South East London Commissioning Strategy Programme

Commissioning Strategy 2014-19

30 May 2014

Version 0.19 – DRAFT (IN DEVELOPMENT)

Contents

Executive Summary

i. Overview

The NHS in South East London is planned by Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs and NHS England (London). Together we are working in partnership with local authorities, local providers and other key stakeholders to define a five-year Strategy for health and integrated care services across south east London.

The strategy complements and builds on local work and has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together. It seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. It also meets the NHS England requirement that all CCGs develop a commissioning strategy and, specifically, the requirement to submit a document for review by NHS England by 20 June 2014.

The approach is commissioner led and clinically driven, and informed by wide engagement with local communities, patients and public.

This document sets out the proposed five year commissioning strategy for South East London, for submission to NHS England on 20 June 2014. It builds on earlier submissions on 20 December 2013 (Headline Strategy, our 'plan for a plan') and 04 April 2014 (Draft Strategy).

This document brings together the content of CCG Operating Plans focusing on changes at borough level predominantly over the next two years, with the emerging system-wide components being developed collaboratively by the NHS, local authorities and partners across South East London, which will have a transformational impact over years three to five of the Strategy.

The Strategy and its component parts are still very much a live working document and should be considered in the context of continuing development, testing and iteration.

Executive Summary

ii. Our vision and ambition

A five year NHS Commissioning Strategy for south east London is being developed in partnership with local authorities and local providers led by our clinicians. It builds on the individual strategies of the CCGs, working in partnership with their local authorities and others, is framed by the Health and Wellbeing strategies and focuses on those issues which would be best done together.

Working with partners we are developing a collective vision for the health system in south east London, based on the following themes:

- 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

iii. The Case for Change in South East London

The vision and ambition reflects the needs of the people of south east London, which are reflected in our case for change:

- The health of south east London's population has improved significantly, but there is much more to do
- The national and London context is changing the way that health and integrated care services are planned and delivered
- Significant developments and opportunities within south east London help us to make a strong and innovative response to the national and London context
- Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long
- Commissioners face a challenging financial position, and need to secure the best value out of **the £2.8bn** spent on NHS services
- Our health and social care partners face a similar and interrelated set of challenges supporting the same populations so working together is the best approach.

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iv. How we will measure success of the Strategy

The Strategy is designed to achieve the following over the next five years:

- Improved health for people in south east London, including sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs, and sustained improvement in life expectancy and particularly healthy life expectancy
- Reduction in health inequalities within all south east London boroughs
- Achievement of London Clinical Standards* across all services where these apply
- All organisations within the health economy to be financially sound and sustainable and to report surplus in 2018/19
- No provider will be subject to enhanced regulatory scrutiny due to performance concerns

v. Our objectives and integrated system model to deliver these

The first two years of the strategy will be delivered by the operational plans of the CCGs; the changes are more locally driven, but will lead us into wider transformation in years three to five.

Seven system objectives have been agreed by the Partnership Group and reflect both local priorities and national framing; and are set out below.

1. Securing additional years of life for those with avoidable and treatable mental and physical health conditions
2. Improving the health related quality of life of people with one or more long-term conditions, including physical and mental health
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community
4. Increasing the proportion of older people living independently at home following discharge from hospital
5. Increasing the number of people having a positive experience of hospital care
6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

* London quality standards - http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/Model-of-care-standards-FINAL-Feb2013-v1.11.pdf

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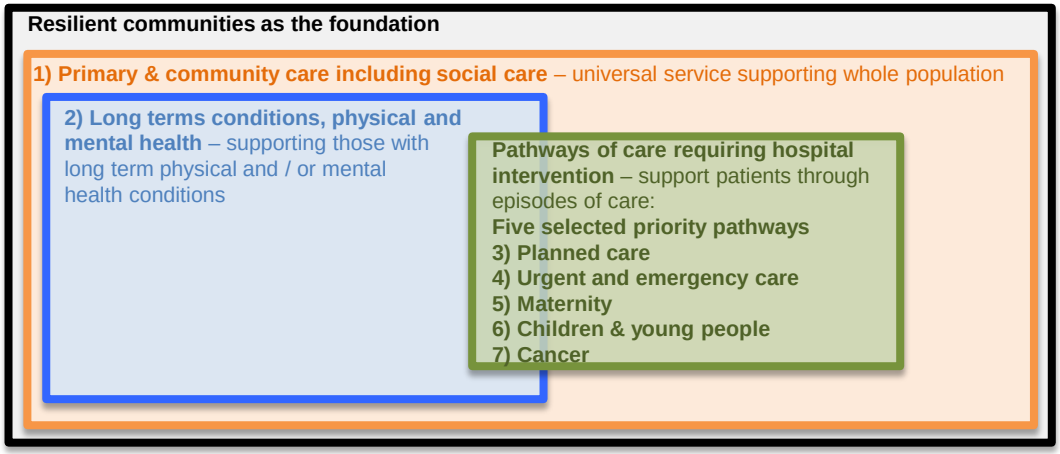
v. Our objectives and integrated system model to deliver these (Contd.)

South east London is developing an integrated system model which brings together the different components of the Strategy into a single health system focused on delivering the objectives of the Strategy. The system model sets out the key elements and characteristics of the health and integrated care system that will be in place by the end of year five of the Strategy.

- The Integrated System Model has at its foundation the recognition that we must and can strengthen the resilience of our local communities. This is the core business of each borough's Health and Wellbeing Board and the partners who have developed this strategy have agreed to ensure that they fully support this work.
- Primary and community care services are the cornerstone of health and social care and 90% of NHS contacts are provided in the community. South east London will deliver these services through 24 **Locality Care Networks** which will bring together GP practices with wider primary care and community services to support their communities and people.
- Those people with long term physical and / or mental health conditions will be able to access services through integrated teams which bring together social care and wider local authority services, NHS funded services and the voluntary sector.
- For people who are most ill and require NHS care provided in hospitals, it is essential that the different parts of the system are well connected as patients experience joined-up care across organisational boundaries. In addition to primary and community care and long term conditions, physical and mental health, the Strategy focuses on a further five priority pathways which support people across hospital and community settings. This strategy does not seek to address each and every pathway that patients need but focuses on those pathways that require coordinated approaches across our SEL boroughs and the different parts of the NHS system.



- The integrated model is underpinned by the eight characteristics of our integrated system, which are to:
  1. Build resilient communities
  2. Promote health and wellbeing
  3. Provide accessible & easy to navigate services
  4. Join up services from different agencies & disciplines
  5. Deliver early diagnosis & intervention
  6. Raise the quality of services to the same high standard
  7. Support people to manage their own health & wellbeing
  8. Achieve improved outcomes for all residents

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vi. Key improvement interventions

The seven strategic interventions that make up the system model are being developed by Clinical Leadership Groups. The interventions were prioritised by the Partnership Group and other key stakeholders, in order to achieve the greatest impact on improving outcomes and reducing inequalities, whilst addressing variation in quality and experience of patients' care. The groups' outputs are in the early stages of definition and testing and will be further developed after the next submission of the Strategy on 20 June.

The key focus of each intervention is set out below.

EMERGING CONTENT– SUBJECT TO FURTHER REVISION / DEVELOPMENT

1. Primary and community care	• Provided at scale by 24 locality care networks supporting whole populations • Universal service covering the whole population 'cradle to grave' • The changes to primary care will focus on four high impact areas: Access, Proactive care, Coordinated care, Continuity of care
2. Long term conditions for physical and mental health	• Those with long term physical and / or mental health conditions will be supported with segmentation into three categories • Locality care networks will play a lead role at all stages • There will be a consistent focus on: reablement (not just the prevention of deterioration, but returning people to better health); coordinated care and care planning; and supporting self management
3. Planned care	• Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and 'one-stop-shops' where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; specialty focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
4. Urgent & emergency care	• Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to 'do and discharge' • Services meeting London Quality Standards
5. Maternity	• Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multips; birth centres for low risk primips • Continuity of care through a 'midwifery led' model with improved/extended consultant cover • Assessing for women's toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
6. Children	• Collective focus on the child including, 'every contact counts' • Improved Access – 'no wrong door' • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
7. Cancer	• Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

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vii. Impact of model

We will measure the impact of delivering our integrated system model by looking at:

- Delivery of the NHS outcomes (which are also our system objectives for the Strategy) and other key outcomes for south east London
- Changes in patient activity across our system
- Changes in the investment and ongoing costs to deliver health and integrated care services.

The impact of delivering the model will be across three key areas:

- Through a much greater emphasis on health and wellbeing, prevention and early intervention we will drive improved health outcomes and reduced health inequalities for our population that enable people to live longer and live healthier lives for longer
- Building on a foundation of community resilience and greater self-care there will be a significant shift of activity and resource from services focusing on late response in secondary care to primary, community and social care, and services enabling self-care. The transformation of our universal primary and community services provided through Locality Care Networks, and the transformation of how we support those with long term physical and mental health conditions will be key to this
- Through delivering consistently high standards of care across all services we will improve patient experience and clinical outcomes and reduce variation for our patients. We will re-shape services to create centres of excellence supporting networks of care. This will require significant one-off investment and will change patterns of spend on local services.

The first two years of the Strategy will be delivered through the Operating Plans of the six CCGs. Years three to five build on those foundations to deliver system transformation, driven by our seven priority interventions. The current stage of development of the Strategy is therefore a combination of a shared vision, detailed plans for years one and two, and an emerging view of the impact of years three to five

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viii. Supporting strategies

When the strategic opportunities and scope of the Clinical Leadership Groups were agreed, it was acknowledged that there would be some overlap and interplay between the groups and further that there would be a need for cross-cutting supporting strategies to enable the delivery of interventions defined through the groups.

Supporting strategies will be a fundamental part of the development of the strategy after the 20 June NHS England submission and successful implementation of any resulting system changes. Clinical Leadership Group workshops and the Partnership Group stakeholder meetings have identified a number of common supporting strategies. Initially, four priority strategies will be developed, which are detailed below.

Priority Supporting Strategy	Overview
IT and Information	To drive a consistent and accessible approach to IT and information across all providers including: • Shared definitions and standards • Sharing of patient data and health information across providers • Use of a virtual patient record
Workforce	To develop a new workforce model that meets the needs of an increasingly community based model of prevention and care including: • Use of multi-disciplinary teams, at the right time in the right place • 24/7 care with an appropriate range of skills • Addressing recruitment and retention issues • Supporting cultural and behavioural change to reflect the emphasis on public health and self care
Commissioning Models	To develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system, including: • Commissioning and providing for outcomes • Development of incentives and contractual levers for change, including quality improvement • Effective co-commissioning to reduce complexity and ensure consistency of approach.
Communications and Engagement	To develop the existing Communications and Engagement workstream to support all aspects of the programme over the coming months including: • Coordination of local and south east London-wide engagement on the strategy, including potential impacts on the health system • Communication with stakeholders, patients, local people and staff • Development of proposals for campaign approach to engage patients and local people in the strategy and management of their own health
Estates	To an Estates workstream with particular focus on: • Supporting Locality Care Networks through enabling the bringing together of staff and services • Promoting co-location of services where appropriate • Establishing primary care estate for the 21st Century.

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ix. Programme approach and governance

Our approach to delivery of the Programme

Our approach to delivering the Programme focuses on partnership, engagement, and clinical leadership, and is reflected in our governance and decision-making structure, including:

- The key decision making body, the **Clinical Commissioning Board**, which brings together commissioners from CCGs, NHS England and Local Authorities and also includes Patient and Public voices as well as Healthwatch representation
- The key partner forum, the **Partnership Group**, which brings together a wide range of senior clinicians and managers from commissioners (including Local Authorities), providers and advisory bodies and also includes Patient and Public voices
- The **Clinical Executive Group**, which provides leadership, challenge and assurance to the individual clinical leadership groups and manages interdependencies across groups
- **Clinical Leadership Groups,** which are clinically led working groups consisting of senior experts drawn from across commissioners, NHS providers, social care, and public health, as well as Patient and Public voices and Healthwatch representation.

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x. Our work to date

In our work to date:

- Over 100 clinicians, 50 patient and public voices, senior management and clinical commissioners from all 6 CCGs, NHSE primary care and specialised teams, six Local Authorities including CEOs, Public Health and social care, members of the voluntary sector, 6 Healthwatches, and the chief executives, medical and nursing directors from local providers have all engaged in planning, discussion, design, challenge and learning over the last 6 months
- An Case for Change has been developed for south east London, on which we have sought further engagement and which has been used as a basis to set the priority areas of focus for the Strategy
- An overarching integrated service model has been developed and all CCG GP member practices have adopted a new and consistent approach to working together in locality care networks.
- New models of service delivery have been designed by Clinical Leadership Groups – clinically led design groups – for primary and community care, long term conditions, planned care, urgent and emergency care, maternity, children and young people, and cancer
- These have been developed at speed and now need to be tested, refined and the detailed planning to implement need to be put in place.

This 20 June submission of the Strategy sets out the vision, model, and emerging transformational impact of delivering an integrated system model of health and social care across south east London. In doing so the Strategy sets out how we will deliver improved health outcomes and reduced health inequalities whilst addressing unwarranted variation in quality and experience and setting the local health system on a sustainable footing.

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xi. Further development after 20 June 2014

Beyond 20 June 2014 our work will be focused on:

- Continued development and delivery of key elements of the strategy, with a particular emphasis on primary and community care and long term conditions
- July to December 2014 and beyond – Work to develop proposed interventions and impacts at an institutional and community level with engagement on the Strategy and implications as they develop
- 2015 – Options for implementation, where appropriate and any business case for significant service change (if required) and potential consultation (if required)

During the next phase of the Strategy from 20 June we will:

- Engage with stakeholders and wider public on emerging strategy including the integrated system model
- Identify potential implications of the proposed integrated system model on communities, institutions and organisations
- Develop financial and economic models to test the likely impact of service models being developed by Clinical Leadership Groups
- Develop draft detailed roadmaps for each Clinical Leadership Group
- Undertake capacity modelling on the existing system and proposed integrated system model
- Establish priority supporting strategies
- Start to engage on the implications of the proposed integrated system model

Our expectation is that at the end of the strategy implementation we will have transformed our health system to deliver better outcomes for public and patients in south east London, doing so in a way that is sustainable for future generations.

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xii. Implementation work already underway

We understand the urgency to change services and significant work is already underway that will deliver foundational elements of the Strategy during years one and two. Collaboration on the Strategy follows a principle of 'shared standards, local delivery'. This means CCGs working together at the right scale: at borough, cross-borough or south east London level. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the Strategy. Some examples of significant work already being implemented are as follows:

- **Development of wider primary care, provided at scale** South east London CCGs are already working to transform local primary and community care:
  - The six boroughs have developed a model under which services will be provided at scale by 24 locality care networks supporting whole populations. This builds on the current pathfinder programme for developing new models of primary care under which there have been 12 applications, each with geographical coherence, with a coverage of more than 750,000 registered patients
  - Southwark CCG have been granted £950k from the Prime Minister's Challenge fund to provide extended access to primary care through neighbourhood working, supporting the implementation of the CCG's Primary and Community Care strategy
  - Lewisham CCG has transformed its Diabetes Pathway through enhancing diagnosis across Primary Care, including 'Peer2Peer support' which involves a dedicated clinical lead supporting practices by providing hands on in-practice advice and guidance
- **Developing a modern model of integrated care** There has been significant progress to date in the development of integrated care, delivered through south east London's Community Based Care programme. In addition to developing plans with local authorities under the Better Care Fund, CCGs have also achieved a number of other key milestones:
  - The development and scaling of the Southwark and Lambeth Integrated Care Programme (SLIC)
  - Greenwich achieving national pathfinder status for Integrated Care
- **Improving and enhancing local urgent and emergency care** Locally driven work to improve urgent and emergency care including the redesign of Guys and St Thomas Emergency Department and Urgent Care Centre (UCC) in Lambeth and the successful transition of the 111 service to London Ambulance Service and subsequent achievement of all targets.
- **Transforming specialised services** The development of new cancer treatment centres at Guys Hospital and a cancer treatment centre at Queen Mary's Hospital Sidcup
- **Building resilient communities** South east London's CCGs are working with local authorities through Health and Wellbeing Strategies, to build and develop **resilient communities**, for example through the award winning Lambeth Living Well Collaborative
- **Partnership working across south east London** The Programme has a strong partnership approach, led by NHS commissioners and involving closely a wide range of local partners, including patients and communities, local authorities and NHS providers. Our Partnership Group provides a strong and collective transformational leadership of the Strategy, with a shared recognition across all members of the scale of the challenge and also the level of organisational and cultural change needed.

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xiii. Risks

We know there are risks to both the development and the implementation of the Strategy. Our key implementation risks are set out below. We understand and are mitigating them. We also recognise that the risk if we do not act, is much greater.

Title	Risk	Impact	Mitigations
Insufficient Impact of Change	• When implemented the impact of the strategy is insufficient to meet the need and ambition	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Collective modelling work and triangulation of strategies and plans across south east London
Insufficient investment to deliver the change	• There is insufficient investment available to deliver the scale of change at the pace required	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Detailed planning and modelling to quantify investment needed and when • Use of non-recurrent funds to pump prime change • Including investment requirements in financial modelling
Financial Sustainability of Health System	• New service models in primary care and community services do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand	• Increased system costs through duplication of services and low productivity leading to poor patient and staff experience • Quality remains variable • System is unsustainable	• Clinical Executive Group and Partnership Group review integrated system model and all draft service models as a whole to ensure that any proposed changes to the health system are effectively balanced. • Impact of areas of early implementation (primary and community care, integrated care) reviewed in models as the develop.
Information Systems	• Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in South East London	• Duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost	• Information Systems to identify and support improvements required to mitigate.
Workforce	• Workforce requirements of new models of services cannot be met in a timely fashion	• Skills not available in right location to support new models of care • Insufficient capacity in system to support cultural change required to drive new behaviours	• Workforce strategy, with input from LETB to identify workforce impacts of proposed changes and develop plans for resolution

Introduction (1 / 2)

- Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs, working with NHS England as co-commissioner, are working in partnership with local authorities, local providers and other key stakeholders to define a five-year Strategy for health and integrated care services across south east London. The approach is commissioner led and clinically driven, and informed by wide engagement with local communities, patients and public.

- This approach is reflected in the programme's governance and delivery structure, which includes the following key groups:

  - The key decision making body, the SEL **Clinical Commissioning Board**, which brings together commissioners from CCGs, NHS England and Local Authorities and also includes Patient and Public voices as well as Healthwatch representation.
  - The key partner forum, the SEL **Partnership Group**, which brings together a wide range of senior clinicians and managers from commissioners (including Local Authorities), providers and advisory bodies and also includes Patient and Public voice.
  - The SEL **Clinical Executive Group**, provides overall clinical leadership, challenge and assurance to the individual clinical leadership groups and manages interdependencies across the programme and helps build consensus across SEL. The group brings together senior clinicians from commissioners and providers as well as Patient and Public voices and Healthwatch representation.
  - SEL **Clinical Leadership Groups,** which are clinically led working groups consisting of senior experts drawn from across commissioners, NHS providers, social care, and public health, as well as Patient and Public voices and Healthwatch representation.

- This document sets out the headlines of the emerging five year commissioning strategy for South East London, for submission to NHS England on 20 June 2014. It brings together CCG Operating Plans focusing on changes at borough level predominantly over the next two years, with the emerging system-wide components being developed collaboratively by the NHS, local authorities and partners across South East London, which will have a transformational impact over years three to five of the Strategy.

Introduction (2 / 2)

This document sets out:

1. Overarching system **vision**
2. Latest **case for change** at headline level
3. The overarching **success criteria** against which the programme will be measured
4. The **integrated system model** setting out key elements and characteristics of the future health and integrated care system
5. The system level **improvement interventions** that will deliver the components of the Strategy
6. An initial view of **system impact** of the Strategy and the specific impacts of key improvement interventions
7. The **supporting strategies** needed to enable the improvement interventions to be delivered
8. Details of **implementation** and key changes already underway
9. Our **approach** to delivering the Strategy
10. An overview of the **programme governance** structure and processes for development of the Strategy
11. A summary of **high-level risks** to delivery of the strategy

The link between each of these sections and the summary Plan on a Page, including headline content, is set out overleaf. This document steps through each of the above sections. Appendix A then sets out individual Plans on a Page for south east London CCGs, and where available for NHS England Direct Commissioning service lines.

