to help support children.
- There are also good examples of the use of technology to promote independence and improve service delivery.
- South east London has some innovative health promotion and prevention services to support children, young people and their families.

The case for change:

- The population of young people is increasing, with a significant number from socio-economically deprived families.
- South east London has a higher than average rate of childhood obesity, undiagnosed mental health issues and teenage pregnancies.
- Our paediatric services do not meet the minimum safety standards agreed by all 32 CCGs and the London Clinical Senate – the London Quality Standards. These include consultants being present on children's wards 14 hours a day, 7 days a week.

Some of the ideas we are considering:

- We should get better at supporting families to keep children and young people physically and mentally well.
- Children and young people should be able to access more joined up care in the community, through new children's integrated community teams.
- We should make sure children and their parents can access the right services in the right place, rather than being passed from one place to another as sometimes happens now.
- We would like to develop a paediatric assessment and short stay unit, working closely with community services to support children and young people back to home/school, reducing lengthier hospital stays.
- All our services should meet the London Quality Standards.
- When specialist support is needed, the support should be there more quickly and effectively than is always the case now.
- There must be less variation when transitioning into adult services for young people with long term conditions.

1 in 10

children and young people

aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.

Questions to consider on services for children and young people:

- How might this new system work for you? What might stop it from working properly?
- What works well in children and young people's services now that we could build on? What needs to improve?
- What support do you as a child, young person or parent need from services based in the community? And in hospital?
- How do we encourage children and young people to adopt a healthy lifestyle?

Cancer

Cancer services across south east London are extensive and involve a wide range of specialist health care professionals.

What we think works well

There are a number of excellent services, in both the NHS and voluntary sector, already providing cutting edge care to people in London who receive a diagnosis of cancer. Across the board there is passion and drive to improve patient experience and outcomes supported by rigorous and on-going research. The cancer clinical leadership group is working collaboratively with such services to bring in best practice and a broad evidence base to proposed interventions, ensuring local, national and international innovation drive the work taking place.

The case for change:

- Cancer is the biggest cause of premature and avoidable deaths in London.
- Some people with cancer wait longer than they should do for their first hospital treatment.
- We do not always diagnose cancer early enough.
- There are differences in patient outcomes and experiences, depending on where and when they access care.
- We must enable people nearing the end of their life to die with dignity, to have more control over where they wish to die and improve the experience of patients and their families during end of life care.
- We should do much more to promote healthy lifestyle choices, including making sure that health services take a holistic approach every time a patient comes into contact with them – including, for example, supporting people to stop smoking and to have a healthy, balanced diet.

Some of the ideas we are considering:

- We should improve patient outcomes through better prevention and earlier detection and diagnosis of cancer.
- We need better coordinated specialist cancer treatment services.
- We need to provide better support for carers.
- We should strengthen support available for people living with and beyond cancer.

Questions to consider on cancer services:

- How might this new system work for you? What might stop it from working properly?
- What works well in cancer services now that we could build on? What needs to improve?
- When we know people are nearing the end of their lives, how can we best support them and their families/carers?

Planned care

Planned care is treatment that is planned in advance, such as an operation that is booked on a certain date.

What we think works well

There are already a number of examples of excellence and best practice within London, nationally and internationally which we can build on. Quality improvement programmes are in place to standardise how planned care works from beginning to end, leading to better outcomes and a more efficient services for patients.

The case for change:

- There are differences in patient outcomes and experiences, depending on where and when they access care.
- Time from first appointment, to diagnostic test, to getting results could be quicker and more efficient leading to early diagnosis and better outcomes for patients.
- Patients should be better informed about what will happen, empowering them to have more choice and control over their own care.
- Patients should be better prepared for their operation/procedure.
- Early supported discharge and a stronger focus on rehabilitation could help patients return home more quickly and safely, preventing unnecessary delays.
- There is unnecessary duplication of paperwork and diagnostic tests causing delays in patient care because different services use different IT systems that are not compatible.

Some of the ideas we are considering:

- We want to put in place high level standards of care for the whole process from referral to treatment and discharge which have been developed with patients and the public through engagement workshops.
- We should ensure that all patients who need planned care across south east London receive the same quality and outcomes, regardless of where they are treated.
- We should improve direct access to diagnostics tests for GPs and improve efficiency and patient experience by standardising the journey from diagnosis to treatment.
- We should improve information for patients before hospital admission.
- We should get better at planning hospital discharge before admission; early discharge should be supported by local care network teams, with a focus on rehabilitation and helping people to return fully to their lives.

