Our Healthier South East London
Sustainability and Transformation Partnership

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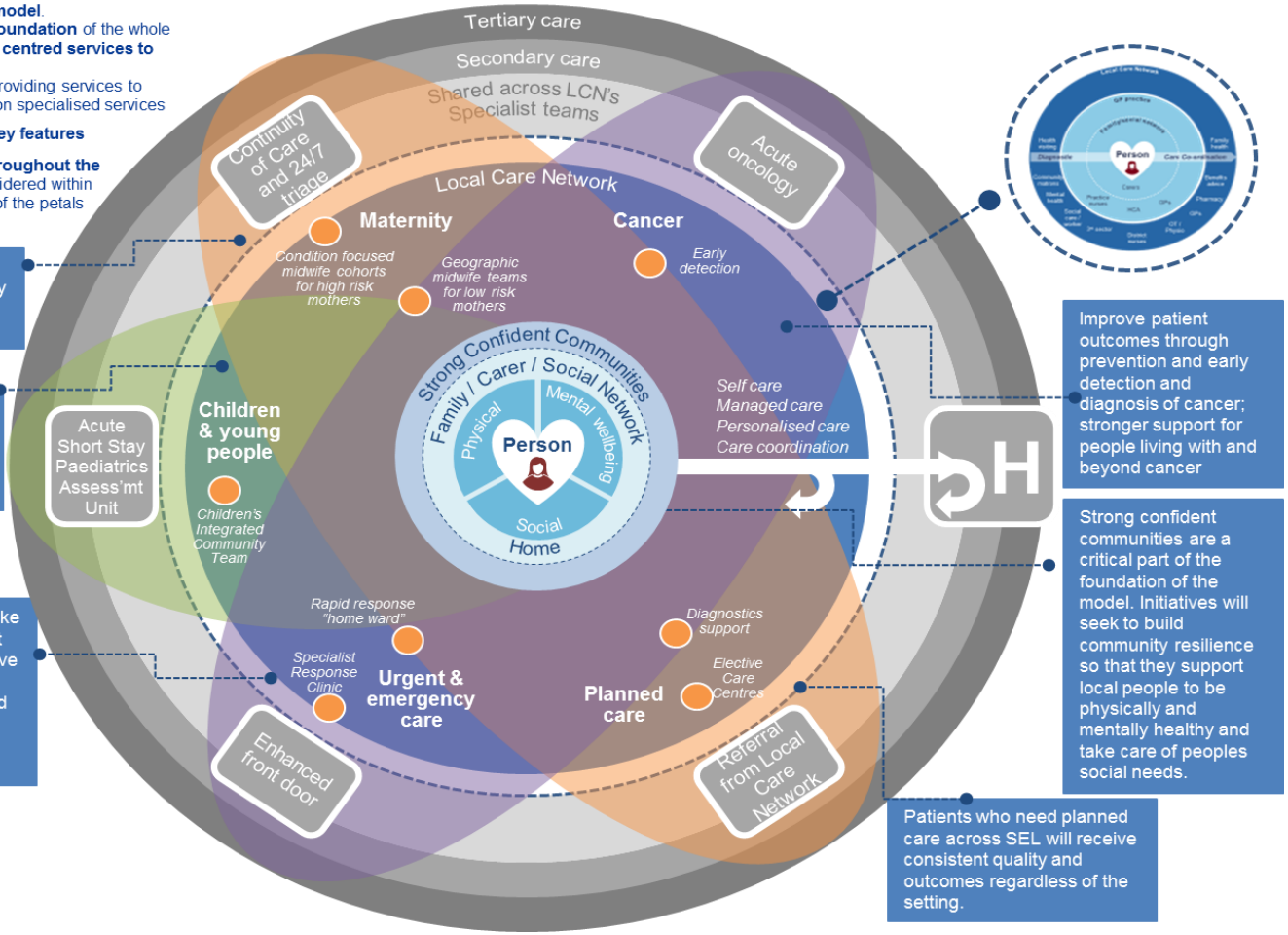
4. Community Based Care – strategy and governance

Local Care Networks are described as the delivery model within our Strategy:

Community Based Care delivered by Local Care Networks is the foundation of the 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.