X = relevant section of this document

South East London

Plan on a page – and how segments of the plan link to the sections of this document

1 System Vision

In south east London we spend £2.3billion 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
- Closing the inequalities gap between worst health outcomes and our best
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes 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.

3 Success criteria

- Improved health for people in south east London, including sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs, and sustained improvement in life expectancy and healthy life expectancy
- Reduction in health inequalities across south east London, to be measured through an agreed reduction in inequalities across life expectancy and healthy life expectancy within all south east London boroughs
- Achievement of London Clinical Standards
- All organisations within the health economy report surplus in 18/19
- No provider under enhanced regulatory scrutiny due to performance concerns

6 System-level objectives and system impact

System objective 1 - Securing additional years of life those with treatable mental and physical health conditions

System objective 2 - Improving the health related quality of life of people with one or more long-term condition, including mental health conditions

System objective 3 - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

System objective 4 - Increasing the proportion of older people living independently at home following discharge from hospital

System objective 5 - Increasing the number of people having a positive experience of hospital care

System objective 6 - Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

System objective 7 - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Under development - Impact on other key measures such as population outcomes and public health measures

Integrated system model for south east London (4 5)

Resilient communities as the foundation

1) Primary & community care including social care – universal service supporting whole population

2) Long terms conditions, physical and mental health – supporting those with long term physical and / or mental health conditions

Pathways of care requiring hospital intervention – support patients through episodes of care:

Five selected priority pathways

3) Planned care
4) Urgent and emergency care
5) Maternity
6) Children & young people
7) Cancer

System characteristics

- Build resilient communities
- Promote health and wellbeing
- Provide accessible & easy to navigate services
- Join up services from different agencies &disciplines
- Deliver early diagnosis & intervention
- Raise the quality of services to the same high standard
- Support people to manage their own health & wellbeing

7 Supporting Strategies

Priority supporting (enabling) changes that have been identified as critical to enable the delivery of the key improvement interventions, including:

- IT and information
- Workforce
- Commissioning models
- Communications
- Estates

8 Building on the strengths of work already underway

Including:

- Primary and community care
- Integrated care
- Partnership working
- Building resilient communities

9 Approach

- Plan for development of the Strategy to 20 June 2014
- Roadmap for ongoing development and delivery of the Strategy
- Approach to engagement
- Equality impact assessment built into approach

10 Governance

- CCG plans and strategies governed through local arrangements
- Governance of collective strategic change through Clinical Commissioning Board, South East London Partnership Group and supporting bodies

11 High level risks

Risks to the development & implementation of the Strategy are outlined in section 11.

Top risks to delivery are:

B1. Insufficient impact of change
B2. Insufficient investment to deliver the change
B3. Service change not fully implemented

2 Case for Change

Developing the System Vision for south east London

- The system vision sets out what the south east London health system will look like in five years time. This will be supported by underpinning vision statements for each system intervention within the Strategy
- The system vision also reflects the six transformational models / characteristics of a high quality and sustainable system set out in the NHS Vision of '*High quality care for all, now and for future generations*.'
- Appendix C provides additional detail of the system vision and shows how this ties back to the the themes included within the vision statements for each south east London CCG.

Further post 20 June submission

- The system vision will continue to be developed and will be updated as a result of wider consultation and engagement with key stakeholder groups
- Vision statements for each system intervention will be further tested and developed

Vision for south east London and for CCGs

The problem we are trying to solve: 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.

The longer we leave these problems, the worse they will get. We all need to change what we do and how we do it.

Our collective vision for the South East London: In south east London we spend £2.3billion 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.

Introduction to the Case for Change

- The Case for Change is south east London's assessment of the current state of the health system, covering: population health needs; quality and performance of local health and integrated care services across the six boroughs; key national and local context; the scale of the financial challenge that needs to be addressed; and key strategic context for our partner organisations.
- The content included in this document is a headline version of our full Case for Change (supported by summary technical and plain English versions), on which local engagement is currently taking place across all six CCGs. These documents are available on the following link, which is replicated across the websites of each of our six CCGs: http://www.southwarkccg.nhs.uk/get-involved/our-projects-and-events/improving-south-east-london%27s-health-services-together/how-to-get-involved/Pages/default.aspx

- The Case for Change has been developed from a number of inputs and sources including:
  - Local Joint Strategic Needs Assessments for each of the six boroughs
  - Commissioning for Value packs provided to each CCG
  - NHSE London Data Packs provided to each CCG and to the South East London Strategic Planning Group
  - Input from Public Health Departments across each of the six boroughs in south east London
  - Stakeholder feedback from our partners across local authorities, local providers, CCGs, our AHSN and LETB, and other key stakeholder organisations
  - Public and patient feedback.

Further development post 20 June submission

- The Case for Change will be updated in September 2014, in line with the next major iteration of the Strategy
- Key areas which will be updated as soon as further information available:
  - Specialised Commissioning – strategic context and scale of financial challenge
  - Primary Care Commissioning – strategic context and scale of financial challenge

The health of south east London's population has improved significantly, but there is much more to do (1 / 3)

South east London has extremes of deprivation and wealth. A high proportion of the 1.67m population live in areas that are amongst the most deprived fifth (quintile) in England, while a smaller proportion live in the most affluent fifth (quintile) in England[1].

The population of south east London is highly mobile. In Southwark and Lambeth, the equivalent of roughly half the current population has moved in or out over a five year period. Even in Bexley, the borough which has the most settled population, the equivalent of roughly a quarter of the current population has moved in and out over a five year period[2].

Premature mortality and differences in life expectancy are both significant issues. There is a difference in life expectancy between the most and least deprived wards of 8.7 years for women and 9.3 years for men. About 11,000 people died prematurely across south east London over the period 2009 to 2011, with four boroughs being classified in the "worst" category for premature mortality outcomes in England[3].

There are large and growing numbers of children living in south east London. Child poverty and obesity are significant challenges.

- Four out of six boroughs are bottom quartile for percentage of children in poverty, with an area average of 27.8% versus national median of 17.1%. The average for CCGs in the top quartile is 10.5%[3]
- Childhood obesity levels in south east London (for year 6 – 10/11 year old pupils) are consistently higher than the London average and significantly above the England average, with levels ranging from 17.3% to 26%. Five out of six boroughs are in the bottom quartile[4]
- Nationally 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[5]
- Helping our children to get the best start in life (through early interventions and prevention, including access to maternity services, delivering the Healthy Child Programme in full, safeguarding, and support for parents) is critical to our children thriving in childhood and into adult life, especially those from disadvantaged backgrounds.

There are higher proportions of older people living in outer boroughs of south east London. Inner south east London has also experienced an increase in conditions associated with older people through increased life expectancy.

- Bexley (with 6.6% of males and 9.3% of females aged over 75) and Bromley (6.9% of males and 9.7% of females aged over 75) have relatively high proportions of older people compared with other boroughs[3]
- Inner south east London boroughs have also experienced an increase in burden of conditions associated with older people, as a result of increased life expectancy (for example in Lambeth, men now live 5 years longer than in 1995 and women 2.7 years) [3].

[1] IMD 2010, http://data.gov.uk/dataset/index-of-multiple-deprivation, [2] Population mobility based on Census 2011 - ONS Migration Indicators Tool, Mid 2012 data, http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-320124 [3] Public Health England [4] Childhood Obesity Rates 2012/13 - HSCIC, National Child Measurement Programme [5] http://www.youngminds.org.uk/training_services/policy/mental_health_statistics

The health of south east London's population has improved significantly, but there is much more to do (2 / 3)

The biggest causes of premature mortality are cardiovascular diseases, cancers and respiratory diseases. Mortality rates for these diseases have decreased significantly over recent years, but rates continue to be considerably above London average

- Cardiovascular disease: Under 75 deaths from cardiovascular disease in south east London have declined steeply and are now in line with the London average though still slightly above the national average. This masks significant variation between the boroughs, with Greenwich having the highest directly standardised rate at 70 per 100,000 in 2012 compared to Bromley with the lowest at 43. If south east London reduced premature deaths from cardiovascular disease to the levels of the best quartile boroughs in England this would lead to a reduction of 245 premature deaths[1]
- Cancer: Whilst there have been some improvements across the six boroughs prevalence is still above London average. If south east London reduced premature cancer mortality to the levels of the best quartile boroughs in England this would lead to a reduction of 164 premature deaths[2]
- Respiratory diseases: Deaths from chronic obstructive pulmonary disorder across south east London are significantly higher than the national average, driven by high instances in the inner London boroughs. If south east London reduced chronic obstructive pulmonary disorder mortality to the levels of the best boroughs in England this would lead to a reduction of 211 premature deaths[3].

Mental health continues to place the highest burden of morbidity in this part of London.

- A 2011 study identified that in south east London all mental health disorders were associated with substantially lower life expectancy compared to National statistics: between 8.0 and 14.6 years lost for men and between 9.8 to 17.5 years lost for women, depending on the specific disorder[4]
- Nationally, three in four people with common mental health problems receive no treatment, and even for psychotic disorders this figure is nearly 1 in 3. People with severe mental illness are in some cases 3 or 4 times more likely to die prematurely from the 'big killer' diseases, when compared to the population as a whole[5].

[1] Premature deaths from cardiovascular diseases 1993 – 2012 HSCIC Indicator Portal, [2] Cancer Mortality (1993 – 2012) - HSCIC Indicator Portal
[3] Deaths from Chronic Obstructive Pulmonary Disorder (COPD) 1993-2012HSCIC Indicator Portal, [4] Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London, Chang et al, 2011, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0019590,
[5] 'Achieving Parity of Esteem between Mental and Physical Health' Norman Lamb MP, Care Services Minister, June 19th 2013 - https://www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health

The health of south east London's population has improved significantly, but there is much more to do (3 / 3)

A number of other health issues have been identified as a 'high burden' of ill health across south east London.

- Alcohol-related diseases: there are above average admission rates for alcohol attributable diseases, and an increase in mortality rates. If south east London reduced premature alcohol specific mortality to the levels of the best quartile boroughs in England this would lead to a reduction of 26 premature deaths[1]
- Sexual health: there are the highest levels of HIV and STIs in the country in inner south east London, with a concentration amongst gay men and black African populations for HIV
- Older People: there is a continuing rise in the numbers of people with dementia in south east London, and only about half of the predicted number of current patients are diagnosed and included on GP dementia registers. Older people tend to have multi-morbidities. National estimates are that 12% of people over 65 will have three or more long term conditions, 34% two or more and 67% one long term condition; 2% of patients with chronic disease account for 30% of unplanned hospital admissions, 80% of GP consultations and 70-80% spend is on people with long term conditions[2]
- Diabetes: there in an increasing burden of ill health from diabetes, with rates increasing in parallel with the increase in London and England as a whole. It is estimated that about one in four people with diabetes are undiagnosed.

The outlook is improving across south East London for a number of other health issues identified as 'high burden' of ill health, but these remain significant challenges.

- Smoking: there are still nearly one in five adults in south east London who smoke. Smoking still remains the biggest current direct cause of preventable mortality and morbidity. If south east London reduced smoking prevalence to the levels of the best quartile boroughs in England this would further reduce smoking prevalence by a total of 24,000[3]
- Teenage conceptions: rates are still significantly above national and London averages in inner south east London. The borough with the highest rate was Southwark with 42.7 per 1000 conceptions to under 18 year old young women[4].

[1] Alcohol Mortality (2004-2010) - PHE, Local Alcohol Profiles for England [2] Department of Health consultation on the Information Revolution [3] Smoking Prevalence 2009-2012 - Public Health England [4] Under 18 conception rates per 1000 (2011) - ONS

The national and London context is changing the way that health and integrated care services are planned and delivered

The way in which health and integrated care services are planned and delivered is changing.

NHS England London has told us that:

- London has growing and ageing population and a rise in long-term conditions (both single and multiple conditions) will require better primary care and more integrated care
- People in control of their own health and patients in control of their own care is essential
- The way hospitals are organised is unsustainable and does not support the provision of high quality care
- Research, education, new technologies and a better understanding of diseases will help us transform the health service.

As part of a Call to Action[1], NHS England has identified six transformational service models that will define the characteristics of the NHS in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

Quality and safety must be at the heart of commissioning and delivery of local services

- Ensuring high quality care requires providers, commissioners and individual professionals to work together and consider the different dimensions of quality to enable the system to:
  - Systematically drive continuous improvements linked to the overarching outcomes or domains set out in the NHS Outcomes Framework
  - Ensure essential standards of quality and safety are maintained (including the London Clinical Standards).

[1] Transforming Primary Care in London: General Practice A Call to Action, NHS England November 2013, http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf

Significant developments and opportunities within south east London help us to make a strong and innovative response to the national and London context

Our CCGs are playing a key role in providing clinical leadership for their local health systems. In practice this includes:

– Maintaining a constant clinical focus on improving quality and health outcomes and reducing health inequalities
– Engaging and providing leadership to their member practices in the improvement of local services
– Ensuring that public and patient voice is at the heart of commissioning decisions
– Working with local Health and Wellbeing Boards and local partnership arrangements to deliver local Health and Wellbeing Strategies; and now to develop and deliver plans in relation to the Better Care Fund.

We have a longstanding history of joint working across the six boroughs, including:

– Integrated governance, joint working arrangements for working across the six boroughs
– A history of working across the six boroughs on strategic and transformational work – including A Picture of Health for South East London, and more recently the TSA Implementation Programme at South London Healthcare Trust.

The South East London Community Based Care (CBC) Strategy has begun to transform community based care through three delivery programmes:

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

South east London has one of the country's six Academic Health Science Centres (AHSCs), King's Health Partners.

South London Health Innovation Network (Academic Health Science Network) is responsible for sharing innovations across the health system, capitalising on teaching and research strengths to drive lasting improvements in health and wellbeing across South London. Programmes being taken forward locally include diabetes, alcohol, musculoskeletal, dementia and cancer.

Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long (1 / 2)

No Trust in south east London fully meets the London standards for safety and quality in emergency care and maternity services.

- Compliance with London Adult Emergency Standards varies significantly. Only 30% of the standards were met by all of the hospitals in south east London[1]
- Across south east London there was broad variation amongst hospitals with no individual hospital either meeting or not meeting all of the key national standards for Adult Acute Medicine, Adult Emergency General Surgery, Emergency Departments, Fractured Neck of Femur Pathway, Paediatric Emergency and Inpatient Medicine, Paediatric Emergency General Surgery, and Maternity Services standards
- In February 2014 Queen Elizabeth's Hospital in Woolwich and Princess Royal University Hospital in Orpington were inspected by the Care Quality Commission under their new inspection regime, designed to determine if they are safe, effective, caring, responsive, and well-led. Both hospitals were scored as 'requires improvement' and in one case, a hospital's safety was scored as 'inadequate'

There is significant variation in the performance of acute Trusts, both within and between organisations[2]. Based on analysis prior to the dissolution of South London Healthcare Trust:

- All Trusts in south east London were in the fourth (bottom) quartile for median time in Accident and Emergency from arrival to treatment
- Patients reported bottom quartile experience of care in three of four Trusts – South London Healthcare, Kings College Hospital and Lewisham Healthcare Trust
- Patients diagnosed with cancer were experiencing higher than average over 31 day waits for their first treatment in the majority of trusts with Guys and St Thomas' being in the fourth (bottom) quartile
- Only Kings College Hospital was above average for number of two week referral to first outpatient appointment for breast symptoms with Guys and St Thomas' and University Hospital Lewisham in the fourth (bottom) quartile
- Three out of four Trusts were in the first (top) quartile for the summary indicator on low hospital mortality, although South London Healthcare Trust was in the third quartile for this measure.

In primary care, many patients find it hard to get an appointment with their GP[2]. The services available are inconsistent and quality and outcomes variable, with lower patient satisfaction scores compared to other parts of England.

- Patients report 4th (bottom) quartile experience of care in four of the six CCGs in south east London with the remaining two CCGs, Lambeth and Lewisham, in the 3rd quartile
- All south east London CCGs have lower than average GP access, with Bexley, Lewisham and Southwark in the fourth quartile nationally; and remaining CCGs in the third quartile
- There is significant variation in achievement of GP outcomes, both within and between boroughs. Between the boroughs, performance varies with between 12% and 54% of practices 'achieving' or 'higher achieving' against GP outcomes. Equivalent England average is 62%
- All south east London CCGs have lower than average (1st quartile) primary care spend compared to the rest of England.

[1] London Quality Standards Self-assessment 2013 – March 2014 [2] South east London Strategic Planning Group Data Pack – NHS England November 2013

Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long (2 / 2)

Within south east London there are specific challenges to ensure that maternity services provision meets the highest standards of care and quality and health outcomes[1].

- Failure to meet a number of national standards and key performance indicators, for example screening and first antenatal appointment
- Employment and retention of the highly skilled workforce required to deliver a service across all health settings, linking to performance against the London Quality Standards set out elsewhere
- Current capacity issues, which results in maternity services being suspended at hospitals, and women being diverted away from their hospital of choice. Between April 2011 and November 2012, providers of maternity services across SEL suspended services on 37 occasions
- The Care Quality Commission's maternity services survey 2013, highlighted patients views on areas for improvement in each of the SEL maternity service providers including staff attitude in postnatal wards, pain relief and breastfeeding information and advice.

As a system we have need to improve quality and to drive consistency and productivity in community and mental health services[2].

For Mental Health services:

- Services deliver top quartile performance on only one out of eleven observed outcomes, namely Care Programme Approach (CPA) review in the past 12 months
- Three out of six CCGs had high (bottom quartile) incidents of serious harm in mental health care (Lambeth, Lewisham, and Southwark) whilst the remanding 3 are in the 3rd quartile
- Three of six CCGs have low employment for adults with mental health conditions (Bexley, Bromley, Greenwich).

For Community services:

- Immunisation of children is bottom quartile for Greenwich, Lambeth, Lewisham, Southwark and 3rd quartile for the rest
- All CCGs struggle with patient safety in the community with 5 of 6 CCGs in the bottom quartile for pressure ulcer prevention (all boroughs except Lambeth), and 3 in bottom quartile for falls in the community (Lambeth, Southwark and Lewisham)
- All of the SEL CCGs are in 3rd quartile on delayed transfer of care.

[1] ChiMat website - http://atlas.chimat.org.uk/IAS/ [2] South east London Strategic Planning Group Data Pack – NHS England November 2013

Patient satisfaction is low compared to national benchmarks – and there are common themes regarding how patients would like to see services improved

Patient satisfaction is low compared to national benchmarks[1].

– Bexley, Bromley, Greenwich and Southwark are in the bottom quartile nationally for patient experience of primary care. Bexley, Bromley, Greenwich and Lewisham are in the bottom quartile nationally for patient experience of hospital care

– In 2013 three of the four acute trusts in south east London (Kings College Hospital NHS Foundation Trust, Lewisham Healthcare NHS Trust, and South London Healthcare NHS Trust) scored in the bottom quartile nationally for the friends and family test.

There is rich local feedback regarding how patients would like to see services improved.

Themes identified which are common across boroughs include:

– Primary care is valued highly

– There is a need for better and consistent access to services at local level – and at times convenient to the patient

– There is support for community hubs and access to services in community based centres

– Local public and patients would like more and better information about various aspects of services and commissioning

– People in Lewisham have told us how much they value their local hospital

– There is support for services being more joined up.

[1] London Quality Standards Self-assessment 2013 – March 2014 ** South east London Strategic Planning Group Data Pack – NHS England November 2013

Commissioners face a challenging financial position

For CCGs:

- Analysis by NHS England shows that as demand for services is rising, if we continue with the current model of care and expected funding levels, there could be a national funding gap of £30bn between 2013/14 and 2020/21 - this is on top of efficiency savings already being met. This means that we as NHS organisations need to make our money go further
- Financial modelling carried out based on the final national allocation settlement indicates that the scale of financial challenge for south east London CCGs increases from circa £60m in 2013/14 to £75m in 2014/15.
  This represents around 5% of budgets in each CCG.
  Each CCG has plans in place to close this gap
- For 2014/15 the assumption is that there will be a net impact from the transfer of funds to local authorities to create the Better Care Fund. Proposals for these funds have been developed in collaboration with Local Authority colleagues and taken for approval through Health and Wellbeing boards in March 2014.