Questions to consider on planned care services (care that is planned in advance):

- How might this new system work for you? What might stop it from working properly?
- What works well in planned care now that we could build on? What needs to improve?
- Would you be prepared to travel further for an operation in a specialist centre if you knew it was more likely to be successful and less likely to be cancelled?

Urgent and emergency care

Emergency care is for people who have a condition that is life-threatening or presents an immediate risk to long term health. Urgent care services are for people who have a problem that needs attention the same day, but is not life-threatening or life-changing. Emergency care is usually provided by a hospital emergency department or in an ambulance; urgent care is provided by various health professionals, including GPs, hospital doctors and nurses in various locations, including hospitals and health centres. If you are unsure whether you need urgent or emergency care, you should contact your GP or dial the 111 helpline out of hours.

Issues Paper
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www.ourhealthiersel.nhs.uk

What we think works well

There are a number of good examples in south east London where community teams work closely with their local Emergency Department to prevent unnecessary hospital attendances and help people to get out of hospital quicker.

You may have heard of some of these local initiatives, which are listed below.

- The '@home' home ward in Lambeth and Southwark
- Bromley Medical Response Team
- Joint Emergency Team (JET) Greenwich
- Rapid Response Team Bexley
- Bromley rehab home pathway and rehab beds
- Greenwich and Bexley Hospital Intergrated Discharge Team (HIDT) and Bromley Intergrated Discharge Team (IDT)
- Integrated teams (six each in Bexley, Greenwich, Bromley)
- Southwark and Lambeth Integrated Care team (SLIC)
- Specialist Long Term Condition teams in each area

The case for change:

- No hospital in south east London fully meets the minimum standards for safety and quality in emergency care set out by the London Quality Standards. These include the requirement that senior doctors (consultants) are present on emergency wards a minimum of 16 hours a day, 7 days a week. Not all our hospitals have their most senior doctors working at night and weekends.
- Many people are going to A&E unnecessarily when other more suitable care is available.
- Patients with mental ill health often have long waits to see a psychiatric liaison nurse, which can lead to patients absconding.

Some of the ideas we are considering:

- We should set up a community-based rapid response team in each area, which would make sure patients who need urgent and emergency care receive the treatment they need in the right place at the right time (including in their own homes if appropriate). This would support the rapid return of patients to their homes, moving back to local health and care services outside hospital.
- When patients go to hospital needing urgent or emergency care, we would like both services to be located together. Patients could be directed to the right department for their needs by an appropriately qualified clinician.
- Local Care Networks, with extended opening hours, should link in to rapid access services to support frail, elderly people and patients with long term conditions.
- Mental health liaison services should work within the Local Care Networks to support patients in crisis - for example, patients using or requiring: perinatal; drugs and alcohol; children's and young people's; and older peoples and dementia services. Mental health patients should be seen more quickly in hospital Emergency Departments.

Questions to consider on urgent and emergency care services:

- How might this new system work for you? What might stop it from working properly?
- What works well in urgent and emergency care services now that we could build on? What needs to improve?
- How can we better support you and your family and keep you out of hospital unless you really need to be there?

How can we best reach you?

We are very keen for local people and organisations to have their say as our strategy develops. You can use the contact details at the end of this paper to get in touch with us.

So, one final question to consider:

How would you like us to communicate with you? (For example, we will be sending out regular email updates and we will have a mailing list for meetings in your area, to which we can add you or your organisation - or there may be other ways which are best to reach you? Please let us know.)

What happens next and how can you get involved?

This Issues Paper is being circulated across south east London from May 2015 for comment and feedback. A summary and Easy Read version are also available. A series of events will be organised at which people can discuss the issues raised. These will be publicised locally and via our website.

We are continuing to develop a detailed plan to improve local health services, making sure that everyone in south east London has access to the same high quality services, wherever they access care. We think this will mean spending our money differently, with more money spent on community-based services while hospitals provide specialist care for those who need it.

We have already started work in each borough, improving and increasing the care available in community settings and supporting these services to work more closely together.

We are still considering what our strategy means for each of our local hospitals. If we come to the conclusion that we need to develop proposals for major service change in any of our local hospital services, we would put these forward for public consultation.