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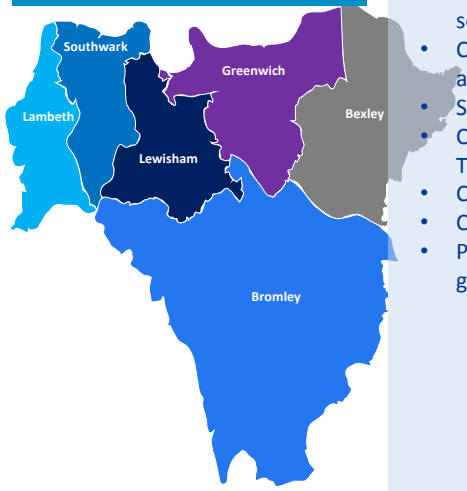
All Local areas have adopted the target model and developed plans with milestones for delivery that also encompass the London Primary Care Standards

Integrated Single System Leadership and Management

Serving geographically coherent populations between 50,000 – 150,000



'The Core' (as a minimum all LCNs should encompass)

- Leadership team
- All general practices working at scale (federated with integrated IT system (s) and leadership)
- All community pharmacy
- Voluntary and community sector
- Community nursing for adults and children
- Social care
- Community Mental Health Teams
- Community therapy
- Community based diagnostics
- Patient and carer engagement groups

Working with…

- Strong and confident communities
- Accessible HOT clinics and acute oncology (urgent and emergency and cancer care)
- Specialist opinion (not face to face) and clear specialist service pathways
- Pathways to MDTs
- Integrated 111, LAS and OOH system (interface with UCCs co-located with ED model)
- Housing, education and other council services
- Community based midwifery teams
- Private and voluntary sector e.g. care homes and domiciliary care
- Cancer services
- Children's integrated communit team and short stay units
- Rapid response services
- Carers
- And there will be others..

High Impact Schemes

1. Supporting people to manage their own health
2. Prevention – Obesity, Alcohol and Smoking
3. Improved Core general practice access plus 8-8, 365
4. Enhanced call and recall – improves screening and early identification and management of LTCs
5. Reduction in gap between recorded and expected prevalence in LTC
6. Supporting vulnerable people in the community including those in care homes and domiciliary care
7. Reduction in variation (level up) primary care management of LTCs
8. Reablement – Admissions avoidance and effective discharge
9. MDT configuration – main LTC groups (incl. MH) and Frail elderly
10. End of Life Care
11. Medicines Management

Integrated Pathways of care

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Local models of care are being developed based on people's experience of current services and what matters most to them

Keeping healthy, preventing illness and managing my condition

Proactive preventative care "There should be more proactive care to stop greater needs arising down the line. This doesn't need to be provided by a highly-paid professional, they could be a volunteer."

Reducing stigma to access care early on "I only went to see my GP when it got really bad." "I don't trust my GP as I know they will judge me."

Care planning "When I became ill I thought it would be gone within weeks or months, I had no idea it would be years. We never made a plan for my reduced mobility, I've piled on the weight and so I'm now at risk of diabetes as well."

Support to adjust to a long term condition or serious illness "I felt unprepared for the impact it would have on my life, financially, emotionally, with my relationships, my job... I would have liked advice on benefits, and to be told what to expect."

Self-management support "I'd have liked resources and tools to help me remain independent, but I had to find everything by myself"

Activating support from my family, friends, carers and community

Support community and voluntary services to come together "Bringing together community services would help enhance their impact."

Provide better links to activities in the community "I would like to know what is available, walking groups for example." "I had to find the services myself." "There should be a single point of access for community," activities."

Create opportunities for people to support others "I'd like to give something back. I don't want to join a support group, but I'd like to be a sort of mentor to someone going through the same thing I did."

Receiving great quality whole person care close to home

Increase access to alternative therapies "I would like more access to alternative therapies, as they take a whole person approach."

Increase training for GPs for end of life care and long term conditions "My GP did not understand my condition or what I was going through."