Scale of financial challenge for CCGs[1]

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

For Primary Care:

- The new allocation policy agreed in December 2013 results in London area teams being over target by 2.8% and therefore receiving a base level of funding increase in 2014/15 of 1.60% against a national average of 2.14%. This further impacts in 15/16 with a resource increase of 1.29%
- National agreements on inflation uplifts through the Doctors' and Dentists' Remuneration Body are yet to be agreed but together with ONS population growth set a minimum uplift of circa 2.0% in 2014/15. This presents a minimum funding gap of 0.4%. Changes in the business rules regarding non-recurrent reserves put further pressure on available recurrent resources
- Primary Care across London has achieved a £28m financial savings agenda in 13/14 but has a carried forward requirement of £22m in advance of the 14/15 settlement.

For Specialised Commissioning:

- The challenges faced follow the work done in 2013-14 to arrive at a baseline allocation for specialised services across London
- There has been a significant loss of resources to other regions, and it is recognised that further allocation adjustments between NHS England and CCGs will be necessary at the end of quarter one 2014-15. Until then allocations are based on the outcome of the work done by the London technical group, which was agreed in December 2013
- These services face a reduction of approximately 6-7% in 2014-15, and further cutbacks in later years.

[1] Final 2014/15 Operating Plan Submissions to NHS England (CCG Financial Templates)

Our partners face a similar and interrelated set of challenges (1 / 2)

South east London's acute, community and mental health providers face a similar and interrelated set of challenges and drivers to commissioners

Key issues and drivers for providers in south east London include:

– A constrained financial environment
– The implications of regulatory changes and recent key recommendations in relation to safety, quality and patient care (including the Francis Report, the Berwick Report, recommendations as a result of Winterbourne View, the Urgent and Emergency Care review, and the Future Hospitals Commission)
– Uncertainty in the system about the long term provider landscape and future patient flows
– Local service integration including primary care and integrated community care
– The likely designation process for major emergency departments nationally, with associated investment requirements for providers and impacts on patient flows
– Specialist service consolidation / designation in line with the national strategic direction
– New workforce models in response to the need for up-skill staff to work in community and ambulatory settings and staff shortages within the existing workforce
– Information Management and Technology, which will be a key enabler of change for providers, but will also demand time and investment.

London's ambulance service is facing increasing and changing needs for care

Some of the key factors affecting the service include:

– Increasing demand, whereby over the last three years we have seen significant changes in the health needs and expectations of Londoners, with a total increase in incidents of 5% between 2011 and 2013
– Changing profile of demand by illness, including an 11% increase in alcohol related calls between 2011 and 2013; a 19% increase in chest pain related calls between 2011 and 2013; and an 11% increase in dyspnoea calls between 2011 and 2013
– Gap between demand growth and level of funding
– Changing patient needs including those on an ageing population, high and increasing diversity of population, increasing issues as a result of population not registered with a GP, and the need to address the symptoms of mental illness
– Levels of staff utilisation are significantly above the rest of the country, contributing to high staff turnover.

Our partners face a similar and interrelated set of challenges (2 / 2)

The challenge for adult social care

- Many Local Authorities 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 provision forms a large percentage of any local authority budget and faces the challenge therefore of reducing expenditure and finding more cost effective ways of working whilst maintaining services that are safe and of high quality. Demand in services is growing in some areas with increasing numbers of older residents, residents living much longer with complex care and health needs, increased mental health service demand alongside the continued need to support those with lifelong health and care needs to live as independently and as full a life as possible
- The Better Care Fund has been established in recognition of the challenge to social care and recognition that this challenge can only be effectively met by redesigning adult social care and health provision together. There is a need for joining care and health services more effectively and where and when they are most needed. Earlier identification of need, supporting residents to be able to help themselves where possible and providing care in a planned way are essential to effective social care services. The challenge is to use this fund and other related expenditure to achieve joint care services that improve peoples' health and care provision rather than cost shunting expenditure from one partner organisation to another
- The overall principles of social care are more challenging to deliver in the current climate but remain as important and have to be addressed in any reconfiguration of services. Service users tell us they want:
  - Care that is co-ordinated and joins up around them
  - Personalised care that gives access to information, knowledge and the resources to be able to support their own care and health more effectively
  - To remain at home and live independently for as long and as well as possible.

Success Criteria

Key overarching criteria against which the success of the Programme will be measured

The vision for the Strategy described in previous pages is our response to the Case for Change and our aspirations for south east London. To deliver the vision (as set out on page 18), the following success criteria have been identified against which the programme will be judged.

- Improved health for people in south east London, measured by:
  - sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs
  - sustained improvement in life expectancy (indicative of length of live) and healthy life expectancy (indicative of quality of life)
- Reduction in health inequalities across south east London, to be measured through an agreed reduction in inequalities across life expectancy and healthy life expectancy within all south east London boroughs
- Achievement of London Clinical Standards across all services where these apply
- All organisations within the health economy report surplus in 2018/19
- No provider under enhanced regulatory scrutiny due to performance concerns.

Introduction to integrated system model

The Integrated System Model has at its foundation in the recognition that we must, and can strengthen the resilience of our local communities. The Kings Fund recently stated that ***Resilient communities are a critical foundation for public health and clinical preparedness. They enable the sustained ability to withstand and recover from adversity: healthy individuals and families with access to health care, both physical and psychological, and with the knowledge and resources to care for themselves and others in both routine and emergency situations.*** (Kings Fund, 2014) This is the core business of each borough's Health and Wellbeing Board and the partners who have developed this strategy have agreed to ensure that they fully support this work.

Primary and community care services are the cornerstone of health and social care and 90% of NHS is provided in the community. SEL will deliver these services through 24 **Locality Care Networks** which will bring together GP practices with wider primary care and community services to work together to support their communities. Those people with long term physical and / or mental health conditions will be able to access services through integrated teams, which bring together social care and wider local authority services, NHS funded services and the voluntary sector.

For people who are most ill and require NHS care provided in hospitals, it is essential that the different parts of the system are well connected as patients experience care across organisational boundaries.

In addition to primary and community care and long term conditions, physical and mental health, the Strategy focuses on a further five priority pathways which support people across hospital and community settings. This strategy does not seek to address each and every pathway that that patients need but focuses on those pathways that require coordinated approaches across our SEL boroughs and different parts of the NHS system.

This section is divided into the following subsections:

- 4.1 Characteristics of the overarching system
- 4.2 Model
- 4.3 Role of primary care
- 4.4 Approach to long term conditions
- 4.5 Priority pathways
- 4.6 Programme / system level measures

Further development post 20 June submission

The integrated system model will undergo further development and testing, including development through engagement with key stakeholder groups

South east London integrated system model

South east London CCGs and NHS England are working together to develop an integrated care system, delivered through the seven strategic interventions set out above. In this system integrated services will have:

- Involved and informed patients and carers
- Engaged and supportive communities
- Adaptable and capable staff

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

System characteristics

The following characteristics underpin how the health and integrated care system will work in south east London:

Characteristic of our system	What this means in our system
Build resilient communities	Resilient communities are capable of managing and compensating for adverse situations. They can do this by actively influencing, preparing for and responding to economic, social and environmental change. When times are bad they can call upon the myriad of resources that make them a healthy community. That includes access to good information and communication networks and they can call upon a wide range of resources. Healthy individuals and families have the knowledge and resources to care for themselves and others in both routine and emergency situation with access to health care, both physical and psychological when they need it. We must ensure we reach and support the whole of our population and facilitate a sense of citizenship to support resilience.
Promote health and wellbeing	The promotion of healthy policies and practices to encourage and protect health and wellbeing, e.g. through advocacy, education and training, campaigns. This may be through public health and health promotion, promoting healthy lifestyles, patient empowerment. This includes working with local authorities and health and wellbeing boards to deliver local Health and Wellbeing Strategies and plans. Every part of the system including health and social care need to ensure that “every contact counts” in promoting health and wellbeing. All staff should understand and be able to deliver brief interventions that support the promotion of health and wellbeing.
Provide accessible & easy to navigate services	Helping people to get appropriate health care resources to maintain or improve their health outcomes and supporting them in a consistent, clear way through the health care system. These services should have limited barriers to access and take into account the health needs of the patient. Navigation of services will be facilitated by effective care co-ordination and care planning where appropriate, particularly for people with long term conditions, complexity of care and those patients who are vulnerable or hard to reach.
Join up services from different agencies & disciplines	Working collaboratively across professions, services and organisations (including health, social care and the third sector) to deliver care around the patient. Multidisciplinary teams may include patients, carers, families and communities as well as community nurses, education professionals, social workers, psychiatrists, occupational therapists, various clinicians, and other professions.

System characteristics

The following characteristics underpin how the health and integrated care system will work in south east London:

Characteristic of our system	What this means in our system
Deliver early diagnosis & intervention	Timely and appropriate diagnosis of the early symptoms, signs and stages of a health problem. Effective and early assessment and signposting, appropriate treatment or referral where appropriate. This applies to secondary prevention as well as primary prevention. Primary prevention addresses the root cause of a disease or injury whereas secondary intervention is early diagnosis and prompt treatment to contain a disease and prevent spread to others and/or “disability limitation” to prevent potential future complications and disabilities from the disease.
Raise the quality of services to the same high standard	Ensuring that services and care are delivered to the same high quality standards throughout the system, raising standards across the system to match the best.
Support people to manage their own health & wellbeing	Proactive involvement of patients in their own health, care planning and treatment. This includes the provision of support strategies, information and structures to help people deal with their health problems and to live as normally as possible. For example information about diagnosis, the health care system, access to services and treatment available, involvement in shared decision-making (including use of decision making tools), engagement with health professionals, utilising support from the community and third sector where appropriate. Patients will be involved in the planning of their care, with a written care plan where appropriate. The patient will be involved in the writing of their care plan which will reflect their own responsibility and expectations as well as those of the professionals involved.
Achieve improved outcomes for all residents	The focus of each intervention and the strategy as a whole is to improve the outcome of care for our residents. By outcome, we mean that people will live longer and when people have long term health problems they will experience a better quality of life. For those people who have a terminal illness and can plan their death they will be helped to do this and where they want to be at home, we will enable this to happen wherever possible.

South east London's primary care offer

Clocktower 78,000	**Beckenham Beacon** 55,000	**Eltham** 56,000	**North (Lambeth)** 92,000	**Neighbourhood 1 (Lewisham)** 67,000	**Bermondsey & Rotherhithe** 85,000
Frognall 53,000	**Addington Rd** 55,000	**Excel** 65,000	**South East (Lambeth)** 110,000	**Neighbourhood 2 (Lewisham)** 109,000	**Dulwich** 76,000
North (Bexley) 94,000	**Princes Plain** 64,000	**Network** 69,000	**South West (Lambeth)** 156,000	**Neighbourhood 3 (Lewisham)** 57,000	**Peckham and Camberwell** 59,000
	Chislehurst Rd 62,000				
	St. Pauls Cray 40,000	**Blackheath & Charlton** 80,000		**Neighbourhood 4 (Lewisham)** 66,000	**Borough and Walworth** 72,000
	The Willows 58,000				

TOTAL 1.8m population of SEL

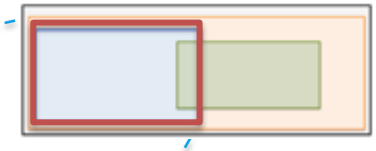
Primary and community care (defined in its broadest sense) will be provided at scale by 24 locality care networks supporting whole populations. This will be a universal service covering the whole population 'cradle to grave'. The changes to primary care will focus on four high impact areas:

- Proactive care
- Access
- Coordinated care
- Continuity of care

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Long term conditions, physical and mental health



Definition – A Long Term Condition could be diabetes, high blood pressure, multiple sclerosis, being born with a learning disability or acquiring a mental health problem such as schizophrenia. As people age more people have many LTCs including dementia. People with LTC often will suffer from depression and anxiety as well as their physical health problem. Living alone can make managing a LTC harder.

Primary & Community Care

a) **People with a stable /well managed long term conditions** - who need support from primary care with some occasional input from community and hospital services

b) People with complex long term conditions - requiring ongoing support from coordinated health and social care

c) People with multiple complex needs where standard services are not effective - requiring personally designed support from multiple agencies including voluntary sector

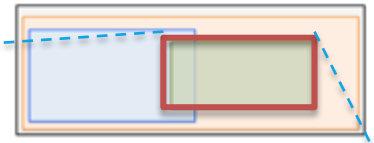
Better Care Fund supports these components of the model

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Key:

Reablement / rehabilitation to enable people to live full and active lives and self manage with support of locality care networks



Priority pathways

EMERGING CONTENT– SUBJECT TO FURTHER REVISION / DEVELOPMENT

3. Planned care including the following key features:	• Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and 'one-stop-shops' where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; specialty focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
4. Urgent & emergency care including the following key features:	• Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to 'do and discharge' • Services meeting London Quality Standards
5. Maternity including the following key features:	• Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multips; birth centres for low risk primips • Continuity of care through a 'midwifery led' model with improved/extended consultant cover • Assessing for women's toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
6. Children including the following key features:	• Collective focus on the child including, 'every contact counts' • Improved Access – 'no wrong door' • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
7. Cancer including the following key features:	• Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

Priority pathways support patients through episodes of care, often including hospital care. These pathways have been prioritised based on our Case for Change and strategic context, feedback from our stakeholders and partners. Locality Care Networks will be engaged as patients access these pathway and as will the wider health and social care teams where people have on-going long term conditions.

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Integrated system objectives

All NHS organisations are required to show continued improvement against the seven NHS Outcome ambitions, the NHS, Public Health and Social Care Outcome Frameworks as well as other constitutional measures. A subset of these measures have been identified on which to develop an overall measurement framework for the Strategy. These emerging measures are set out below.

Elements of the "problem we are trying to solve"	Elements of "what are we trying to achieve?"	Outcome measures (Programme level)	Process & proxy measures (Programme level)	System level measures
	Helping people to live independently and know what to do when things go wrong.		➢ (11) Increasing the proportion of older people living independently at home following discharge from hospital	1) Life expectancy 2) Healthy life expectancy 3) Gap in life expectancy 4) COPD mortality 5) Cancer mortality 6) CVD mortality 7) Smoking cessation 8) Healthy weight 9) Alcohol related admissions 10) Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 11) Increasing the proportion of older people living independently at home following discharge from hospital 12) Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital 13) Emergency admissions 14) Emergency attendances 15) Increasing the number of people having a positive experience of hospital care 16) Delivering the London Quality Standards and other agreed quality standards 17) Health-related quality of life for people with long-term conditions (EQ5D) 18) Sustained financial balance
Too many people live with preventable ill health or die too early.	Making sure primary care services are consistently excellent and with an increased focus on prevention.	➢ (1) Life expectancy ➢ (2) Healthy life expectancy ➢ (3) Gap in life expectancy ➢ (4) COPD, (5) Cancer, (6) CVD mortality ➢ (7) Smoking cessation ➢ (8) Healthy weight ➢ (9) Alcohol related admissions		
	Closing the inequalities gap between worst health outcomes and our best	➢ (3) Gap in life expectancy		
We don't treat people early enough to have the best results.		➢ (4) COPD, (5) Cancer, (6) CVD mortality		
Patients tell us that their care is not joined up between different services.	Developing joined up care so that people receive the support they need when they need it.		➢ (12) Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital ➢ (13) Emergency admissions ➢ (14) Emergency attendances	
People's experience of care is very variable and can be much better.	➢ Delivering services that meet the same high quality standards whenever and wherever care is provided. ➢ Reducing variation in healthcare outcomes by raising the standards in our health services to match the best.		➢ (15) Increasing the number of people having a positive experience of hospital care	
The outcomes from care in our health services vary significantly and high quality care is not available all the time.		➢ (4) COPD, (5) Cancer, (6) CVD mortality ➢ (10) Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	➢ (16) Delivering the London Quality Standards and other agreed quality standards	
	Supporting people to be more in control of their health and have a greater say in their own care.		➢ (17) Health-related quality of life for people with long-term conditions (EQ5D)	
➢ The money to pay for the NHS is limited and need is continually increasing. ➢ It is taxpayers' money and we have a responsibility to spend it well.	Spending our money wisely, to deliver better outcomes and avoid waste.	➢ N/A	➢ (18) Sustained financial balance	

Introduction to Improvement Interventions

The Clinical Leadership Groups have taken forward the development of the seven key improvement interventions. This section sets out the following elements for each key intervention:

- Service vision
- Service model

Each improvement intervention is described over the following pages, Section 5.1 – 5.7. Section 5.8 sets out a consolidated system roadmap detailing the route to implementation for the improvement interventions (to follow for 20 June draft). The emerging impact of each intervention against programme measures is then set out in Section 6.5.

Content on the vision, model and impact for each intervention are still very much a live working content and should be considered in the context of continuing development, testing and iteration.

Further development post 20 June submission

The following will be progressed for each intervention post 20 June:

- Detailed engagement with stakeholders including re-engagement with local authority colleagues post the purdah period
- Further development of the service model and its underlying components
- Quantification of the impact of key changes and elements of the service model (links to Section 6)
- Exploring the implications: what does this mean in practice for communities, institutions and organisations
- Developing a more detailed understanding the implications for supporting strategies (Section 7).

Primary and community care

Service Vision

Summary of emerging Vision themes

- Primary care in the broadest sense delivered to geographically coherent populations and at scale (up to 150,000 population, certainly 40,000 to 80,000)
- A broadly defined “care team” for the population, including community & community mental health services, social care and specialists rather than individual teams, that come together based on patient need
- Services delivered in ways that respond to the varied needs and characteristics of our communities
- Primary and community care which delivers prevention, coordination, access and continuity
- Clear outcome measures that can demonstrate what difference the strategy and its implementation will make
- Primary and community care delivered to consistently high standards across south east London
- Recognition that the future model needs to be sustainable, with a shift in the balance of spend towards prevention
- This will require investment. The percentage of spend will be greater in 5 years time than it is now

Primary and community care

Service Model (1 / 5)

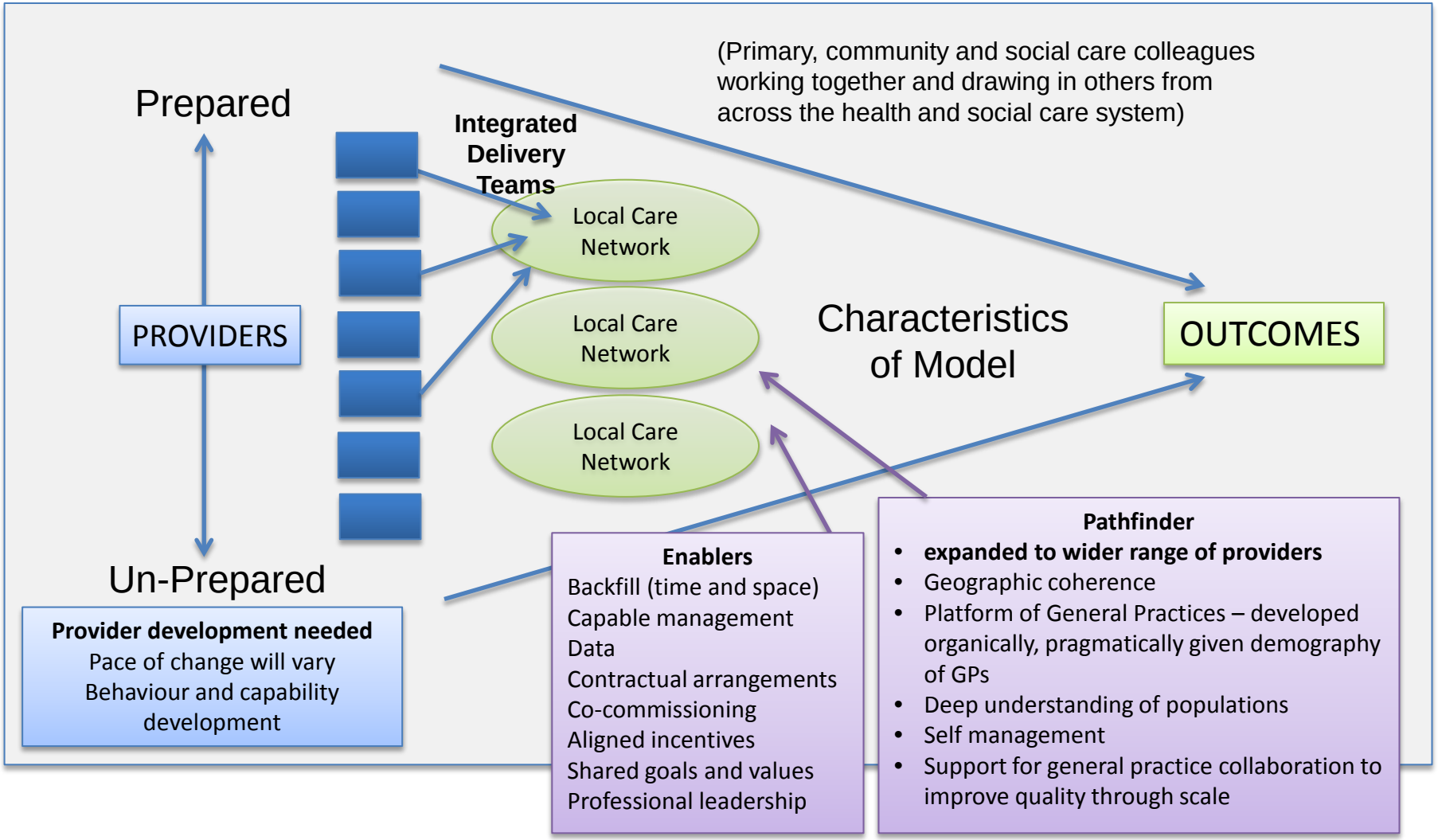
Characteristics of a Primary and Community 'Model'

- Population based and geographically coherent as the basis for primary and community care services
- Broadly defined integrated 'care team' (general practice, community services, social care, mental health, pharmacy, specialist care), with registered list held by general practice at its core
- Enhanced range of services available out of hospital - equitable and consistent quality of care and service offer
- Flexible and responsive to both population and individual patient needs
- Architecture reflective of population characteristics or segments within it
- Relational dependency between or within providers
- Emphasis on early prevention in all areas of care
- Stronger links with mental health, pharmacy and social care
- Sustainable – both the service and system beyond five years
- Exact form may vary… BUT local care networks of community based providers, forming the platform for integrated care systems that utilise the registered list as a unique feature of our primary care system
- Key service characteristics: proactive, accessible & coordinated service, with a flexible, holistic approach, offering continuity

Primary and community care

Service Model (2 / 5) – Key characteristics

A visual 'Model' of the characteristics of the model identified, based on aligning population outcomes and development of integrated delivery teams to deliver them.