Local clinicians, councils, hospitals, Healthwatch organisations and members of the public have helped us to develop our thinking.

We would like you to get involved.

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

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

To respond to any of the questions, or all of them, please also email **ourhealthiersel@nhs.net**

If you want to keep in touch with our plans as they develop, please email your contact details to the above address.

You can also write to us at:

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

To request this document in other formats or languages email
ourhealthiersel@nhs.net

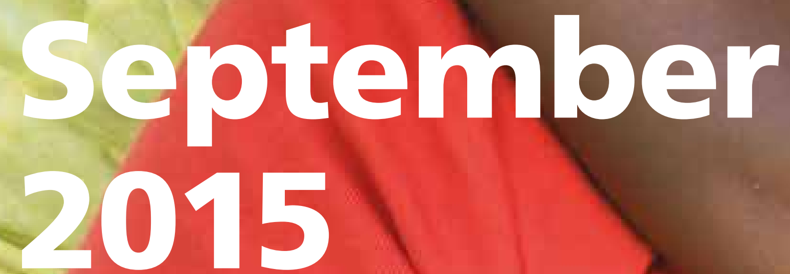
Our Healthier South East London
Improving health and care together

NHS

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



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.

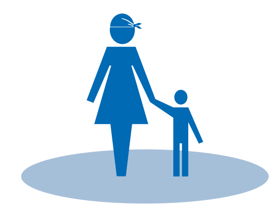
Help us improve your local NHS

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

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

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

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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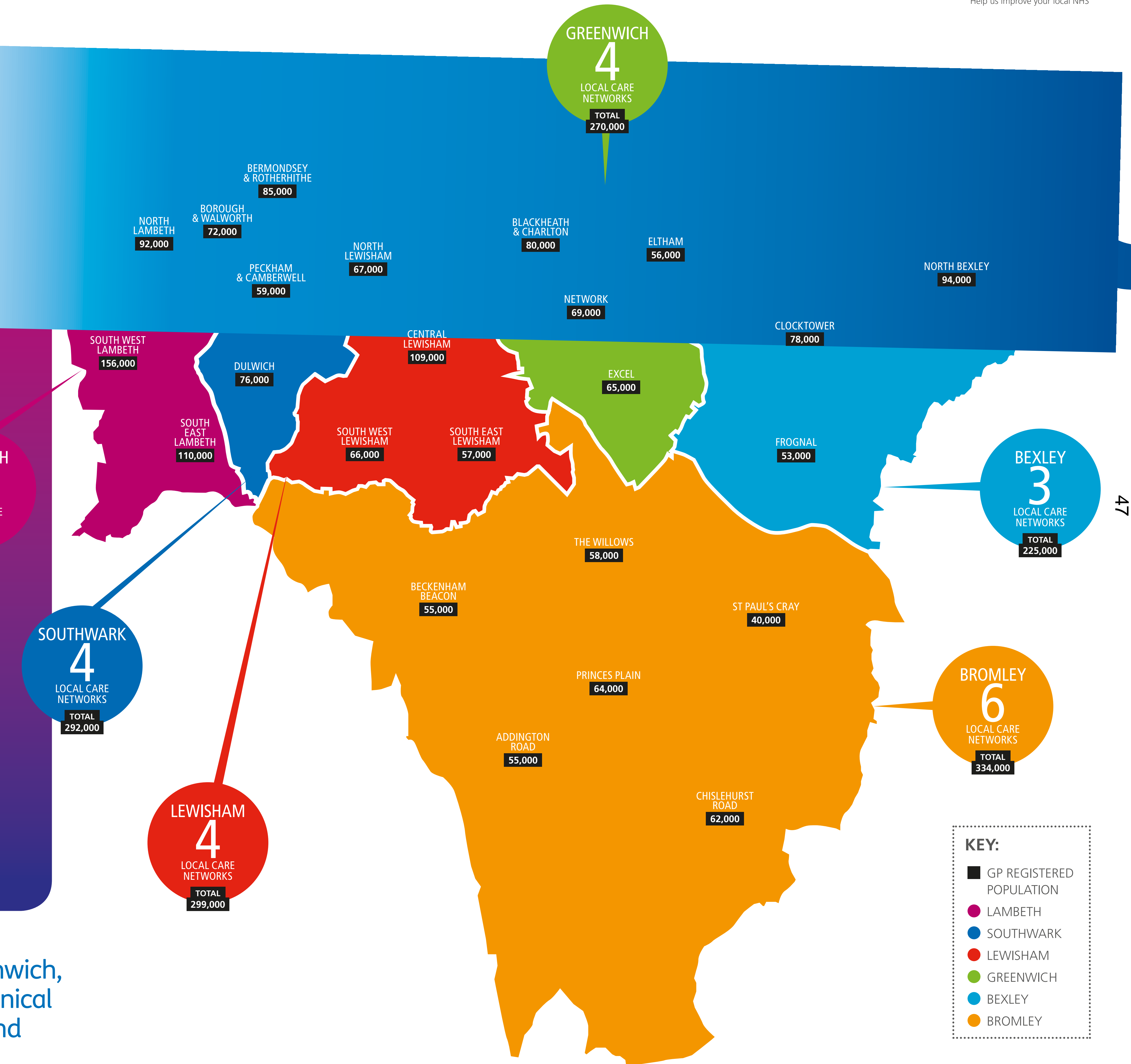
Local Care Net