Quick access to specialist expertise in the community "The diagnosis took months. I would really value direct access to specialists and a quick diagnosis in the community." "I would prefer to be treated in my own environment as much as possible."

Enhanced role of pharmacies "I love going to my local pharmacy. They have been run by the same family for three generations and have great knowledge. I can find everything I need there." "Pharmacies could play a bigger role such as helping with medications management."

Easy transitions in and out of hospital

Better transition across health services "There should be better communication between professionals across the system. This could be through shared health information passports, or improved technology systems."

Direct contact to a trusted expert "I could just email the team and they'd get back to me within the same day.They know me and give good advice. I know they are always there for me, I will never come off their books."

FEATURES *These are features of the proposed model of care*

- Self management tool kits
- Public health programmes
- Health coaching
- Social prescribing
- Optimising neighbourhood assets
- Active case management
- Disease management
- Wider community infrastructure police, fire service, schools, housing
- Improved access to diagnostics
- Longer opening hours in the community to prevent hospital admission
- Joint working Pharmacies, social care, mental health, nursing, benefits, GPs and charities
- Specialist input provided in the community consultants, geriatricians, nurses, end of life expertise

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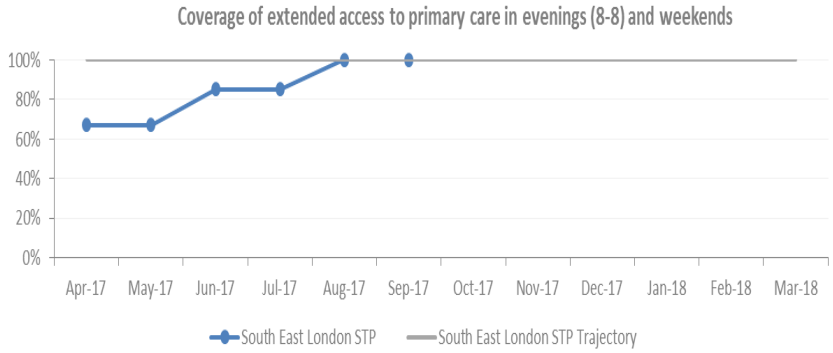
Local systems have been developing local care models in line with our community based care model for South east London

Longer opening hours in the community - Enhancing our primary care offer:

- With effect from Quarter Three 2017/18, South East London will be making 260,000 additional primary care appointments per annum available through Access Hubs
- A review of the evidence of the enhanced primary care offer across Southwark and Lambeth suggests that the increase of 10,500 primary care appointments could be related to a reduction of 3,500-4,500 attendances at urgent care
- 100 % Coverage of extended access to primary care across SEL



Support self management & improving access - Digital technology:

- Piloting NHS First (Bexley) to build a seamless patient-facing digital experience to access the NHS
- Supporting Virtual collaboration CCGs have provided a video-conferencing infrastructure to support virtual consultations, communications, remote access and virtual training
- Supporting the uptake of patient online

Social prescribing - Supporting patients to manage their own health;

- Developing offers to wider support and signposting (social prescribing) For example, working with Age UK to provide the successful Safe and Independent Living (SAIL) service. This service aims to support older people to maintain their independence, safety and wellbeing by providing a quick and simple way to access a wide range of local services

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Improved access to diagnostics -Supporting the management of Long Term conditions (LTC):

- Early Diagnosis programme in Greenwich to increase LTC early detection rates in the primary care setting, in order to prevent or delay the onset of acute illness and improve health outcomes
- The increase in recorded prevalence from these early diagnoses has further enabled improvement in the management of conditions. Of the cohort of Diabetes patients who had a HbA1c > 75, for example, 35% now have an HbC1c under 75. This is expected to lessen co-morbidity in this population in the future

Joint working & specialist input in the community - Supporting re-ablement:

- Southwark has taken forward work with Guy's and St Thomas' Hospital to design and deliver a new provider alliance model bringing together the urgent response and short term treatment, rehabilitation and re-ablement functions to create a single health and social care service. This service went live on 1st April.