Primary and community care

Service Model (3 / 5)

To address the challenges in primary and community care and support the emerging model that will drive its transformation, four high impact interventions have been identified. These are activities and interventions which contribute to improving health and wellbeing by increasing self-reliance, capacity and resilience in both patients, the people who support their care and across local community networks.

Proactive Care – providing a holistic approach that supports population health, wellbeing and prevention building on community networks and encouraging self-reliance.

- Locality Care Networks delivering an 'Every contact counts' approach where each patient contact is an opportunity to address a patient's preventative health needs, to sign post or provide brief intervention and to share a record of that encounter across the network of delivery
- Greater sense of shared responsibility - Primary and community care working with others to support and empower people to take responsibility for their own health, to remain healthy and to stay connected with their community by being able to identify the kind of services that would be most beneficial for them
- Residents have access to and are encouraged to have a personal health plan even if they are generally well, to help them lead a healthier lifestyle
- Residents will be engaged upon and informed about the services available and will be sign posted to appropriate services to help them achieve health and wellbeing
- Local Care Networks that reach out to people who have difficulty accessing services or would benefit from greater access to ensure that they get the appropriate care they need
- Local Care Networks will prioritise ease of system navigation for their population through shared directories of services and single points of access right across health and social care and wider community services (e.g. Housing). A navigator role (with the appropriate skillset) will be key in patient awareness of the services available and personal planning to stay healthy
- Population focused networks of care will strengthen screening and immunisation efforts as a key part of prevention
- Use of technology to more efficiently and more comprehensively support and enable better proactive care

Primary and community care

Service Model (4 / 5)

Accessible Care – supporting all patients, irrespective of their individual circumstances, lifestyle and condition, by providing options to access care that are appropriate to their needs and support their continuity of care.

- Local Care Networks (to be locally defined) will enhance the accessibility of the local community based health and social care system rather than give focus to default and traditional access points. Local Care Networks will provide local access plans which will be determined by and respond to local population characteristics and needs (e.g. language, religion, culture, population mobility)
- Access to care as appropriate – e.g. accessing urgent appointments as needed, which may need to be supported by robust triaging, care navigators (to access complex care), better patient information and incentives to deliver the appropriate care on contact where possible. Access will be based on a minimum offer of care with tiered enhancements as needed
- Strong marketing and branding of the range of primary and community care available to better inform all patients on how to access services
- There are systems within each Local Care Network (LCN) to ensure patients receive appropriate care and in appropriate time in the case of emergencies
- Patients would then have a choice of access options and can decide on the route most appropriate to their needs. Patients with urgent conditions can access the appropriate service on the same day. Local Care Networks will ensure the inclusion of the wider health and care professionals as part of any same day access offer
- Patients can access pre-bookable routine appointments for general practice (Monday to Saturdays) and can access primary care 8am – 8pm every day in their local geographic area for immediate, urgent and unscheduled care
- Use of technology to improve access to support different types of patient interactions that are appropriate to their needs
- Access to services underpinned by an understanding of the key factors that affect patient experience and access to services e.g. patient transport

Primary and community care

Service Model (5 / 5)

Co-ordinated Care – providing an enhanced level of service for patients who require continuity, support, care planning and continuous review in order for them to live a healthier and stable lives in their communities.

- Local Care Networks will systematically identify those people in their area that will benefit from co-ordination of care and a care plan
- Those patients will have a care plan that is:
  - accessible by all care professionals across all providers (in all areas of care) in the network to promote a proactive, integrated, coordinated and holistic approach to patient care, to ensure that every contact counts
  - patient focused which will be regularly reviewed to ensure that it is up to date
  - based on patient goals to support patient agreement and ownership to their care plan and better self-management
  - is patient owned and acts as a patient "passport" to their health services
  - managed by a care coordinator (with the appropriate skillset) when necessary
- Linked to proactive care – Local Care Networks will ensure that all patients have a right to care plan as early as possible to promote better health and well being

Continuity of Care – providing continuity of care for patients who need it, enabled by the effective and timely communication and information sharing between heath care professionals, which ensures that patient care can be coordinated by one clinician or safely transferred between clinicians to provide consistent and coordinated care

- LCNs, working with other related providers or people, identify patients who benefit from coordinated care and proactively review them on a continuous basis and on moving to the LCNs, to ensure good care
- Patients have a named health care professional at the relevant skill level who is accountable for their care
- Having a care coordinator (with the appropriate skillset) who will coordinate the patient shared care plan and effectively navigate through the health system, in coordination with the health care professional accountable for the patient's care and the patient

Long term conditions, physical and mental health

Service Vision

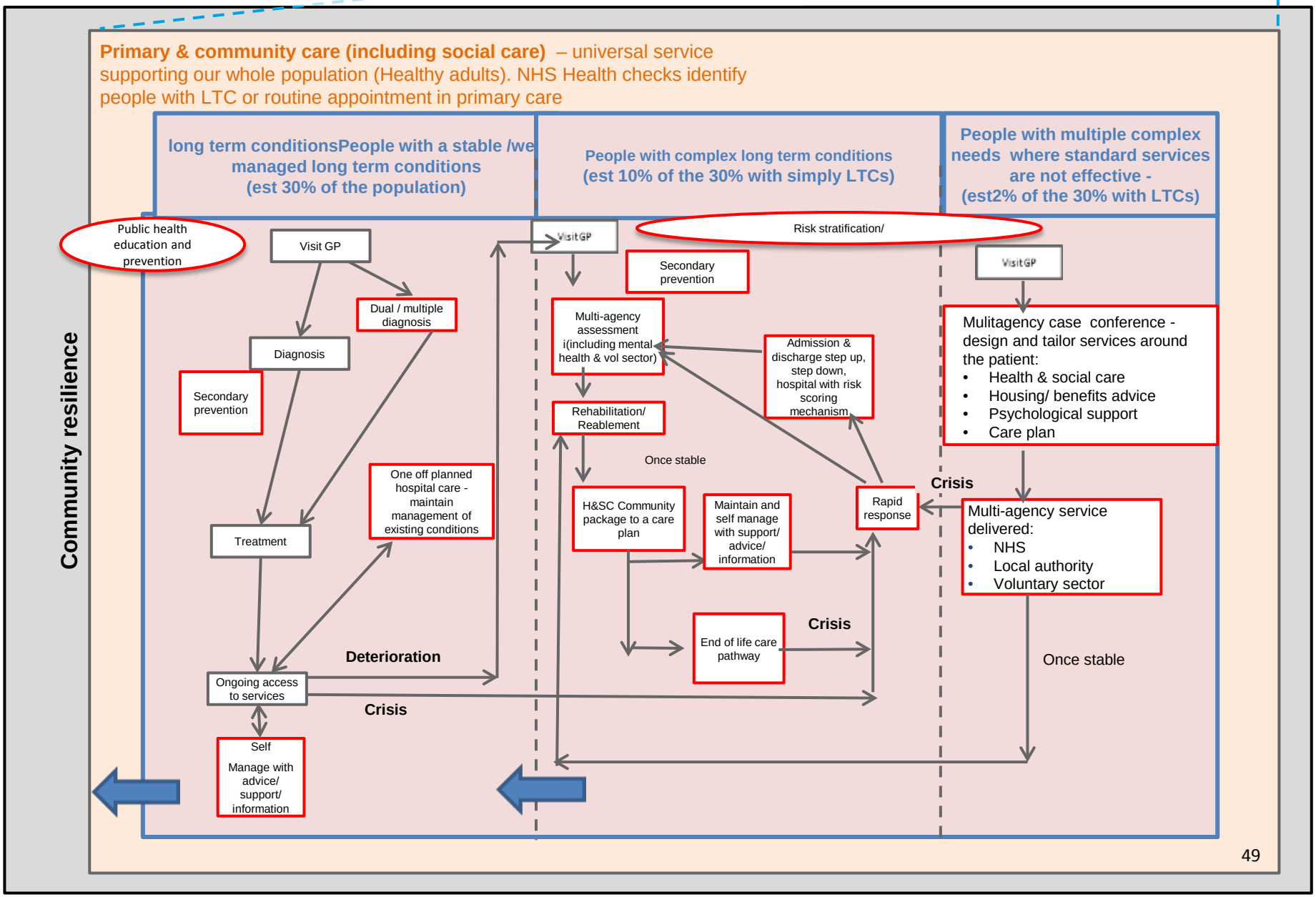
'Ensuring there is high quality integrated services for high risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health, social care & 3rd sector) are working together, putting individual citizens at the centre. This will enable people to be active and to feel well-supported in their own homes wherever possible.'

Integrated services will have:

- Involved and informed patients and carers, with care plans developed by and with them, to support them to stay independent and active
- Engaged and supportive communities helping patients to continue to live at home
- Adaptable and capable staff – working together between hospital and community services, mental health, social care and the voluntary sector to provide joined up, flexible assessments and care packages to provide a seamless service from a patient's perspective
- Services designed around the individual patient's needs, with a named care coordinator to ensure these are delivered effectively, and to encourage self-management
- Information flows and record sharing between providers to support coordinated care and proactively identify patients before a crisis
- Connected and intelligent IT that shares health information not just data and the use of systems such as Telehealth to support self-management
- Responsive services so that patients are confident they will receive a prompt assessment if they are at risk of admission to hospital, and proactive discharge planning when necessary
- A relentless focus on the health and well being of people with long term mental health, particularly depression, and physical health problems

Long term conditions, physical and mental health

Service Model (1 / 2) - Emerging more detailed model



Long term conditions, physical and mental health

Service Model (2 / 2) - Long term conditions model in action

The Long Term Condition model is one system that describes different levels of complexity depending on the person's need. People can move between the elements as required. People with physical and mental health problems will be supported by integrated health and social care teams and will access specialised services are required with information flowing between services so that the person experiences a continuity of care. Primary care will be at the heart of the model of care.		
a) People with a stable /well managed long term conditions. Identified by NHS Health Checks or routine appointment with primary care. Where people's condition is not being well managed they would move into complex condition pathway	b) People with complex long term conditions identified by primary care or through systematic risk stratification. The aim is to support people from teams working together. Only where this is not working would they move into the multiple complex need pathway	c) People with multiple complex needs where standard services are not effective identified by any services or risk stratification. The aim will be to take a problem solving approach and to support people from standard services.
Services mainly GP and pharmacy with access to hospital and wider community care as required. Mental health screening for depression and anxiety for people being diagnosed with LTC.	People who have ongoing need for ongoing support to live their lives. Identified by GP or through risk stratification. Locality care networks to coordinate services.	People who access many different services frequently but are not having their needs met. Likely to experience mental health problems and lack support from family networks
Focus on secondary prevention with the aim of improving underlying condition and preventing deterioration/ development of further long term conditions		
Support to the person to manage their own condition through information and signposting; support groups etc.	Multi professional and multiagency assessment including voluntary sector, reablement and rehabilitation with a care package to support once stable or end of life care pathway	Wider multi agency / professional assessment with involvement of wider council (housing, benefits etc), voluntary sector as well as health & social care. Problem solving approach.
Aim to live full and active life with access to primary care as required.	Access to rapid response if care needs change suddenly; care package reviewed with further reablement. Admission to step up/ step down or hospital facilities as required with the aim of enabling people to live their lives fully. Includes support to die at home.	Unique package of care to support the individual to live their life. Transfer package into (b) as required and to support in a crisis. VIP access to services to keep people safe should changes occur.
Focus on reablement and rehabilitation at each step to enable people to live a full and active life and not depend on services except where necessary.		

Planned care

Service Vision

A seamless, high quality planned care service that enables patients to be seen by the right person, in the right place, at the right time.

'*For episodes where people require it, they should receive simple, timely, convenient and effective planned care with seamless transitions across primary and secondary care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics*.'

An effective Planned Care service will be based on a number of emerging **design principles**:

- Where possible and appropriate take standardised approaches, including:
  - For providers (GPs, community and acute): processes, equipment, implants and consumables, discharge planning, preoperative care, pre-hospital care and assessment
  - For commissioners: agreeing standards and a common commissioning approach across south east London; agreement of standardised referrals processes and access protocols
- Organise elective and diagnostics services based on pathways with similar patient flow characteristics and separate these flows where appropriate. This is not as simple as a top-down separation of elective and emergency surgery
- Expert involvement (though not necessarily from a hospital consultant) as early as possible in the pathway. Where appropriate involvement of hospital consultants in community referrals
- Having the right information (patient information, tests, diagnostics) in place early in the pathway, and in a way that follows the patient and avoids duplication, inefficiency, re-work
- Involving patients throughout the design of service models and ensuring that they are supported and empowered in their decisions
- Reassign tasks to optimise scarce skilled resources, with staff focusing on the tasks most appropriate to their level and expertise
- Where we have capacity in the system (for example staff, equipment), make best use of this.

TO BE FURTHER DEVELOPED FOR 20 JUNE DRAFT

Planned care

Service Model (1 / 3) – emerging model

TO BE TESTED WITH CLINICAL LEADERSHIP GROUP

Enablers
- **Workforce** - empowered, skilled, trained, supported, cultural change
- **IT** - shared access of appropriate information
- **Patient engagement in design**
- **Commissioning differently -** and in a way that makes sense across south East London
- **Clear Communications -** supporting everything we do

Pre-treatment and diagnosis
- Standardisation
- Patients involved, communication, engagement and expectations
- Clear care plan
- Multi-disciplinary approach
- Hubs and one-stop-shops where appropriate
- Diagnostics - once in right place at right time
- Senior opinion early
- Reduced handoffs
- Reduction in waiting for all diagnostics
- More treatment in the community - where appropriate

Treatment
- Productive and efficient
- Standardisation
- Appropriate scale
- Specialty focus in specific areas:
  - orthopaedics
  - ophthalmology
  - urology
  - others (to be defined)
- Use critical mass
- Movement towards day case procedures - when safe
- Review current use of out patient model

Post treatment
- As much at home / in the community as possible
- 7 day a week transfers to community
- Early planning throughout pathway

Outcomes
- Every contact counts - all pathways and providers
- Incentives aligned to outcomes
- Outcome focused approach to pathway
- Through commissioning:
  - Measure the value - the patient reported outcome as well as clinical outcomes as a measure
  - Measure outcomes not inputs
  - Measure productivity and efficiency

Planned care

Service Model (2 / 3) – emerging characteristics

Key characteristics of a potential service model are set out below. These have build on evidence and best practice and have been further refined to reflect the emerging thinking of the Planned Care Clinical Leadership Group at their seminar on 28 May 2014

Scope	• Models should be developed based on pathways with similar patient flow characteristics. Potential pathways to further explore: end to end eye services, orthopaedic surgery (or with specific focus e.g. hip and knee replacements), urology, gynaecology, general surgery, standardised approach to MSK.
Access and referral	• Access policies for elective care and cancer shared with primary and community care. This will help GPs outline to patients prior to referral the patient's responsibilities to attend appointments • A pathway approach with agreed standards to managing referral to treatment and patient information • A referral management or assessment service that accepts referrals and may provide advice on the most appropriate next steps for the place or treatment of the patient? • Central point of receipt of referral that includes prioritisation and triage of referrals and effective booking of appointments.
Diagnostics	Approach diagnostics on a pathway basis rather than in isolation: • Consider having a single two-week diagnostics pathway replicating the approach taken for the cancer two week pathway • GP direct access to diagnostics to reduce the length of a patient's non-admitted pathway and reduce any unnecessary onward referral to a consultant led service • Efficient booking of patients referred for diagnostics • Walk in diagnostics to reduce the timeframe from referral to treatment • 'Sweating' of existing assets and capacity – longer working days / potential remote models • Explore potential for diagnostics capability / hubs situated across the Locality Care Network structure.

Planned care

Service Model (3 / 3) – emerging characteristics

Key characteristics of a potential service model are set out below. These have build on evidence and best practice and have been further refined to reflect the emerging thinking of the Planned Care Clinical Leadership Group at their seminar on 28 May 2014

Improving patient outcomes and experience	• Planned patient scheduling to ensure that all patients are reviewed in the clinically appropriate timeframe • The use of shared decision making and other tools • Standardised approaches to pre-hospital care and assessment, preoperative care, discharge planning • Post operative care provided by dedicated team to follow up patients with effective liaison with primary and community care.

Workforce	• Use of multi- disciplinary teams – for example building on the success of the cancer 'MDT' approach
	• Consultants working on rotation avoiding de-skilling units and breaking up pre-existing teams
	• New ways of working for staff and utilisation of greater skill mix where appropriate
	• Reassign tasks to optimise scarce skilled resources, with staff focusing on the tasks most appropriate to their level and expertise:
	  • Trained nurses carrying out less demanding / complex medical processes where clinically appropriate rather than consultants
	  • Consultants working at the 'top of their license'
	  • 'Super-triage' roles.

Information and measurement	• Patient pathway management information based on milestones: first outpatient appointment, key diagnostic test or tests, diagnosis, decision to treat, multi disciplinary team discussion, transfer to another provider, treatment (or decision not to treat) • Agreed KPIs for key parts of the pathway, for example: patient experience & outcomes, theatre productivity, end to end flow, all waiting & defects • Better use of technology to speed up reporting cycles.