Local Care Networks are at th of Our Healthier South East L These are networks bringing different organisations, indiv agencies involved in the care

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



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

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)

“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.

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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.

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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.

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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

www.ourhealthiersel.nhs.uk

Healthy Communities Committee
Personalisation and Personal Budgets

The Healthy Communities Scrutiny Sub-Committee looked closely at the delivery of personalisation and personal budgets by Southwark Council. This report provides an overview of the work carried out by the Committee and recommendations to support the delivery of the current programme.

The Committee would like to thank all of those who submitted written evidence and presented oral evidence to the Committee as part of this inquiry.

This inquiry considered the issues around the introduction of personalisation and personal budgets; the impact on residents, carers and providers.

It aimed to consider the current barriers faced by each set of stakeholders and make recommendations that can ensure a smooth and successful journey from assessment to final plan.

Summary of key recommendations

1. Service standards and timescales should be adopted in regards to carrying out an eligibility assessment, completing a support plan and the provision of services. This should be monitored and information made available on an annual basis.

2. Residents should be given a named case officer, who will work with them throughout the process, except in exceptional circumstances, and where the officer has to change, residents are kept informed.

3. Named council officers should be trained to provide support services to those accessing personal budgets. This should include training around support planning, brokerage, direct payment management support, managed account service, payroll service, personal assistant and employment support services.

4. Assessments should be carried out in an individual's home, and carers should be identified and offered their own assessment to be carried out at the same time.

5. The Council should look to develop a preventative strategy that includes financial support for the maintenance of open door services for vulnerable and elderly residents, to help them remain healthy and active, and ensure that they are not isolated.

6. The Council should create a suite of materials with accessible information for carers, as well as providing this clearly on the Council website.

7. There should be a commitment for carers to have the same case workers throughout the process, except in exceptional circumstances.

8. The Clinical Commissioning Group should be encouraged to ensure that GP services are promoting carer assessments.

9. The Council should look to work in conjunction with Healthwatch to provide regular monitoring and feedback on the process for carers in receiving an assessment through to plan delivery.

10. All VCS organisations should be kept fully aware of where they stand with regards to contracts and transitions to personal budgets.

11. The Council should provide specific information about personal budgets, particularly focused on eligibility criteria to help residents understand what services they can access.

12. The Council should work with CAS on the creation of an e-marketplace which will collate all available services for personal budget holders.

13. The Council should look to support providers on how best they can market themselves – potentially linked to creation of the e-marketplace.

14. The Council should consider the potential of maintaining a reduced grant for service providers, particularly building-based services, to support the moves from block grants to personal budgets.

Personalisation

The Social Care Institute for Excellence (SCIE) describes personalisation as 'recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support.'

Southwark Council recognises that a traditional service-led approach to support has often previously meant that people have not been able to shape the kind of support that they receive, and personalisation now allows for individuals to tailor their support to their requirements.

Following the Coalition Government of 2010-2015's introduction of personalisation, Southwark has been working to implement and embed a personalised approach to adult social care. In 2011, the Council agreed a vision for adult social care, focused on maintaining the principles of independence, choice and control, while recognising that there were significant changes in the public sector and the need to increasingly operate with a reduced public purse.