Joint working & specialist input in the community - End of Life care:

- We have Increased home based care, including accelerated discharge, support for frail elderly and developed MDT approaches across SEL to support enhance and support care in care homes
- We are improving the co-ordination and delivery of care for people with progressive and advanced illness or frailty. Bromley Care Coordination (BCC) service has bought together services around the patient to deliver improved quality of care and reduced unnecessary admission to hospital.

Example: Bromley's local transformation work

PROACTIVE CARE: THE PATHWAY

1

An initial **HOLISTIC ASSESSMENT** (Guided conversation) is carried out with the patient by the most relevant person, who will usually be the Community Matron

INITIAL ASSESSMENT

2

An **INTEGRATED CARE AND SUPPORT PLAN** will be developed by the Community Matron with the patient, supported by the **CARE NAVIGATOR** role (when required)

INTEGRATED CARE PLAN

3

A **MULTI-DISCIPLINARY TEAM** carries out an initial review of the person, updates and ratifies the **INTEGRATED CARE PLAN**, and assigns a **CLINICAL LEAD** based on the agreed **PRIMARY NEED** of each person

INITIAL MDT MEETING

4

The **NOMINATED GP CHAIR** will Chair the MDT meetings to ensure all the patient's needs are considered and actioned, ensuring that the best interests of the patient are considered and prioritised

CLINICAL GOVERNANCE

5

The **CLINICAL LEAD** is the first point of contact for the patient for their **PRIMARY NEED**, supported by the **MDT LIAISON COORDINATOR** who will be the main point of contact for all other needs (including self-management support)

POINT OF CONTACT

6

The updated **INTEGRATED CARE AND SUPPORT PLAN** is shared with the patient by the most relevant person and the care plan is implemented, overseen by the **CLINICAL LEAD** and coordinated by the **CARE NAVIGATOR** with support from the **MDT LIAISON COORDINATOR**

PATIENT INVOLVEMENT

7

The **MDT LIAISON / CARE NAVIGATOR** arrange **MDT** reviews at the intervals set out in the **INTEGRATED CARE AND SUPPORT PLAN** to review the care plan progress and make changes to the patient's care as required (70% of patients will require discussion at a 2nd MDT)

REGULAR REVIEW

8

When required an **HOLISTIC ASSESSMENT** (guided conversation) is carried out to re-assess the needs of the person, and where appropriate reduce the intensity of support they need

RE-ASSESSMENT

NHS Bromley Clinical Commissioning Group

CASE STUDIES AND FEEDBACK

"SG" was given advice on benefits and the need to maintain provisions e.g. buy non-perishable items by the Care Navigator (Age UK). Contact was made with a food bank to provide assistance, EDF energy to place credit on his meter and credit was added to his Oyster card to enable him to travel to planned medical appointments.

In the six weeks before the MDT intervention, SG had called 111 on 16 occasions, visiting A&E 4 times.

Six weeks after there have been no emergency contacts.

"CS" wouldn't previously accept support with personal care, is non-compliant with medication and refused to attend a memory clinic. With help from the Care Navigator and Oxleas, she accepted a memory assessment and power of attorney with next of kin. A social care package and review from Medicine Optimisation Service was also put in place.

Medicine compliance is now greatly improved resulting in a reduction in calls to primary care. Measures are now in place to prevent secondary care admission.

"PB" was seen by the Community Matron and St Christopher's in a joint visit. Age UK also visited to discuss benefits and services such as befriending. She also saw the Consultant Gerontologist in clinic directly arranged through the MDT.

Reviews were performed by District Nursing who arranged for the podiatry service to visit and joint management with the falls service. Assessments were made for aids around the home and a physiotherapist visited to review mobility.

Feedback from the patient's carer:

"I can't thank you enough for everything you have done for my family. It was such a relief for me personally to be able to hand over the management of mum's various problems to someone knowledgeable and competent, instead of travelling through unfamiliar territory on my own when much was at stake for us. With kind regards and gratitude."