Urgent and emergency care

Service Vision

There is a high quality consistent 24/7 emergency and urgent care service in which patients are seen quickly by the right person in the right setting with the following components:

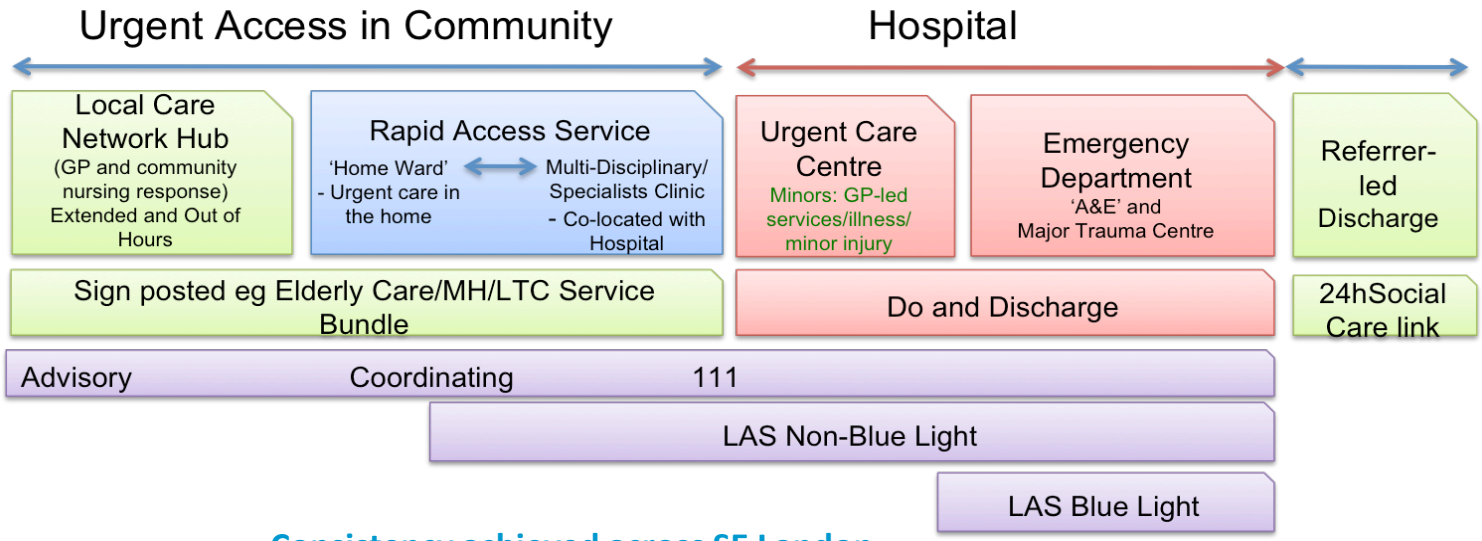
- A proactive, multi-agency approach to managing patients and helping them to remain in the community
- A risk stratification approach that identifies patient at risk and manages them in the community
- When needed, there are services the patient can be referred to for assessment, diagnostic tests and simple treatments in the community (A Rapid Access Service of home ward and specialist clinic co-located in a hospital)
- A&E is truly a specialist service for those in need of emergency care that can only be delivered in hospital
- Care planning for discharge home or normal place of residence commences from the start of an episode of urgent care, with the aim of getting a patient home quickly
- All parts of the health and social care system collectively own and manage system blockages together and throughout the year, seek to improve patient flows and reduce length of stay. This is supported by strong commissioning arrangements to include arrangements for care homes, joined up Information Technology (IT), telemedicine and 'referrer-led' discharge. Emergency and urgent care is supported by Virtual Patient Record and information sharing
- The system is collectively monitored on outcomes with improvements in morbidity, mortality and patient experience, supported by a dashboard, which includes patient experience

Urgent & Emergency Care

Service Model (1 / 4)

Note: further work underway to explore how the service model for urgent & emergency care may be further brought together with thinking on proposed locality care networks

Note:
ED = Emergency Departments (A&E in DGH, Major Trauma Centres)
UCC = Urgent Care Centres



Consistency achieved across SE London

Urgent Access in the community

- 24/7 access across Urgent and Emergency Care
- Local Care Network Hubs deliver more of urgent care – in extended hours
- Rapid Access Service: Home Ward + Specialist 'centre/clinic' co-located with hospital – Multi-disciplinary
- Channelling patients to appropriate services, using risk stratification, full ranges of community and care services wrapped around general practices
- Care homes patients provided with assessment and treatment close to home to support patients with LTCs including mental health – avoiding unnecessary admissions and reduce presentations at Emergency Departments
- Signposted service for elderly care 'bundles of care' away from EDs and UCCs, with a single point of access for all services in the community
- Different relationship and interface between acute/community services and care homes . Give all settings the confidence to 'hold' patients
- 24/7 Cross Boundary Social Care Link implemented including 'Referrer Decides' to facilitate discharge
- Enhanced 111 role as coordinator of responses and sign posting

Urgent Care Centres, Emergency Departments

- Implementation of networks based on London Trauma, Stroke, Cardiology, pathways into community care or hospital
- GP/Primary-led services in UCCs
- Minimum Band 6 Emergency Nurse directing streams into ED
- EDs (local DGH) see fewer patients but with greater acuity
- UCCs manage some/more non-blue light flow and stream patients through faster i.e. compliance with LQS targets
- Experts at the front 'door' getting initial decision right (extends the approach in the Trauma and Stroke pathways)
- 'Do and Discharge' implemented; reducing Length of Stay
- Balanced configuration of Major (Trauma) and Local DGH A&E Centres in SE London in which demand and capacity are aligned
- Integrated net of health and social care out of hospital – clear access routes, mutual understanding of patient need using automated, real-time patient records and tests tracking - connected to signposted services
- Access to paediatric specialist at 'front door'
- Mindset is that whilst ED is a specialist service it sees itself as an extension of community working

Urgent & Emergency Care Service Model (2 / 4)

Local Care Network (LCN) Hub
(GP and community nursing response)

Extended and Out of Hours
GP/Primary cover

- Local Care Network (LCN) Hubs supporting urgent care, includes EDs able to book urgent appointments with GPs (PCC CLG to define)
- Extended LCN Hub hours and Out of Hours giving 24/7 cover (PCC CLG to define)
- Staffed by GPs, primary care nurses
- 24/7 (extended hours and out of hours services when closed)
- Access to GP appointments by ED
- Out of hours covers services when closed
- Vision for improved timely access
- Access to specialists (e.g. through Telemedicine/Hotline and also see ED (Bypass phone number for ED consultants with GPs or/and access to shared email inbox service)
- Out-of Hours co-located with ED

111 Advisory & Coordinating
LAS Conveyancing to right place

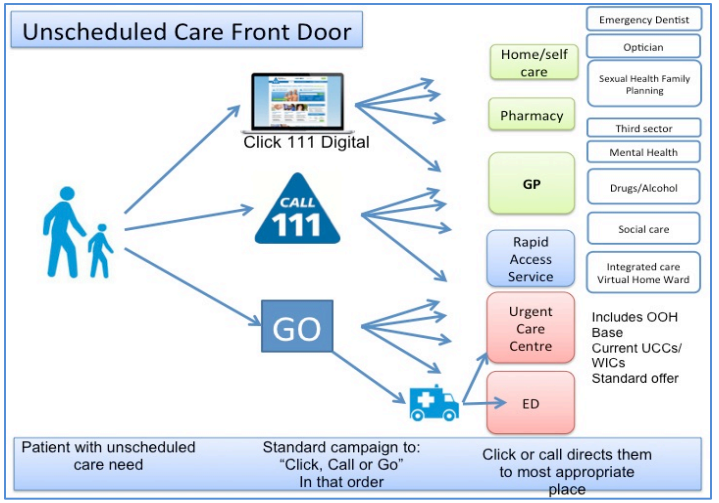
- 111 Call handlers educated/trained in the model (advice and coordination)
- 111 Triage role pre-ED attendance – need to know other parts of system
- 111 24/7 Managing 'appointments' to Out-Of-Hours service or ED – explicit role in demand management
- 111 Key access and signposting role – advising and coordinating – see chart below
- 111 enhanced capability: Directory of Services simplified, accurate, up-to-date; excel in navigating patients, operating an 'internal triage' approach to improve directing patients to best access point
- LAS – rapid access to information/ medics (patient specific plans) – dedicated phone line to GPs during opening hours
- LAS implements 'intelligent conveyancing' and Alternative Care Pathways successfully
- LAS Non-blue light goes to ED 'Initial Contact'

IT – virtual record; NHS No. as identifier to enable coordinated care

SE London IT System

- One system across SE London
- GP record – 'eMIS' Web - visible *within* the One System (Summary Care Record)
- Data sharing agreements across all practices/OOH/ Rapid Access Service providers
- Visible within all EDs
- Access by LAS, community services providers too
- Link to Hospital EPR
- Visible to patient

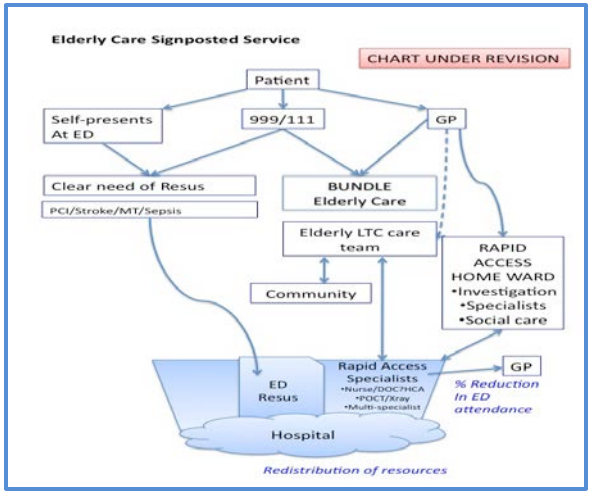
Improved and timely access to unscheduled care



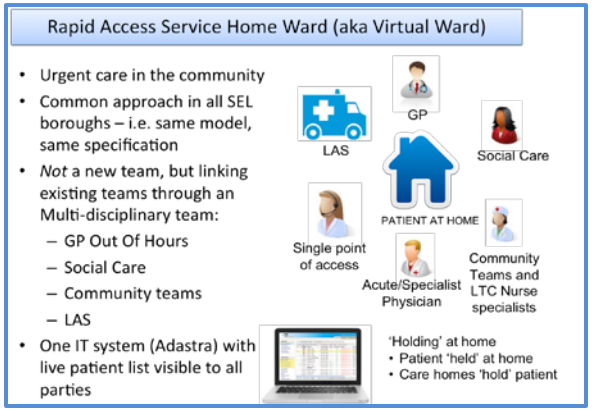
Urgent & Emergency Care Service Model (3 / 4)

Signposted Elderly Care
'Bundles of care' supporting navigation

- Role of the voluntary sector in-reaching and ongoing support to avoid unnecessary admissions and speed up discharge
- Elderly Care LTC team navigate care



Home Ward



Rapid Access Service:
Home Ward + Specialist Response 'clinic' (Co-located within Hospital)

Rapid Access Service

Home Ward + Specialist Response 'clinic' (Co-located with Hospital)

- Community based team with single point of access
- Consistent approach to service across Elderly/MH/Social care pathway
- Gerontology service for home and hospital-based, assess and treat
- GP/Healthcare referral – possibly carers
- **111 Flag 'known to system'**
- Telemedicine – clinical advice to GPs including acute physician and navigation service for GPs (specialist nurse?)
- Direct access for MH/Alcohol in same model
- Rapid discharge support including cross boundary
- Also preventing re-admissions post hospital discharges
- Networked services away from major centres
- IT integrated – One system/'eMIS' Web and patient-held – see chart on previous page
- Very rapid response directing (Single point of access) to:

Home Ward (Urgent care in the Home) – see chart on left

- Consistent 'Home Ward' capable of assessing and treating people in their own home or nearby, including LTCs
- 'Holding' the patient safely until patient can move to next part of the system
- Care homes are confident of holding patient and bringing assessment in

Specialist response (Co-located with hospital): 'Specialist' Gerontology/MH/SMU community service in a hospital

- Complex needs, holistic, risk stratification
- Blood and urine testing, X-Rays, examination couches (not beds)
- 1st call within 24hrs
- Multi-disciplinary service
- Support discharge home

Urgent & Emergency Care Service Model (4 / 4)

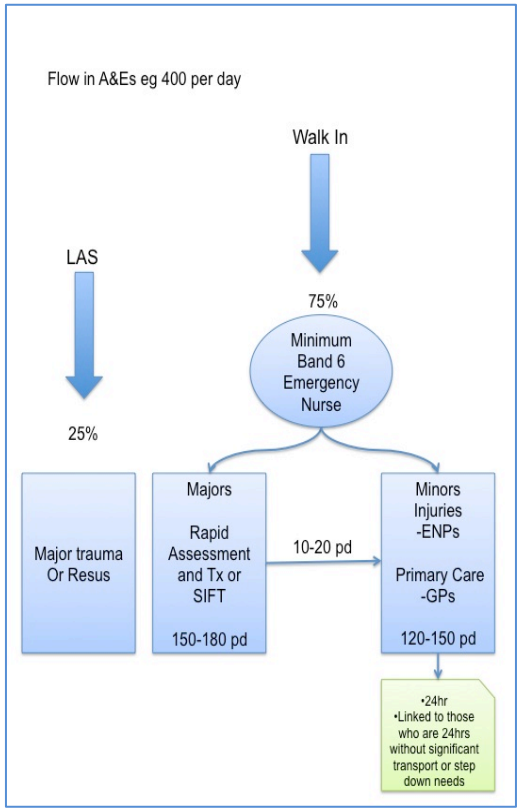
Urgent Care Centre

- 24/7
- All ages, 'No Wrong Door' principle for children
- LAS non-blue light brought to UCC
- Minor illness, injuries and burns
- Diagnostic, X-Ray, Prescribing – antibiotics, analgesics
- Co-location with A&E and Out of Hours – both 24/7
- Non co-located UCC may only be able to operate 12/7 depending on access to diagnostics and access to specialists (e.g. through Telemedicine/Hotline and also see ED (bypass phone number for ED consultants with GPs or/and access to shared email inbox service)
- UCC manages 1st access and triage to A&E if necessary for non-blue lights; Exclusion criteria defined and managed proactively; Flow management protocol (streams)
- Streams managed by GP or experienced nurse – an 'appropriately trained' clinician
- Workforce development across whole system in A&E – GPs with interest and A&E nurses seeing more
- Complete clarity in the information to patients

Emergency Departments

EDs

- Implementation of London Trauma, Stroke, Cardiology, pathways; Experts at the front 'door' getting initial decision right (extends the approach in the Trauma and Stroke pathways)
- Link to Specialist - Rapid Access Service reducing non emergencies; Bypass phone number for ED consultants with GPs or/and access to shared email in box service
- Do and Discharge – see below
- Co-locate with UCC in same area; Common governance model
- Ability to view patient records (passive) with need to record patient consent; includes diagnostic tests and imaging
- Flow management – see chart right
- Clinical Decision Units (CDUs) provide appropriate assessment and treatment completed within 24 or 48 hours and thus preventing formal hospital admission
- CAMHS intensive support to avoid admissions



Do and Discharge (avoiding Admit to do)

Do and Discharge

- **Avoid 'admission to do' by treating and discharging in ED**
- Reducing admissions and ED Length of Stay (LoS) frees up capacity
- Direct access from ED to community services – 'Referrer decides' system
- Ambulatory Pathways consistent, available 24/7 e.g. DVT/PE, Arrhythmias, Cellulitis/other non-septicaemia, Catheters
- Access to immediate and urgent decisive diagnostics ('scheduled') 24/7/POC testing/'sick patient panel' (see Planned care CLG)
- Senior experienced decision-maker
- Post diagnostic review clinics not in ED – 'Hot'/ambulatory care clinics eg Rapid Access Service
- Coordinator /H@H/Home support set up
- Virtual Condition-specific centres enabled by: 'Rich Communication'; IT system joined up patient information
- teleconference/video/skype

Referrer-Led Discharge

24hr Social Care Link

- Single access point across Borough/for a population – and cross boroughs 24/7 365
- Social care/Occupational Therapy and Physiotherapy, Mental Health
- Expedites home care
- IT systems link to manage risk, organize pick up by Community/GP resource
- Link to Rapid Access Service to manage discharges (Community Paediatric Team for children and Young People with LTCs/Complex needs)

Maternity

Service Vision

"To place the needs of women and their families at the centre of maternity care, which supports choice and continuity of care. From preconception through to postnatal support, maternity services will be delivered by a committed and dedicated workforce, who will ensure a safe and positive experience."

Women can expect to receive:

- Timely access to community based antenatal and postnatal maternity services which are closely linked with other community based health, social and voluntary sector services all supporting pregnancy, childbirth and new parenthood;
- Midwifery-led continuity of maternity care as standard;
- Support from clinically expert and highly-skilled multidisciplinary teams delivering high quality, kind, safe and effective services;
- Hospital based medically-led intervention when necessary;
- Support to have a normal birth, in the right location for them, with the least intervention as possible;
- Services and a workforce that promote healthy lifestyles which have a positive effect on the health outcomes for mother and child;
- Involvement and engagement with their wider family supporting healthier lifestyles and better well-being.

Maternity

Service Model (1 / 3)

Introduction

The service model can be summarised as midwifery-led continuity of care ensuring the availability of and access to obstetric-led and specialist care for those who require it. This model emphasises the importance of the maternity workforce, and how their interventions at each stage can contribute to the achievement of high quality and safe maternity care. The model focuses on access to services, the standardisation of care across all providers including protocols and processes as well as more seamless access to specialist services, such as mental health, cardiac or fetal medicine when required.

Continuity of care will put the woman at the centre of her care ensuring timely access to community maternity services. These services will be aligned and work closely with primary care, health visiting and social care services as well as linking into other opportunities for community support, such as children's centres, for women and their families.

The NHS Mandate sets out an aim to improve the women's experience of maternity services through giving the "greatest possible choice of providers" and stating that "every woman has a named midwife who is responsible for ensuring that she has personalised, one to one care throughout pregnancy, childbirth and the postnatal period".

There are a number of definitions of continuity of care and these vary, essentially there is not currently an agreed definition of continuity and whether this relates to the whole maternity pathway or parts of it. However this SE London model puts the woman at the centre of care, with care being provided by a multi-disciplinary team (when necessary) with the named midwife acting as a named trusted other but linking into the multi-disciplinary team for delivery at different points in the care pathway.

There are a number of benefits associated with midwifery-led continuity of care and no adverse effects compared with models of medical-led care and shared care, including for example a reduction in epidurals and instrumental births and increased chances of a spontaneous vaginal birth [DN – reference / evidence being checked].

In terms of the SE London service model, a number of factors needed to be considered, the evidence relating to continuity and midwife-led care in terms of outcomes and benefits to mother and child, combined with the reality of current services and the constraints placed on achieving continuity with catchment boundaries, together with the ambitions for those services over the next five to ten years as discussed and defined within the Maternity Clinical Leadership Group.

Maternity

Service Model (2 / 3) Key Elements

Key Elements

Pre-conceptual Care

Population changes and the increase in complexity and acuity due to a number of factors led to the identification of the need for maternity services to work in conjunction with primary care, public health and others to improve awareness of problems in pregnancy and the impact on outcomes caused by a range of lifestyle choices. This would include the development of strategies around obesity, smoking and childbirth and other wider determinants of health including health education and planning parenthood.

Access to Maternity Services

Improving access to maternity services through a single point of access across SE London as well as direct access to midwifery services to achieve early identification of risk and to develop timely risk and care plans. The model will seek to develop robust standardised care pathways for both low and high risk women to achieve the best possible health outcomes for mother and child. Ensuring that maternity services are designed, located and able to meet the needs of women and their families as well as being more closely aligned to other health, social and voluntary services in the community.

Improving continuity of midwifery-led care across the maternity pathway

To support equality and equity of access developing a core and standardised offering for every woman with a named midwife providing continuity and co-ordination of care ante-natally and post-natally in community and hospital settings including the communication of information across the multi-disciplinary team and institutional and professional boundaries. This includes developing a relationship over the period of the pregnancy with the woman to support improved patient experience and outcomes.

Developing more specialist midwifery teams that offer enhanced midwifery and multi-disciplinary team support for high risk groups including developing care plans whilst still ensuring as high a level of continuity of care as possible across the high risk or specialist pathway.

Maternity catchment areas will be aligned with our borough populations in order to optimise integration with other services in particular health visiting, primary care, social care and children's centres. The purpose being to maximise the opportunity for integrated working and to support continuity of care especially across the antenatal and postnatal pathways.

Maternity

Service Model (3 / 3) Key Elements

Obstetric and Specialist Care

Improved continuity of care and community alignment will help to ensure timely identification, referral and access to specialist services for those women with more high risk or complex needs. This includes standardised protocols and processes across South East London as well as excellent information and communication through an improved IT interface. In addition, developing a South East London approach to meet the required standards for consultant cover, particularly for high risk women that provides the maximum quality and safety for women and babies. This is a challenge to implementation and will be addressed by the setting of a trajectory (as a commissioned minimum) to achieve 24/7 with evaluation / adding to evidence as we progress.