Southwark has undertaken work to transform care and support to enable people to live independently and well for as long as possible. This includes:

- Developing and implementing a dedicated telephone response for all queries about care and support
- Funding a range of community support services in the voluntary sector
- Ongoing and increasing investment in short-term support through practical re-ablement and intermediate care support services
- Developing a re-ablement service in mental health
- Focusing the approach to assessment for ongoing care and support on outcomes for individuals and working with people to develop a support plan that shows how a personal budget will be used to meet someone's identified social care outcomes
- Creating the Southwark Resource Centre
- Transforming day services, including developing a Centre of Excellence
- Creating an offer of free telecare

Residents and personal budgets

Southwark has made significant progress in providing local residents with personal budgets providing 68.66% of clients with personal budgets by 2013/14. Performance is in line with the London average of 67.5% and above the national average of 62.1% of people using community services with a personal budget. In 2013/14, 97% of community service users who were eligible for a personal budget accessed one.

There are four main stages to a personal budget:

1. **The assessment:** enabling the service user and staff to identify and understand the eligible needs that will need to be addressed in the support plan
2. **Support planning:** The support planner and the service user work together to identify the outcomes the service user wants to achieve, and the user decides how they would like their budget managed. A plan is developed from this.
3. **Agreement of support plan:** The Council agrees the support plan
4. **Implementation of the support plan:** If a direct payment is required, this is signed and the service user receives the schedule of monitoring, the personal budget is paid and the plan is actioned.

At present, there are no national requirements on timescales for the completion of the support planning process, and Southwark does not currently record the length of time the process takes for a person to have a complete and active support plan. The original estimate was that the process takes between 8 and 12 weeks.

At the July 2015 meeting of the Healthy Communities Committee, Jay Stickland, Director of Adult Social Care confirmed that there had been a long waiting list, with over 260 people in the process of assessment for personal budgets, but that this has now been reduced to 20 people with a two week timescale for beginning the process.

The Local Account 2012/13 included a number of case studies of individuals who accessed personal budgets through Southwark Council.

Isayas Solomon

Isayas Solomon used a self-managed personal budget which allowed him to directly employ two personal assistants, rather than previously having to use carers from an agency. It allowed him to feel in control of the support he received.

He also enjoys the flexibility of the budget which has helped to improve his quality of life.

Derek

Derek developed his plan so that he can employ a key worker from the day centre he attends as a personal assistant, so he is able to attend the day centre, but also have other ways to be sociable and feel part of the community.

Whilst there are positive stories about the personalisation journey, there does not seem to be regular surveying of those who complete the process to understand their thoughts.

Members of the Committee however raised numerous examples from their own casework where residents had experienced difficulty throughout the process of trying to obtain a personal budget.

This included the time taken to complete the process, and the difficulty in finding relevant information and resources.

The Committee received a number of materials from Richmond Council to assess the difference in approaches between other Boroughs across London.

Richmond Council has established an Adult Social Care Charter, which sets out their principles for supporting residents through the personalisation process. They have also developed standards of service, which sets clear timescales for the provision of support. This includes:

- Answering 80% of telephone calls to the Access Team within 20 seconds and resolving enquiries within one working day where they cannot be dealt with immediately
- Resolving 80% of enquiries to the Access Team with the first point of contact, with a named person so the resident can follow up if required.
- An appointment will be made within two working days if a resident is eligible for support, and the visit will take place within the next eight working days. Any equipment will then be provided within the next seven working days.
- The overall aim is for there to be a maximum wait of 20 days for an assessment
- A reablement service provided free of charge for six weeks

- For long term and self-directed support, a single point of contact will be assigned and any family carer who supports the resident will be offered their own assessment.
- A support plan will be completed within four weeks of the assessment

Whilst Richmond is a very different Borough from Southwark, members of the Committee felt that there were many approaches that we could benefit from exploring further in our own Borough.

Recommendations to support service users

- Service standards and timescales should be adopted in regards to carrying out an eligibility assessment, completing a support plan and the provision of services. This should be monitored and information made available on an annual basis.
- Residents should be given a named case officer, who will work with them throughout the process, except in exceptional circumstances, and where the officer has to change, residents are kept informed.
- Named council officers should be trained to provide support services to those accessing personal budgets. This should include training around support planning, brokerage, direct payment management support, managed account service, payroll service, personal assistant and employment support services.