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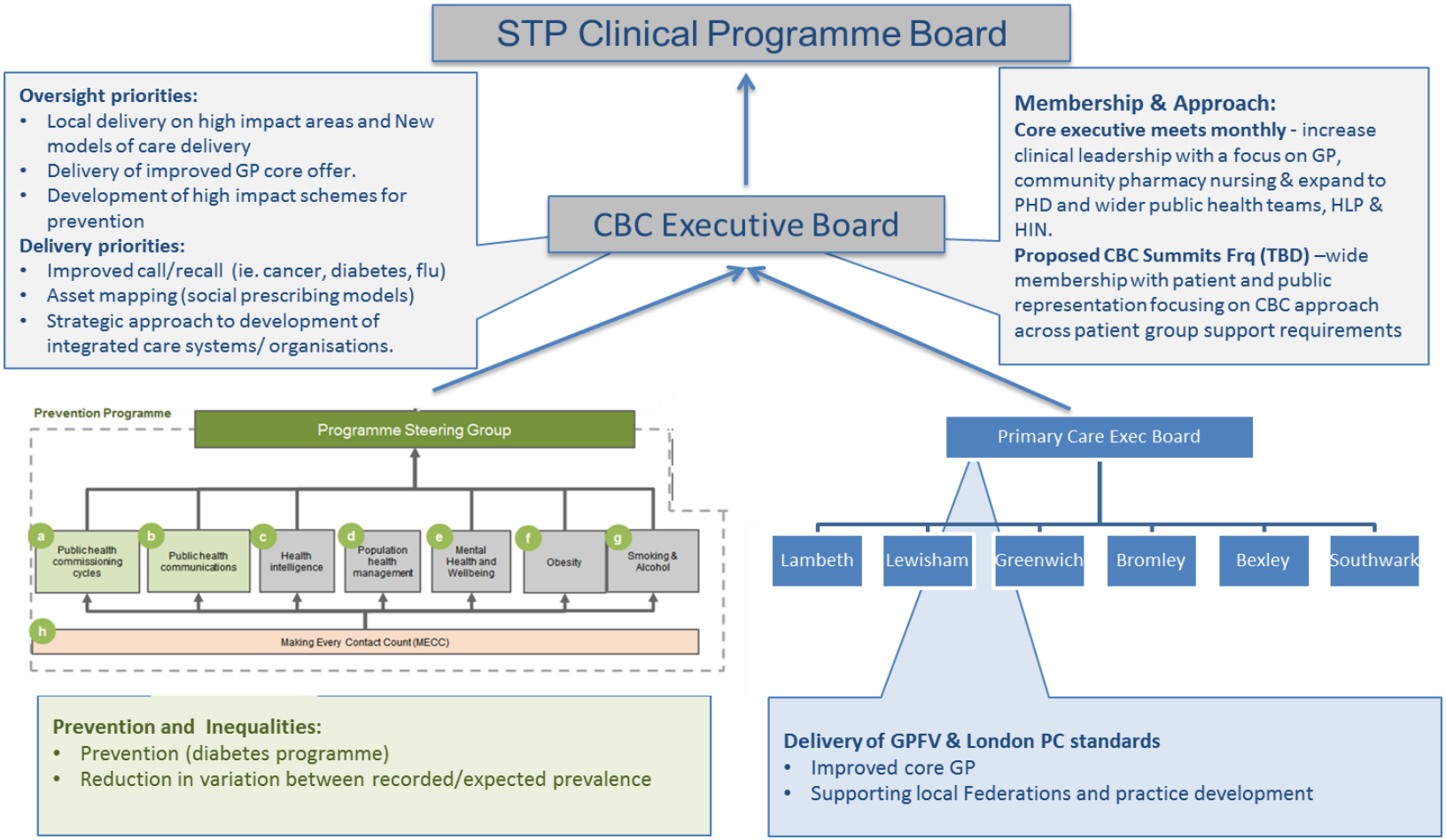
An updated governance structure has been agreed to support the leadership and oversight of the community based care strategy.



Updated governance structure for community based care: The clinical leadership groups for CBC will feed into the STP clinical programme board supported by two key sub groups to increase the focus on SEL wide leadership on; prevention and tackling health inequalities; and the delivery of the GPFV and London primary care standards as the focus for improved general practice at the core of local care network development and delivery