Neonatal Care

Supporting a reduction in neonatal admissions and access to excellent neonatal care when required, including improved access to postnatal services supporting a reduction in neonatal admissions for conditions such as jaundice, weight loss or feeding issues.

Postnatal Care

All maternity units in South East London will aim to achieve the full Unicef Baby Friendly accreditation with midwives being part of the team around the child moving from maternity to community based services. The provision of postnatal care services will include improved access to midwifery and breastfeeding support following birth and discharge. It will include a seamless postnatal overlap and transition to health visiting and primary care linking in to the broader locality/community network to support new parents and babies.

Children and young people

Service Vision

- Services and interventions are focused on providing the best start in life, health and wellbeing, early identification and early intervention, driving better health outcomes and delivering value across pathways for children and young people.
- Pathways for children (eg with complex long term conditions or long term disabilities) receive a consistent approach and highest standards of care across south east London.
- Meet London emergency paediatrics standards and deliver improved health outcomes for specialist paediatrics and community services for children including CAMHS.
- Support a child's physical and mental health needs from birth providing safeguarding and support through promotion of attachment, and psychological support via a network that will provide resilience into adulthood. Working together with other partners and communities to support families in dealing with stress that affects their children's growth and resilience.
- Services that provide a single point of access via "no wrong door", at the right place, at the right level, with the right person, at the right time thus ensuring unscheduled care is delivered to its highest standard. This will be facilitated through comprehensive integration of health and local authority services.
- Will draw on national and local research and evidence to inform practice and the spread of innovation across South East London, and to ensure a highly skilled and effective workforce.

Children and young people

Service Model (1 / 5)

- The integrated system model being developed through the **Clinical Leadership Group for Long-Term Conditions** has been developed to frame the development of the service model for children and young people in the following pages:
- Those with long term physical and / or mental health conditions will be supported with segmentation into three categories. Locality care networks will play a lead role at all stages and there will be a consistent focus on reablement; not just the prevention of deterioration, but returning people to better health
- The service model in the following pages supports the continuum of care:
  - Prevention/universal
  - Early intervention
  - Targeted intervention and urgent care
  - Most complex needs (including mental health), emergency care and conditions requiring highly specialised care
- The following chart summarises the broad framework in which the service elements support children based on needs

Framework for meeting needs of children and young people with LTCs, complex and urgent needs

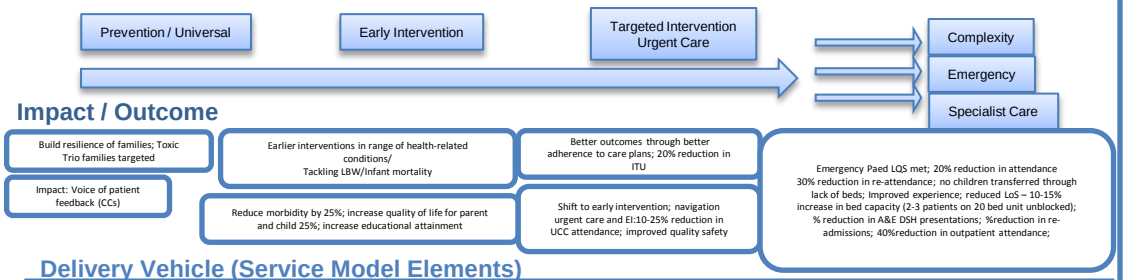
	Children with an LTC	Children with an LTC and other risk factors including psychological / mental health needs	Children with 1+ LTC / complex needs particularly if effective support package not in place

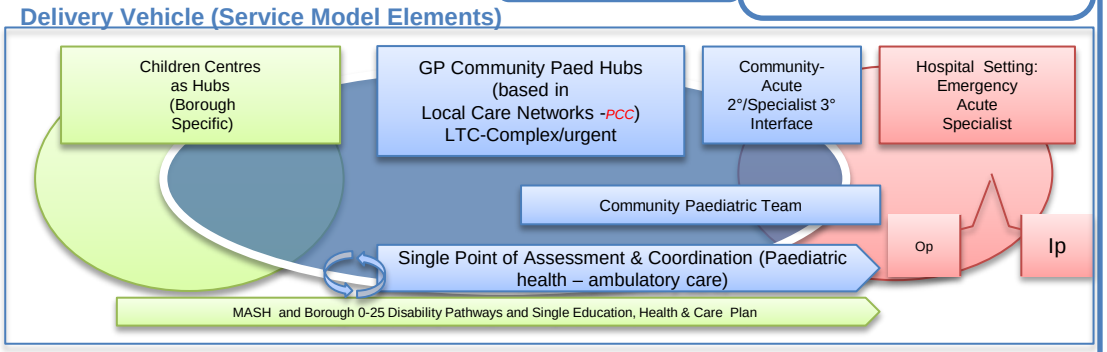
Assessment	• GP centre Community (Local Care Network) Hub in each Locality Care Network
	  • Routine
	  • Urgent access
	• Own GP
	• Link with MASH in some cases
		• GP (Local Care Network) hub diagnosis re unwell
		• Escalate to Community Child Health Team – Specialist Burse, medical, mental health
			• Integrated assessment through Community Child Health Team
			• Linked closely with social care (MASH / Single Plan assessment processes)

Example of child	• Acute illness • Worried but 'well' • Serious injury	• Diabetes, Sickle cell, ASD, range of physical disabilities with health risk components • Social / psychological factors exacerbating condition • Motivation and following care plan important to outcomes	• Children with disabilities and range od identified health records • Children with conduct disorders/ LD/ identified MH conditions/ASD • Safeguarding-related health needs / trauma • Children with a Single Education, Health and Care Plan
Key model elements	• GP Centre (Local Care Network) Hub • Universal services • Children's Centres – linking to health education, parenting, support, signposting, voluntary and peer support • Community Health – Specialist HV, Family Nurse, Practitioner • Linik to safeguarding (MASH where injuries of failure to develop are identified • Hospital Emergency / Acute – ill and injured	• Integrated assessment and coordination particularly for ambulatory care • Community Child Health Team • Community – Acute/Specialist Interface: short stay Paediatric Assessment Unit and Community Child Health Team • Acute Hospital (Planned- e.g. annual sickle cell review – and unplanned)	• Role of GP Hun un universal service working as MDT • Integrated assessment and coordination particularly for ambulatory care including Paediatric Assessment Unit • Community Child Health Team including psychological support • Community – Acute/Specialist Interface:: particularly important in managing for avoidable admissions including short stay Paediatric Assessment Unit • Acute and specialist (tertiary)

Children and young people Service Model (2 / 5)

- There is acknowledgement that strong cohesion link between local authority services and health services is imperative to enable an effective response to the needs of children and young people. Making full use of the Children's Centres and Community services. There is a need to have a strong link between safeguarding hubs such as MASH and the single point of assessment for Paediatric care
- Early identification and intervention as key to improving outcomes and reducing costs
- Underpinning service delivery is a cross-cutting approach based on:
  - Collective focus on the child (Child Centred)
  - Improved access 'No Wrong Door'
  - Psychological and Mental Health support to children and families
  - Working in partnership; capacity and demand planning





Collective focus on the child (Child centred)
- The need to design the service model around the child
- Emphasis on prevention and early intervention – achieving better outcomes
- Every Contact Counts across settings
- Acute – pathway owned by paediatric service front door onwards
- Integrated step-down from hospital designed around child
- Common transparent pathways – asthma, diabetes, autism – followed across SE

Improved Access –'No Wrong Door'
- Access including out of hours with flexibility including community services
- Paediatric Assessment Unit link with tertiary care
- 24/7 care with appropriate range of services
- Hubs and locating expertise where it is needed:
  - Children's Centres; GP Centres; Acute – Community interface - Clarity of each Hub's role and capacity/capability needed
- Community Child Health Team

Psychological and MH support
- Early intervention in universal/community settings; families at risk
- Health and schools working together eg DSH
- Support for families with children under five; intensive support to avoid admissions
- Psychological consultation to primary workers
- Supporting ill children and families

Partnership
- Extending and building on existing networks eg Psychiatric Intensive Care Unit network, Neuro-disabilities
- All organisations need to work in partnership regardless of organisational boundaries eg Lambeth Early Intervention Partnership (LEIP)
- System wide but reflect local borough plans eg HV expansion
- Changing the way services are contracted – health and local authority commissioning

Capacity and demand planning
- Academic Health Unit for Children (Institute of Child Health / Child Health Network)
- Capacity Modeling data
  - Transfers (within and between institutions – before and during treatment)
  - Re-attendance figures – note that this may not be at same institution
  - Complex needs audit
  - Workforce
  - Coordination (note Evelina starting to do this for 3 boroughs)
  - Resource distribution
- Need data to accurately map system for baseline for design and measurement of new system

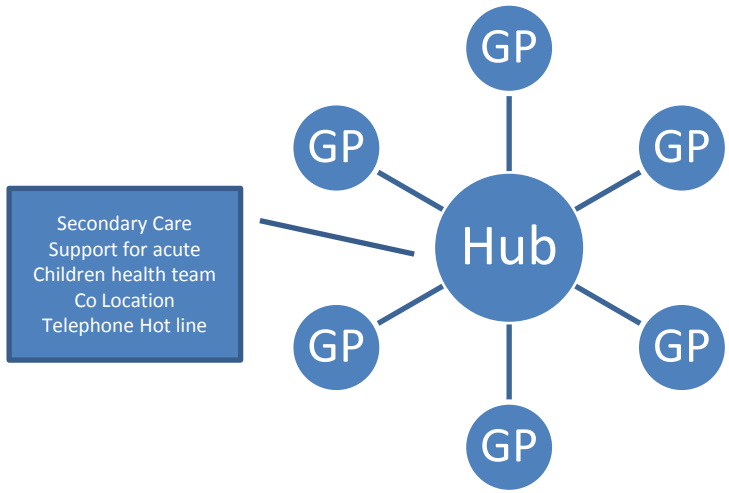
Children and young people Service Model (3 / 5)

GP (Local Care Network) Community Hub

- Centre for management of LTCs and urgent care; upskilled; access to specialist; Centre for Community Child Health Team?
- Increased role of Primary Care centres in management of LTCs and complex needs in children
- Equal access to all - No wrong door
- Based around GP
  First point of entry for a child in community
- Different levels preventative – primary – aspects of secondary – i.e. asthma
- Helping GP deliver good secondary care – asthma, diabetes
- Diagnostic, access to specialists – hotlines
- Practitioners follow patient
- **Ambulatory paediatrics – in reach**
- **Hospital outreach secondary and tertiary**
- Empower parent / careers and YOP; enable self-management
- Flexible pathways:
- How they will work: Acute care plan
- Resource centre
- Tertiary / Specialist - Patient pathways journey
- Secondary +- specialist secondary service; Secondary care expertise in GP / Centre / HUB – a number of models – secondary staff in the locality – referral direct from GP resource
- Assessments – health visitors / health checks
- Outreach skills mix
- Multiagency: Primary – Health, SC, Education, Voluntary
- Secondary universal service - Targeted
- Parenting interventions – post diagnosis, peer support, intensive crisis support
- Access CAMHS some specialist service i.e.consultant

Children's Centres as Hub (Specify through PCC CLG)

- With social care, promote well-being and health
- Midwives, Family Nurse Practitioners (FNP)
- Early years service 0-5; extend as access point for 0-25
- Targeted : speech therapy
- Early identification and intervention of health and developmental issues; upskilling eg MH - low level CAMHS in one stop unit
- Children centres have same geographical boundaries in 5 years –
- Access to physical and MH specialists working in primary centres
- Link with MASH and Single Education, Health and Care Plan processes
- Parenting interventions – peer support and issues based workshops



Consistency across 21 Localities of SE London:

GP (Local Care Network) Hubs are linked

- Virtual Links
- Peer groups
- Could be common standards to link together review outcome together
- Commission pathway of care
- Standards across the localities
- Easily able to access specialist advice
- Consistent outcomes
- Communications on practice
- Reduce boundaries (myth or real)
- Parents / Children view : access – tell story once or understand or action are delivered – support mechanism

Community Child Health Team

- LTC pathway management
- Out of Hours support; Easy access to Paediatric Specialist
- Specialist paediatric nursing for LTCs eg epilepsy, asthma; Joint working with Acute in community settings; nursing across boundaries; neonatal specialists; Paediatric Nurse Consultants; nurse prescribing; Nurse-led Transition
- Coordinating/keyworker for most complex children/LTCs
- Working with school nursing
- Building family resilience and enabling self-management
- Integrated step-down from hospital designed around child to reduce Length of Stay (LoS), improve experience and increase bed capacity through quicker discharge
- Intensive support to avoid admission including MH specialists offering consultation and short intervention
- Doctors remit and safeguarding, social paediatrics, adoption
- New disabilities, complex new developed problems
- Some prevention work – public health overlap
- Some behaviour emotional overlap with CAMHs

Children and young people Service Model (4 / 5)

Integrated assessment and coordination
Two components:

1. Community based, cross-borough multidisciplinary assessment and care coordination
2. Paediatric Assessment Unit (PAU) – short stay health, social care and mental health at front door: hospital-based Short term assessment beds – short stay (consultant led / nursing); link to CAMHS

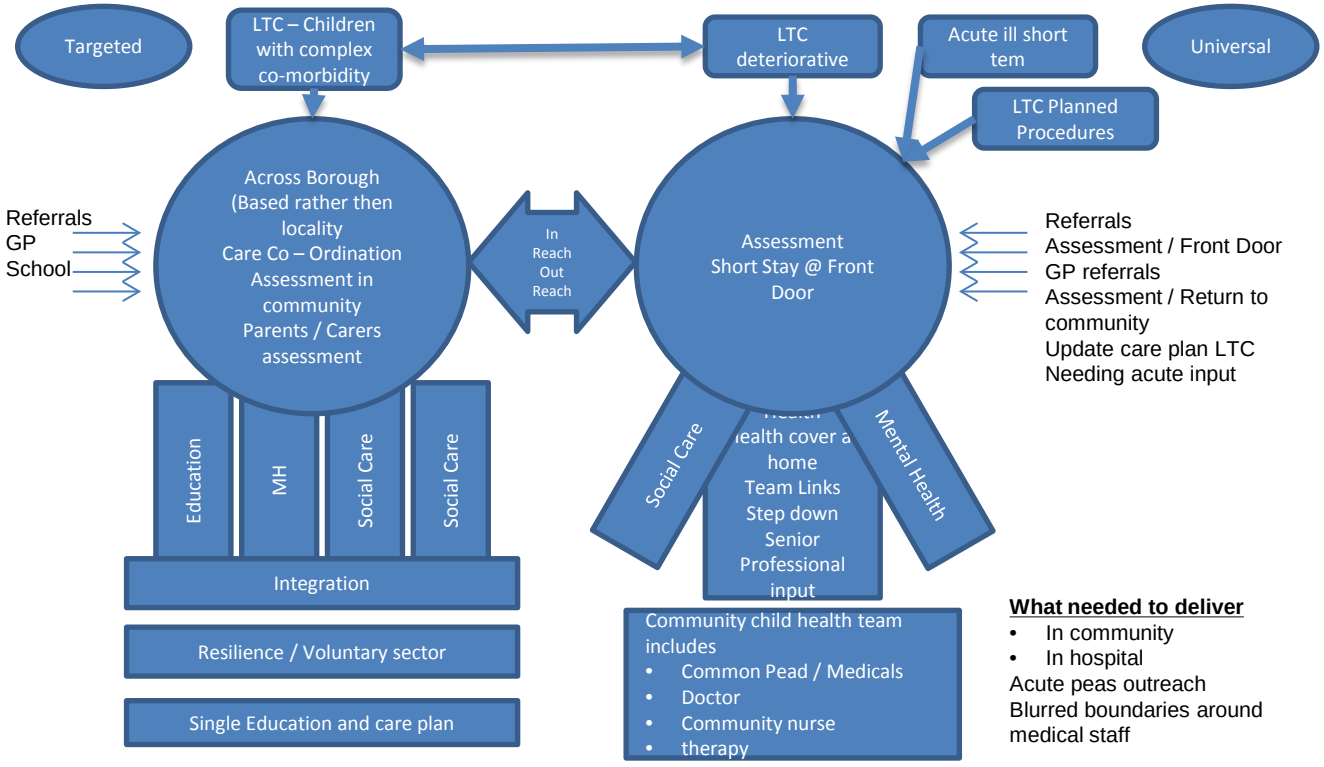
Features of Integrated assessment and coordination

- Access including out of hours with flexibility including community services; Tertiary Centres work as one Single Point of Access for advice, investigations and definitive care linking through PAUs inreach to secondary care
- **Ambulatory paediatrics – in reach**
- **Hospital outreach secondary and tertiary**
- Expect initial assessment at early stage – access – referral
- Screening tool
- Navigation - Access to appropriate level Paediatric specialist knowledge and skill
- Information / Signposting
- Early ID to early intervention
- Not necessarily via children centre hubs more health specific (GP Hub)
- MDT MASH Approach
- Triage across agencies for children with complex needs – social care and health; Continuity of care plans across boundaries eg LTC package in/out hospital
- Information / families
- Support onward referral

Integrated step down from hospital

- Principles – delayed discharges while community cares are triaged; Care planning – shared decision making, relevant /Statement

Integrated assessment and coordination



Children and young people Service Model (5 / 5)

Community-Acute/Specialist interface

- Clarity of each Hub's role and capacity/capability enabling smooth transition
- Type of children – short term illness – discharge / prevention; Deteriorating LTCs – improved assessment wider professional input; Spectrum of children – Acute ill; Deteriorating LTC
- Ambulatory care – in reach / out reach interface
- Short term – short stay Paediatric Assessment Unit (consultant led / nursing) link to CAMHS; Ambulatory – Front door – ambulatory care – includes MH and social care – Assessment beds
- Acute – pathway owned by Paediatric service front door onwards; Senior professional input early
- Condition specific therapy input for LTC children
- Community Multi Agency Planning Pathways (MAPPs e.g. Lewisham) – Care coordination in hospitals for LTCS Deteriorating; Equivalent in community - Link to acute ambulatory care
- Planned-for urgent need
- Trigger point need for ambulatory – escalation
- Referred care plan and support in community – Community Child Health Team (especially nursing specialists)
- Diabetic Nurse specialist outreach / in reach into SNS / initial teaching of staff etc. Management of allergies for example
- Appointments for sharing – critical mass
- Keeping child mobile / maximise independence of child and family; Prevention of admission
- Cross-boundary – tertiary / secondary / community –between, health, education, social care – MASH-type approach support aligned to commissioning; Social care input
- Integrated step-down from hospital designed around child to reduce LoS, improve experience and increase bed capacity through quicker discharge e.g. to Community Paediatric team
- CAMHS 'intensive support' to avoid MH admissions
- Working with GP Out Of Hours to avoid admissions and presentations at A&E e.g. medically led urgent clinics in community settings until 10pm
- Joint working between Acute and Community teams in community settings; nursing across boundaries; Integrated Managers, cross boroughs management

Hospital: Emergency

- 7 days a week, 365 days per year 14 hours per day
- Paediatric competency in A&E; Paediatric specialist available in Emergency Departments
- Consultant-led; Consultant cover till 10pm.
- Quantify the size of unit. Nursing experience / HDU / ITU / Anesthetics
- Safe transfer of critically ill children
- Acute – pathway owned by Paediatric service front door onwards
- Short Stay Paediatric Assessment Units - Unit (consultant led / nursing) link to CAMHS; Ambulatory – Front door – ambulatory care – includes Mental Health and social care – Assessment beds
- Customised environment for children and young people
- Designed around child
- Working with Adult ED
- Adequate inpatient beds
- Multi-disciplinary team training
- Paedriatric A&E, Inpatient, HDU Anaesthetics Integrated
- Appropriate discharge planning
- Integrated care step down (Community Child Health Team)
- Out Of Hours paediatric cover – those units with no paediatric backup – the ability to receive sick children

Integrated step down from hospital

- Principles – delayed discharges while community care is triaged. Care planning – shared decision making
- Step down from tertiary to secondary care
- Paediatric home care team (home support)
- Multicare in-reach – Community Child Health Team
- Ownership of Care Plan
- Nero rehab support – early supported discharge – need whole package and coordination – they could be at home
- Ambulatory care – combined funding with social care – integrated and reflecting on schools and social care
- Ownership of Social Care Pathway defined and owned by appropriate team in complex care
- Step down in complex cases

Hospital: Acute and **Specialist**

- 7 days a week, 365 days per year 14 hours per day
- Acute – pathway owned by Paediatric service front door onwards
- Consultant-delivered care, including "resident shift-working consultant"
- Paediatric A&E, Inpatient, HDU Anaesthetics Integrated
- Integrated step-down from hospital designed around child
- Increasing community support (GP Hub/Community Child Health Team to reduce re-attendance; reduce hospital outpatient attendances
- Psychological support to ill children and families
- In-reach from Community Child Health Team to support discharge
- Outreach from specialists to support GP Hub and prevent (re)admissions and unscheduled care
- Integrated care step down
- Appropriate discharge planning

Cancer

Service Vision

"That SE London make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience. That the population of SE London should have cancer outcomes to match best in world and that all SE Londoners receive excellent care and support".