Carers and personal budgets

Healthwatch, the independent consumer champion for patients and the public, conducted a focus group in January 2015 with carers looking at the initial awareness, the process and its outcome on the carer.

Their key findings include:

- There is a lack of awareness and information surrounding a carer's assessment
- The process itself could be long and confusing, and eligibility criteria is unclear
- There was a lack of continuity with point-people in the Council which meant relationships were difficult to build

Recommendations for supporting carers

- Assessments should be carried out in an individual's home, and carers should be identified and offered their own assessment to be carried out at the same time.
- The Council should look to develop a preventative strategy that includes financial support for the maintenance of open door services for vulnerable and elderly residents, to help them remain healthy and active, and ensure that they are not isolated.
- The Council should create a suite of materials with accessible information for carers, as well as providing this clearly on the Council website.
- There should be a commitment for carers to have the same case workers throughout the process, except in exceptional circumstances.
- The Clinical Commissioning Group should be encouraged to ensure that GP services are promoting carer assessments
- The Council should look to work in conjunction with Healthwatch to provide regular monitoring and feedback on the process for carers in receiving an assessment through to plan delivery.

Providers and personal budgets

Between 15th July and 29th August 2014, Community Action Southwark (CAS) ran a survey on organisations' experiences and expectations around personal budgets.

Key findings from that report include:

- Only 20% of respondents have half or more users paying via personal budgets.
- Organisations are providing information and advice to users, as well as providing support planning and budget management services.
- There is concern around eligibility for personal budgets and awareness of eligibility criteria.
- Nearly half of organisations expect to lose contract or grant money.
- The majority of organisations think personal budgets do not provide enough cash to cover prior levels of support.
- Marketing is seen as an issue for organisations.

Recommendations for changes to support providers

1. All VCS organisations should be kept fully aware of where they stand with regards to contracts and transitions to personal budgets.
2. The Council should provide specific information about personal budgets, particularly focused on eligibility criteria to help residents understand what services they can access
3. The Council should work with CAS on the creation of an e-marketplace which will collate all available services for personal budget holders.
4. The Council should look to support providers on how best they can market themselves – potentially linked to creation of the e-marketplace
5. The Council should consider the potential of maintaining a reduced grant for service providers, particularly building-based services, to support the moves from block grants to personal budgets.

Agenda Item 8

Healthy Communities Scrutiny Sub-Committee
Workplan 2015/16

7 July 2015

1. **Review 1: Personalisation: Making Southwark Personal**

- What is the Council's vision for personal budgets?
- What are the options for service delivery and how robust is the safeguarding of individuals?
- Are service users satisfied with the way personalisation is being introduced?
- What recommendations would we make to make the journey for end-users easier?

    - Community Action Southwark (CAS)
    - Healthwatch
    - David Quirke – Thornton /Jay Strickland (Strategic Director/ Director adult social care)
    - Richmond Update
    - Cllr Stephanie Cryan – cabinet lead

Care Opinion to be promoted over the summer to gain insight. Findings to be circulated in advance and fed into final report.

2. **Agree workplan**

7 October 2015

1. *Review 1: Sign off Personalisation Review for 20 October OSC (17 November cabinet)*

2. **'Our Healthier South East London': An update from the Clinical Commissioning Group (CCG)**

3. **Review 2: Care in our community**

- How are we delivering on the Care Home Improvement Strategy?
- How are we delivering on the Southwark Ethical Care Charter?
- What is our approach to Home care and reablement?
- What further things should we be doing as a Council to support care in our community?

    - Council officer & Cabinet lead

• CQC • CCG • Lay inspectors
17 November 2015

1. **Review 2: Care in our community**
 	
• How are we delivering on the Care Home Improvement Strategy?
 	
• How are we delivering on the Southwark Ethical Care Charter?
 	
• What is our approach to Home care and reablement?
 	
• What further things should we be doing as a Council to support care in our community?
 	
    o Age UK
    o SLIC
    o Safeguarding independent chair
    o Police
    o Citizen Forum
    o Local community organisations
    o Local care users (could be identified using Care Opinion)
 	
** this session will be conducted as a roundtable

9 December 2015
1. *Review 2 : Sign off Care in the Community Review for 13 January OSC (9 February Cabinet)* 2. **Review 3: Progress report: Health of the Borough Report** • Written reports from all those who had recommendations to enact • Discussion amongst Committee 3. **Review 4 Joint Mental Health Strategy: A joined up approach?** • Does the mental health strategy set out a convincing enough case for a joined-up approach to mental health in Southwark? • What more do we need to do to ensure a joined up approach to mental

health?

- What further recommendations should we make to the Cabinet Member regarding the strategy after 6 months of it being enacted?

    - Andrew Bland (CCG)
    - Current contract provider
    - Cllr Cryan
    - David Quirke-Thornton

26 January 2016

1. *Review 3: Sign off Progress on Health of the Borough Report for 1 February OSC (9 February Cabinet)*

2. **Review 4: Joint Mental Health Strategy: A joined up approach?**

- Does the mental health strategy set out a convincing enough case for a joined-up approach to mental health in Southwark?

- What more do we need to do to ensure a joined up approach to mental health?

- What further recommendations should we make to the Cabinet Member regarding the strategy after 6 months of it being enacted?

    - Centre for Mental Health
    - MIND
    - Other mental health charities/organisations
    - Patient Opinion
    - Guys & St Thomas Hospital Foundation Trust
    - Kings Hospital Foundation Trust
    - South London & Maudsely (SLaM)

** this session would be in a roundtable format

2 March 2016

1. Cabinet Member interview: Cllr Stephanie Cryan
2. Cabinet Member interview: Cllr Barrie Hargrove
3. Council Local Accounts

22 March 2015

1. *Review 4: Sign off Mental Health strategy review for 4 April OSC (12 April Cabinet)*

2. Annual Safeguarding Report

3. Hospital Quality Accounts

4. Hospital mortality and morbidity statistics.

    - hospital ward staff turnover and levels of ward staffing
    - Scrutinise hospital mortality and morbidity statistics.
    - Scrutinise hospital ward staff turnover and levels of ward staffing
    - Receive and consider Serious Incident Reports, including analysis of root causes.

5. **Review 5: Public Health: Delivering for Southwark Residents**

- How has the Public Health function been integrated into the Council?
- What are the national expectations for public health?
- What were the priorities for the last 12 months and what are the priorities for the coming 12 months?
- How do we measure the success of public health outcomes?

    - Public Health England
    - Council officers
    - Health & Wellbeing Board
    - Clinical Commissioning Group
    - Cabinet Member for Public Health

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2015-16

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Councillor David Noakes (Vice-Chair)	1	Andrew Bland, Chief Officer, Southwark CCG	1
Councillor Jasmine Ali	1	Malcolm Hines, Southwark CCG	1
Councillor Paul Fleming	1	Dr Ruth Wallis, Public Health Director	1
Councillor Lucas Green	1	Jin Lim , Public Health Assistant Director	1
Councillor Bill Williams	1	Alexandra Laidler, Acting Director, Adult Social Care	1
Councillor Maria Linforth-Hall	1	Rachel Flagg, Principal Strategy Officer	1
Health Partners		Shelley Burke, Head of Overview & Scrutiny	1
Matthew Patrick, CEO, SLaM NHS Trust	1	Sarah Feasey, Legal	1
Jo Kent, SLAM, Locality Manager, SLaM	1	Chris Page, Principal Cabinet Assistant	1
Zoe Reed, Director of Organisation & Community, SlaM	1	Niko Baar, Liberal Democrat Political Assistant	1
Steve Davidson, Service Director, SLaM	1	Julie Timbrell, Scrutiny Team SPARES	10
Marian Ridley, Guy's & St Thomas' NHS FT	1	**External**	
Professor Sir George Alberti, Chair, KCH Hospital NHS Trust	1	Rick Henderson, Independent Advocacy Service	1
Julie Gifford, Prog. Manager External Partnerships, GSTT	1	Tom White, Southwark Pensioners' Action Group	1
Geraldine Malone, Guy's & St Thomas's	1	Fiona Subotsky, Healthwatch Southwark	1
Sarah Willoughby, Stakeholder Relations Manager, KCH FT	1	Sec-Chan Hoong, Healthwatch Southwark	1
		Elizabeth Rylance-Watson	1
Electronic agenda (no hard copy)		**Total: 42**	
Reserves		**Dated: May 2015**	
Councillor Maisie Anderson			
Councillor Helen Dennis			
Councillor Jon Hartley			
Councillor Eliza Mann			
Councillor Johnson Situ			