Key elements

- Encouraging patient/public ownership of health
  - Promoting healthy lifestyle choices for patients and family including during and after treatment
  - Better health promotion and primary prevention
  - Patients supported to self-manage, underpinned by excellent information and rapid re-entry access when needed
  - 24/7 patient helpline
  - Care plans and care co-ordination in place
- Patient experience
  - Improved patient experience and shared decision making
  - Less variability in dying at home
  - Access to diagnostics treatments and services based on clinical need, reducing inequalities including for older patients
  - Equity of access to psychological support
- Pathways
  - Improved screening
  - Stratified pathways
  - Delivering Cancer Waiting Times (CWT) or going further where possible
  - Streamlined access to diagnostics

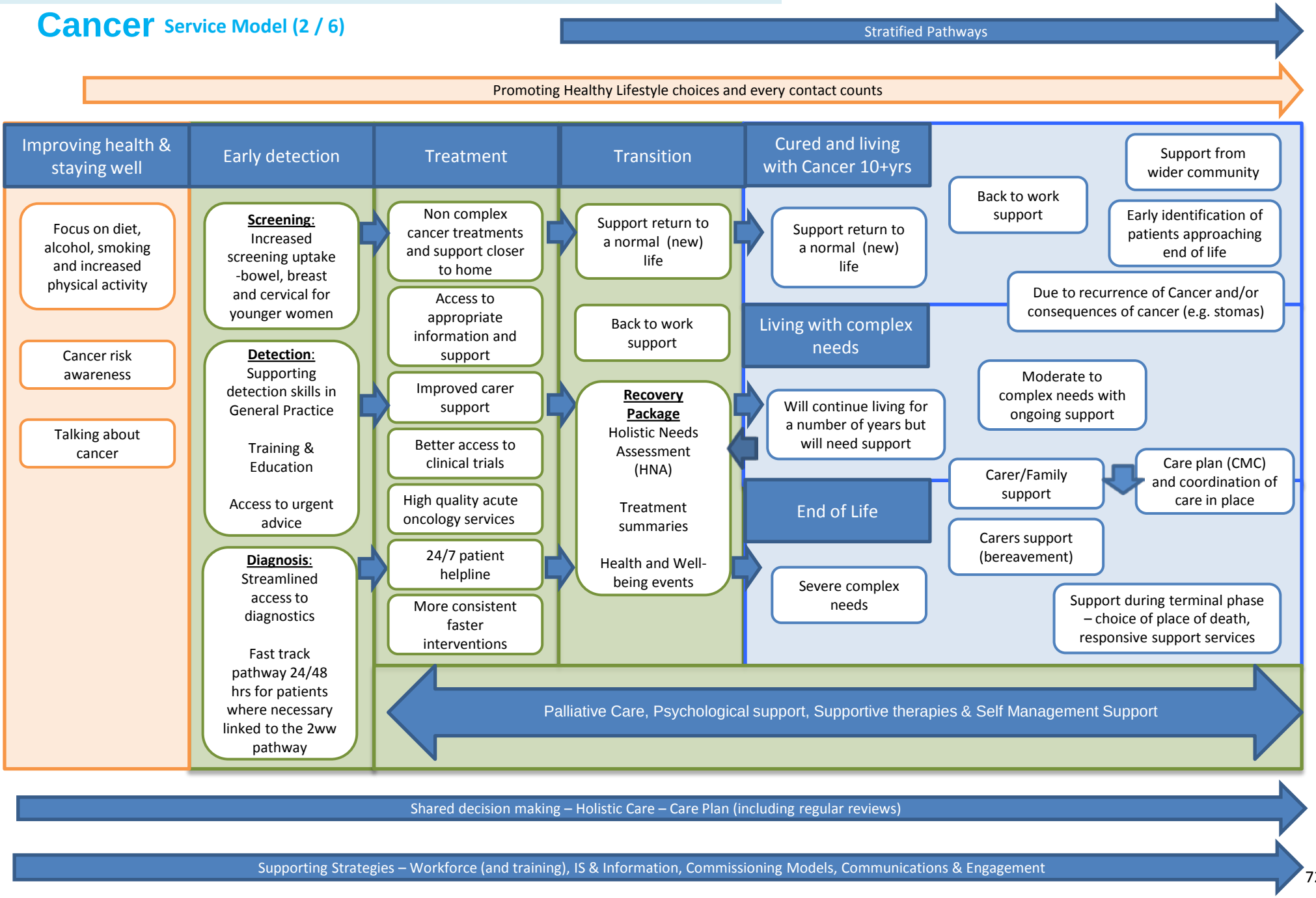
Cancer

Service Model (1 / 6)

The service model for Cancer focuses on five stages from the cancer pathway with improved carer support key at every point :

- Primary prevention with an interdependency on the Primary and Community CLG
- Early detection for both screening and diagnostic pathways with an emphasis on reducing the number of patients diagnosed in A&E. A key feature being to develop an urgent pathway for patients that cannot wait for 14 days, but are not appropriate for A&E.
- For the treatment phase an emphasis on providing effective Acute Oncology Services with excellent referral processes from A&E to include patients presenting for the first time.
- Enable & support those patients who are cured and living with cancer to return as far as possible to a normal (new) life, with supported self management
- Patients living with complex needs as a result of their cancer and/or their cancer treatment to be managed in the same way as other long term condition patients. There is an overlap between the Long Term Conditions (LTC) CLG and the Cancer CLG
- To provide end of life and palliative care with enhanced carer's support and specialist packages of care. There is cohesion between Cancer and LTC CLGs.

Cancer Service Model (2 / 6)



Cancer

Service Model (3 / 6)

Pathway	Features
Improving health & staying well - primary prevention model	• Consistent healthy lifestyle messages at all points of contact – everyone's job • Physical activity opportunities • Motivational interviewing skills • Targeting of hard to reach groups particularly, and reducing inequalities • Talking about Cancer • Survey patient literature to understand effectiveness • Consistent health checks across all practices • Consistent focus on smoking cessation and aiming to decrease the % of the population that smokes
Early detection and screening	• Increased screening uptake (specifically bowel), better detection • Symptom awareness raising • Talking about Cancer • Systematic messaging about benefits of screening from primary care, pharmacies, secondary care • Follow-up of non-attenders • Urgent pathway for access to specialist within 24-48 hours for patients where necessary. Waiting 2 weeks not always acceptable • Supporting new national screening programs

Cancer Service Model (4 / 6)

Pathway	Features
Early detection - diagnosis	• Reduction in cancer patients diagnosed through A&E • Improved access to appointments and call back service • Support for carers • Improved pathways reducing hand-offs • Increasing patient awareness and understanding reasons for late diagnosis– scope opportunities through pharmacies/other routes, support Be Clear On Cancer (BCOC) • Streamline access to diagnostics including timely results and 1 stop shops • Scope access to specialist advice for GPs • GP/PN training to maximise effectiveness of 2WW referrals – Train The Trainer (TTT), CCGs support Lead, GP role, Significant Event Audit (SEAs) as part of GP appraisal • Support the roll out of Clinical Decision Support (CDS) tool to all practices • Urgent pathway for access to specialist within 24-48 hours for patients where necessary. Waiting 2 weeks not always acceptable
Treatment	• Support for carers • Access to appropriate information and support including psychological therapies, physical activity (and Living With & Beyond Cancer phase) • Provision of non complex cancer services closer to home • Urgent pathway for access to specialist within 24-48 hours where necessary. Waiting 2 weeks not always acceptable • Effective Acute Oncology Services (AOS) with excellent referral processes from A&E to include patients presenting for the first time • High quality acute oncology services • Better access to clinical trials • 24/7 patient helpline • Opening of QMH cancer treatment centre (aim is August 2019) • Implementation of e-prescribing • Increased access to supportive therapies • Palliative care input to start early where needed

Cancer

Service Model (5 / 6)

Pathway	Features
Transition	• Rehabilitation and support to return to normal life • Cancer care review in primary care • Recovery package including holistic needs assessment, treatment summaries, and health and wellbeing events
Cured and living with Cancer for 10+ years	• Stratified pathways • Re-ablement • Support to return to a normal life • Supported self management • All cancer patients flagged on GP systems • GP continuity • Support for carers • Rapid access back into specialist services if needed
Living with complex needs	• Annual invitation with GP or nurse practitioner for simple check and to discuss concerns • All cancer patients flagged on GP systems • GP continuity • Specialist involvement after treatment to take account of consequences of cancer treatment • More than just palliative care as the only after care provision • Support for carers • Implement Holistic Needs Assessment (HNA), stratified follow up • Cancer managed as a Long Term Condition with risk assessment and good supporting information from specialist services (treatment summary) • Patient information and staying healthy advice

Cancer

Service Model (6 / 6)

Pathway	Features
End of life (EOL)	• Support for carers (bereavement) • Primary and community work together to provide coordinated high quality EOL care team around the patient • Regard EOL as beyond cancer and beyond specialist palliative care • Early identification patients approaching EOL to plan and manage better • Use of Multi Disciplinary Team (MDT) for treatment decisions – include palliative and elderly care input as required • Timely and convenient access to equipment • Scope ways to improve support to patient and family/carers 24/7 • Support more patients to achieve their wishes at their end of life • Full implementation of Co-ordinate my Care programme (to ensure sharing of information)

TO BE ADDED FOR 20 JUNE DRAFT

THIS SECTION WILL BE COMPLETED FOR 20 JUNE 2014 SUBMISSION

Introduction to System Impact (1 / 2)

- Commissioners face a substantial challenge over the next five years in terms of improving outcomes, quality, reduced variability and sustainability
- Baselines and trajectories for outcome ambitions have been developed based on a number of triangulated sources including the Case for Change, JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas
- The first two years of the Strategy will be delivered through the Operating Plans of the six CCGs. Years three to five build on those foundations to deliver system transformation, driven by the seven priority interventions described in Section 5 of this document. The current stage of development of the Strategy is therefore a combination of a shared vision, detailed plans for years one and two, and an emerging view of the impact of years three to five
- Local Health and Wellbeing Boards have been involved in the approval of Operational Plans and Better Care Fund plans containing this data, as well as in many cases the outcome ambition trajectories themselves. These therefore set out the initial level of ambition and minimum requirement for a sustainable system
- In years three to five of the plans this ambition is shown in changes in activity and outcomes to address the scale of challenge for south east London as a system. The combined plans of the CCGs show the required scale of QIPP delivery needed on a recurrent basis to achieve a sustainable economy and reflect the current status of each of the individual CCGs and where they have further ambitions to transform, and collectively build on each others achievements to date. This is underpinned by the work of the CLGs to provide the detail for delivery of these ambitions, including achievement of the London Quality standards.

The impact of delivering our proposed model will be across three main areas:

- Through a much greater emphasis on health and wellbeing, prevention and early intervention we will drive improved health outcomes and reduced health inequalities for our population that enable people to live longer and live healthier lives for longer
- Building on a foundation of community resilience and greater self-care there will be a significant shift of activity and resource from services focusing on late response in secondary care to primary, community and social care, and services enabling self-care. The transformation of our universal primary and community services provided through Locality Care Networks, and the transformation of how we support those with long term physical and mental health conditions will be key to this
- Through delivering consistently high standards of care across all services we will improve patient experience and clinical outcomes and reduce variation for our patients. We will re-shape services to create centres of excellence supporting networks of care. This will require significant one-off investment and will change patterns of spend on local services.

FOR 20 JUNE DRAFT: FURTHER ANALYSIS OF CURRENT AND HISTORIC TRENDS AND DEMOGRAPHIC CONTEXT (APPLIES THROUGHOUT THIS SECTION). DEVELOPMENT OF BRIDGE ANALYSIS

Introduction to System Impact (2 / 2)

This section sets out these impacts in further detail based on the following sections:

- 6.1 Outcomes
- 6.2 Context for financial sustainability
- 6.3 Activity
- 6.4 Finance
- 6.5 Sensitivity
- 6.6 Clinical Leadership Groups impact on programme outcomes

Further development post 20 June submission

- Engagement with stakeholders and wider public on the integrated system model
- Identification of potential implications of the proposed integrated system model on communities, institutions and organisations
- Further development of programme measures to refine selection, confirm baselines and set appropriate milestone targets
- Further work with colleagues in Public Health and more broadly across the Programme to understand impact and trajectories for key population and public health measures
- Development of financial and economic models to test the likely impact of service models being developed by Clinical Leadership Groups
- Capacity modelling on the existing system and proposed integrated system model
- Modelling of investment and transitional costs

Improving outcomes – system objectives

Each CCG has set an initial five year trajectory across the following five outcome ambitions. These are being further refined, particularly for years three to five, through the work of the Clinical Leadership Groups, colleagues in Public Health and broader programme stakeholders in developing the measurement framework for the programme.

Outcome Ambition	Metric	CCG	Baseline	14/15	15/16	16/17	17/18	18/19	INDICATIVE TRAJECTORY
1 Securing additional years of life for the people of England with treatable mental and physical health conditions	PYLL* (Rate per 100,000 population)	BEXLEY	1816.0	1757.7	1701.3	1646.7	1593.8	1542.7	
		BROMLEY	1513.0	1464.6	1417.7	1372.4	1328.4	1285.9	
		GREENWICH	2365.4	2204.9	2124.6	2044.3	1964.1	1883.8	
		LAMBETH	1914.0	1793.5	1736.1	1680.5	1626.7	1574.7	
		LEWISHAM	2114.0	2046.0	1981.0	1917.0	1856.0	1796.0	
		SOUTHWARK	2042.0	1977.0	1913.0	1852.0	1792.0	1736.0	
2 Improving the health related quality of life of people with one or more long-term condition, including mental health conditions	Average EQ-5D** score for people reporting having one or more LTC	BEXLEY	74.6	74.9	75.2	75.5	75.8	76.1	
		BROMLEY	75.7	76.0	76.3	76.6	76.9	77.2	
		GREENWICH	73.3	73.5	73.6	73.8	73.9	74.0	
		LAMBETH	75.4	75.4	75.5	75.5	75.6	75.6	
		LEWISHAM	74.2	74.3	74.3	74.7	75.1	75.4	
		SOUTHWARK	73.4	73.7	74.0	74.4	74.9	75.4	
3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Emergency admissions composite indicator	BEXLEY	1781.0	1704.4	1687.4	1670.5	1653.8	1637.3	
		BROMLEY	1547.9	1470.5	1397.0	1383.0	1369.0	1355.5	
		GREENWICH	2185.9	2124.0	2093.0	2062.0	2031.0	2000.0	
		LAMBETH	2074.0	2032.0	1990.0	1950.0	1910.0	1870.0	
		LEWISHAM	2146.4	2145.0	2144.0	2143.0	2142.0	2141.0	
		SOUTHWARK	2250.0	2137.5	2084.1	2063.2	2042.6	2022.2	
5 Increasing the number of people having a positive experience of hospital care	Proportion or people reporting poor patient experience of inpatient care	BEXLEY	176.5	174.0	172.0	171.5	169.0	167.0	
		BROMLEY	184.9	183.1	177.6	172.2	167.1	162.1	
		GREENWICH	177.5	173.8	171.9	170.1	168.2	166.4	
		LAMBETH	138.0	138.0	137.0	137.0	136.0	136.0	
		LEWISHAM	165.3	164.0	163.0	162.0	161.0	160.0	
		SOUTHWARK	137.0	136.0	135.0	134.0	132.0	130.0	
6 Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Proportion of people reporting poor experience of general practice and out of hours	BEXLEY	7.0	6.7	6.3	6.0	5.7	5.4	
		BROMLEY	7.4	7.2	6.9	6.7	6.4	6.2	
		GREENWICH	6.7	6.6	6.5	6.4	6.3	6.2	
		LAMBETH	6.1	6.0	5.9	5.8	5.7	5.6	
		LEWISHAM	6.7	6.6	6.5	6.4	6.3	6.3	
		SOUTHWARK	7.5	7.4	7.3	7.2	7.0	6.7	

* Potential years of life lost from causes considered amenable to healthcare
** Standardised generic self-completion measure of health status

TO BE FURTHER REFINED FOR 20 JUNE
DRAFT + CHART TO BE ADDED

Context for financial sustainability

- Financial modelling carried out based on the final national allocation settlement indicates that if QIPP within the Operating Plans is not achieved then the spend profile will continue to grow across all areas of care in line with demographic and non demographic assumptions, placing further pressure in the system, as demonstrated in the table, right.

SEL Total	Baseline inc growth excl QIPP years 3 - 5				
£000s	14/15	15/16	16/17	17/18	18/19
Acute	1171695	1157812	1219708	1238145	1250520
Mental Health	299381	293930	307514	311641	316264
Community	216388	204311	218646	230523	242603
Continuing Care	81628	80039	83848	86758	89915
Primary Care	231223	234643	247400	255907	265888
Other Programme	93655	205237	211823	221036	229623
Total Programme Costs	2093970	2175973	2288939	2344011	2394813

- CCG Operating Plan assumptions in relation to activity form a starting basis upon which further modelling is being carried out as part of Clinical Leadership Groups.

DN - to be added for 20 June draft – activity data excluding impact of QIPP

- The scale of financial challenge for south east London CCGs is a minimum cumulative savings of £307m between 2014 and 2019.

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

TO BE FURTHER REFINED FOR 20 JUNE
DRAFT + CHARTS TO BE ADDED

Sustainability – Activity at point of delivery (1 / 2)

Acute activity by key point of delivery

CCG Operating Plan assumptions in relation to activity form a starting basis upon which further modelling is being carried out as part of the ongoing work of Clinical Leadership Groups. This work is being expanded to more fully consider non-acute points of delivery, working in conjunction with other commissioners, including the NHS England and Local Authorities.

Hence the figures and assumptions used for the 2014/15 Operating Plan submissions should be viewed as a subject to further refinement and potential 'stretch', particularly for years 2016 to 2019.

ACTIVITY by acute point of delivery Total across all CCGs in south east London	2013/14 F'CAST OT	2014/15	2015/16	2016/17	2017/18	2018/19
Elective Admissions - Ordinary Admissions	36423	36729	37086	37096	37156	37222
Total Elective Admissions - Day Cases (FFCEs)	151860	153599	154854	155477	155509	155569
Total Elective FFCEs	188353	190327	191940	192573	192665	192791
GP Written Referrals (G&A)	310692	303619	300089	294600	287479	279580
Other referrals (G&A)	226773	223087	219126	214747	212743	211280
Total Referrals	537465	526706	519215	509347	500222	490860
Non-elective FFCEs	128214	126720	125212	123826	121868	119938
All First Outpatient Attendances	490054	479005	470753	461241	450452	438894
First Outpatient Attendances - following GP Referral	280525	272613	267032	261127	253573	245267
All Subsequent Outpatient Attendances	1146923	1127112	1121830	1119810	1115273	1111180

TO BE FURTHER REFINED FOR 20 JUNE
DRAFT + CHART TO BE ADDED

Sustainability – Activity at point of delivery (2 / 2)

A&E Attendances (excludes Urgent Care Centre activity)

Collective and borough-level interventions for urgent and emergency care include a focus on controlling and reducing A&E attendances across south east London. The high level activity assumptions included in Operational Plans set out the initial level of ambition, subject to further collective challenge as well as quantification of impact through the Urgent and Emergency Care Clinical Leadership Group and other interdependent Clinical Leadership Groups such as Primary and Community Care.

	2013/14 F'cast OT	2014/15 Total	2015/16 Total	2016/17 Total	2017/18 Total	2018/19 Total
Bexley A&E Attendances - All types	82520	82933	81652	80390	79964	79540
% Change		0.5%	-1.5%	-1.5%	-0.5%	-0.5%
Bromley A&E Attendances - All types	115084	107592	109790	111945	114467	117050
% Change		-6.5%	2.0%	2.0%	2.3%	2.3%
Greenwich A&E Attendances - All types	115033	115834	116621	117379	117849	118309
% Change		0.7%	0.7%	0.6%	0.4%	0.4%
Lambeth A&E Attendances - All types	151789	153747	155638	157459	159191	160830
% Change		1.3%	1.2%	1.2%	1.1%	1.0%
Lewisham A&E Attendances - All types	126753	125486	125486	125486	125486	125486
% Change		-1.0%	0.0%	0.0%	0.0%	0.0%
Southwark A&E Attendances - All types	144846	141800	138750	136985	136005	135324
% Change		-2.1%	-2.2%	-1.3%	-0.7%	-0.5%

Notes

The attached profiles reflect a range of local assumptions including anticipated population growth and impact of local schemes in urgent and emergency care such as new urgent care centres. Some key illustrations of this are:

1. *Impact of new Urgent Care centre at Princess Royal University Hospital on Bromley attendances in Year 1*
2. *Impact of new Urgent Care centre at Guys on Southwark attendances in Years 1 to 5*
3. *Impact of significant local development at Vauxhall and New Mills in Lambeth with significant impact on population growth in Years 1 to 5*

Sustainability – Finance (1 / 2)

Over the next five years SEL CCGs revenue allocation is forecast to increase by an average of 10% cumulatively. The table shows the amount per CCG.

Recurrent Revenue, 000s	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	264,443	273,712	283,129	290,196	297,399
Bromley	383,109	401,481	416,361	431,727	443,402
Greenwich	338,918	350,042	356,380	362,241	368,189
Lambeth	429,218	441,410	449,779	457,965	466,165
Lewisham	381,240	395,138	404,667	414,120	423,581
Southwark	373,656	390,219	400,905	411,294	421,505
SEL Total	**2,169,584**	**2,252,002**	**2,311,221**	**2,367,542**	**2,420,241**

Expenditure is set to increase at approximately the same rate cumulatively, after delivery of QIPP.

Forecast Expenditure, 000s	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	261,317	271,027	280,375	287,372	294,503
Bromley	379,278	397,465	412,197	427,409	438,967
Greenwich	332,409	350,370	349,369	355,115	360,945
Lambeth	424,924	436,995	445,279	453,381	461,498
Lewisham	368,854	382,697	392,083	401,394	410,716
Southwark	369,684	386,249	396,895	407,169	417,279
SEL Total	**2,138,454**	**2,217,591**	**2,276,200**	**2,331,841**	**2,383,909**

All SEL CCGs are planning to deliver a surplus year on year over the next five years. This ranges from 1% to 2% each year across the individual CCGs within SEL.

Surplus / (Deficit) %	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	0.05%	1.00%	1.00%	1.00%	1.00%
Bromley	1.00%	1.00%	1.00%	1.00%	1.00%
Greenwich	1.92%	1.97%	1.97%	1.97%	1.97%
Lambeth	1.00%	1.00%	1.00%	1.00%	1.00%
Lewisham	1.00%	1.00%	1.00%	1.00%	1.00%
Southwark	1.06%	1.02%	1.00%	1.00%	1.00%

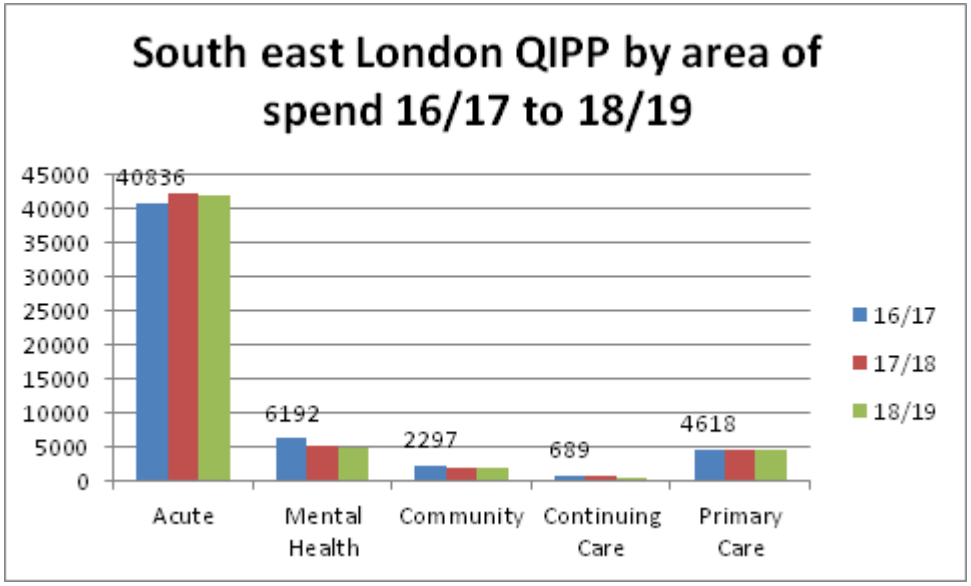
Sustainability – Finance (2 / 2)

In order to meet the rising demand and cost of living increases, CCGs have forecast a requirement to deliver a total of circa £307m net QIPP efficiencies. The first two years are underpinned by plans for delivery. The south east London commissioning strategy is the mechanism for delivering these efficiencies, together with the outcome improvements within the system.

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

Excluding the CCG running costs the level of QIPP required across the CCG spend on care is £162m across south east London. Operating Plans show this is as being delivered primarily from reductions in spend in Acute (75 – 78%).

SEL Total (£'000s)	16/17	17/18	18/19
Acute	40836	42258	41822
Mental Health	6192	5094	4776
Community	2297	1859	1837
Continuing Care	689	561	498
Primary Care	4618	4568	4399
Total	54632	54340	53332



Better Care Fund

- The June 2013 Spending Round announced the creation of a £3.8 billion Integration Transformation Fund – now referred to as the Better Care Fund – described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.
- The six south east London CCGs have all been working with their respective Local Authorities and Health and Wellbeing Boards to develop plans for improving outcomes for south east London residents through improving how health and social care services work together. The Better Care Fund is reflected within the south east London commissioning strategy and our shared plans to commission a transformed model of integrated care and support that is appropriate to their needs, and supports them to live as independent and fulfilling lives as possible.
- It is not new or additional money and commissioners jointly have to make important decisions about how the fund is used.
- The south east London commissioning strategy reflects a sound understanding of the key local challenges and the underlying issues that need to be addressed, with reference to "*Making best use of the Better Care Fund: spending to save?"* which offers an evidence-based guide, using evidence from The King's Fund and others in a number of different areas to aid the discussions between clinical commissioning groups and local authorities through health and wellbeing boards on how the fund would be used to make an impact through primary prevention; self-care; case management, for example.
- Recognising that this is a new initiative, sensitivity analysis has been undertaken which assumes that if the fund does not have the impact assumed, the spend in health will not decrease, requiring the need for increased QIPP to compensate.

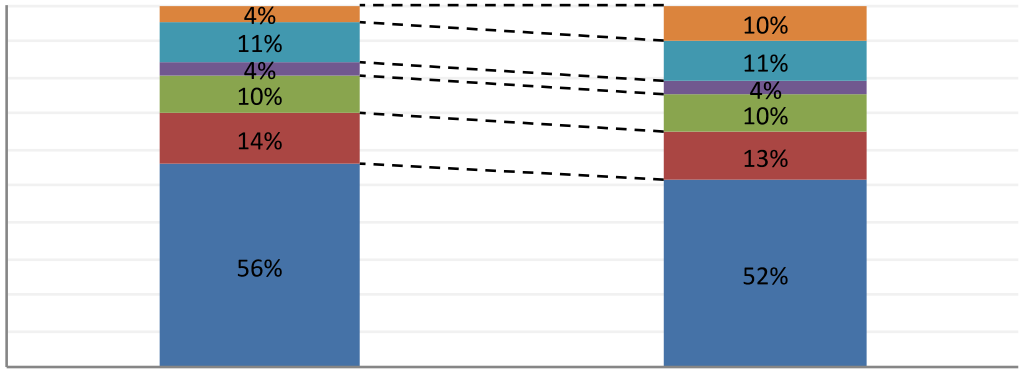
£'000s	Bexley CCG	Bromley CCG	Greenwich CCG	Lambeth CCG	Lewisham CCG	Southwark CCG	SEL Total
2015/16 allocation	13,708	20,837	19,771	22,007	19,740	20,478	116,541
2015/16 spend	13,708	20,837	19,771	22,007	19,740	20,478	116,541

Response to the Challenge – impact on the health system (1 of 2)

- The south east London commissioning strategy as defined by the CLGs is about quality, improved health outcomes, reduced inequalities and sustainable services delivered in the most effective way.
- To achieve this will alter where and how care is delivered and will require investment.
- The Operating Plans reflect the need to reinvest savings generated through QIPP to drive the shift. The investment levels are forecast and will be reviewed through an iterative process to refine. To assess the potential impact of increased investment required, this has been modelled as a sensitivity.
- Indicative impact of the implementation of the strategy have been determined with reference to opportunity for the CCGs within south east London identified in the JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas.
- The shift, within the combined Operating Plans, shows a reduction in Acute spend from 56% in 2014/15 to 52% in 2018/19 after year on year growth and delivery of QIPP.

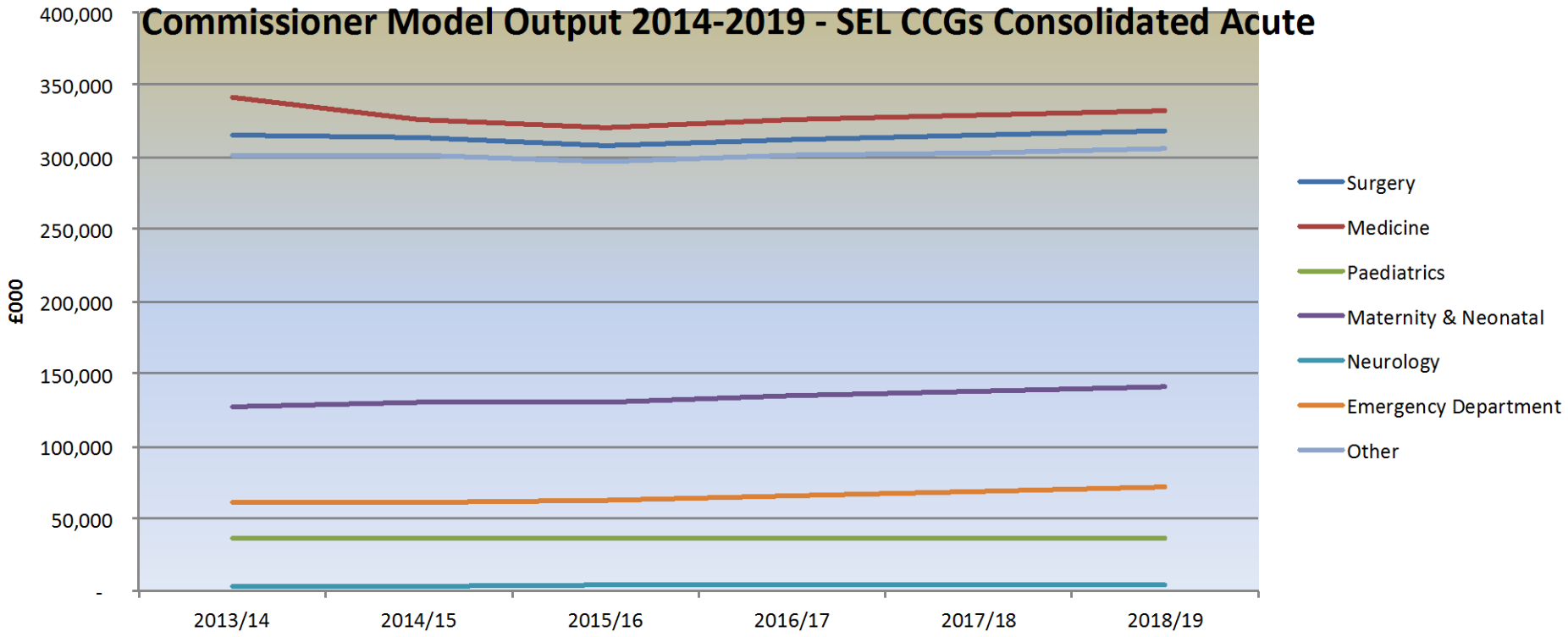
Projected shift in spend over the duration of the Strategy

based on current operational planning assumptions



Response to the Challenge – impact on Acute (2 of 2)

- The south east London commissioning strategy shows a shift in how and where the needs of the local population are met
- In line with growth projections, the demand for services is expected to increase
- Allowing for that growth and through transforming the way in which care is delivered through collaboration and partnership across health and social care, with a resulting impact on services within hospitals
- Over the next five years, the growth in acute specialities is relatively flat, reflecting the shift to provide services differently.



Sensitivity

- The Operating Plan QIPP assumptions are based on the national planning guidance trajectories and linked to the outcome ambitions, based on a number of triangulated sources including the Case for Change, JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas
- In order to assess the potential scale of risk in relation to delivery of QIPP, the impact of the Better Care Fund and the costs of implementation of the strategy, sensitivity analysis has been undertaken which assumes that if the fund does not have the impact assumed, the spend in health will not decrease, requiring the need for increased QIPP to compensate.
- These have not been applied in a “monte-carlo” style, which would have the impact of applying each sensitivity cumulatively but are shown as their respective impact on the existing scale of the challenge
- The range of impact on the £307m savings required would be an increase of between a further £15m to £45m, based on this assessment.

<table>
<tr><th>Sensitivity</th><th>Impact (£’000s / %)</th><th>Rationale</th></tr>
<tr><td>QIPP under achievement years 3-5 (by 20%)</td><td>Adverse £32,461k (10.56%)</td><td>Difficulty to implement/ scale of challenge</td></tr>
<tr><td>Better Care Fund impact lower than Operating Plan assumptions, resulting in higher QIPP to maintain sustainability (5 - 15%)</td><td>Adverse £8,115k - £24,346k
(3% - 8%)</td><td>Allocation received but savings in spend do not materialise at scale in plan</td></tr>
<tr><td>Investment including cost of supporting strategies higher than in Operating Plans (+ £5m, £10m and £15m)</td><td>Impact on total QIPP required:
<table><tr><th></th><th>16/17</th><th>17/18</th><th>18/19</th></tr><tr><td>+£5m</td><td>59632</td><td>59340</td><td>58332</td></tr><tr><td>+£10m</td><td>64632</td><td>64340</td><td>63332</td></tr><tr><td>+£15m</td><td>69632</td><td>69340</td><td>68332</td></tr></table></td><td>Require detail and management to contain costs effectively during implementation</td></tr>
</table>

Primary and community care

Key Impacts

The matrix below show how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	H
COPD mortality	M
Cancer mortality	M
CVD mortality	M
Smoking cessation	H
Excess weight (children / adults)	H
Alcohol related admissions	H
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	L
Delivering the London Quality Standards and other agreed quality standards	M
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	H

As the core of our integrated system model for south east London, Primary and Community Care has to potential to drive a significant improvement, either directly or in combination with Long Term Conditions and the priority pathways, across the majority of the integrated system objectives, for example:

- Primary prevention activities, together with social care, will have a high impact on:
  - key public health measures including smoking cessation, excess weight and alcohol related admissions
  - Reducing inequalities in health outcomes and life expectancy
- Increased community support and resilience, together with improved coordination of care and access to local services, will support the objectives of increasing proportion of people living independently at home and reducing time people spend avoidably in hospital
- Taken together with the impact of other priority pathways, Primary and Community Care interventions will have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions
- Through successful implementation of these interventions and corresponding changes driven through other Clinical Leadership Groups, Primary and Community Care will make a significant contribution to the overall sustainability of the health system
- Robust baseline activity data is needed to sufficiently inform the impact on activity especially in emergency admissions and emergency attendances
- The impact on each system objective will vary in the short, medium and long term, depending on the starting point of the individual programme
- Additional measures proposed by the group should include wider primary care activity such as mental health, patient experience of seamless care, pharmacy and end of life
- The impact of primary and community care is closely linked to social care so there is a need to reflect some of the social care objectives in the system objectives e.g. employment, housing, debt

Long term conditions, physical and mental health

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	M
Gap in life expectancy	H
COPD mortality	H
Cancer mortality	H
CVD mortality	H
Smoking cessation	M
Excess weight (children / adults)	M
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	L
Delivering the London Quality Standards and other agreed quality standards	L
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	H

The Long Term Conditions (LTC) CLG in collaboration with the Primary and Community CLG and the Cancer CLG priority pathway will have a high impact on:

- Reducing the gap in healthy life expectancy between boroughs
- Increasing the proportion of people living independently at home following discharge from hospital and being able to self manage their LTC.
- With increased community support and resilience in place the CLG will improve coordination of care, access to local services and support the numbers of people living independently at home
- This will reduce the time people spend avoidably in hospital and have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions

Further specific measures the CLG are considering:

- Additional years of life for the people of England with treatable mental and physical health conditions
- Reducing Cancer, CVD and COPD mortality
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Potential savings associated with avoided hospital care, after costs of care in the community taken into account
- Savings associated with reduced acute bed days
- Reduction in delayed discharges to social care

Planned care

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure. The Clinical Leader ship Group is also developing its own measures and objectives specific to elective and diagnostics scope.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	M
Gap in life expectancy	M
COPD mortality	H
Cancer mortality	H/M
CVD mortality	M
Smoking cessation	H
Excess weight (children / adults)	M
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	H/M
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H*
Health-related quality of life for people with long-term conditions (EQ5D)	L/M
Sustained financial balance	H

* = not London Quality Standards per se but emerging model characteristics are likely to drive quality and reduce variation against clinical standards generally e.g. NICE

Focus on faster access and reduced waiting time across the pathway coupled with standardised approaches will contribute to earlier detection and intervention for patients with cancer and other cohorts requiring elective surgery. This has the potential to contribute to improving life expectancy and healthy life expectancy.

Working towards a system where every contact counts with clear clinical signposting can help maximise the impact of smoking cessation and healthy weight with the patient being in the centre of the care pathway. This is also likely to positively impact COPD mortality and CVD mortality.

Standardisation will help to reduce variation and duplication which in turn will drive quality of services up with improved clinical outcomes (for example lower infection rates), potentially reducing the number of avoidable deaths in hospitals. This is also supported by getting a senior opinion early (from an expert not necessarily a consultant).

Increasing capability within the community for diagnostics and some minor elective work will help to reduce waiting time and cancellations will help reduce the amount of time people spend in hospital and improve the flow of the patients that present properly. This will also help to improve the quality of care and in turn improve patient experience through clear linear pathways.

Some reduction in emergency admissions and attendances as a result of improved access reducing the number of patients that need to be admitted as an emergency.

Ensuring that communication and sharing of information that occurs between secondary care, primary care and social care is the best it can be has the potential to drive prevention and discharge management. This will help to empower the patient to understand their condition and the critical things they (or their family) need to know to help manage their condition after an elective episode.

Collaboration between primary care and secondary care, with social care and social services has the potential to reduce the amount of time people spend avoidably in hospital (including reducing lengths of stay) and ensure that elderly patients are able / supported to live independently when moved back in the community. This also has the potential to prevent some admissions through patients being better supported.

Working together to address rising demand for elective care and diagnostics, delivering services more efficiently and effectively whilst maximising value across the pathway will help to deliver sustainable financial balance across the system.

Urgent and emergency care

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	L
Gap in life expectancy	L
COPD mortality	L
Cancer mortality	L
CVD mortality	H-M
Smoking cessation	L
Excess weight (children / adults)	L
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	M
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	M
Health-related quality of life for people with long-term conditions (EQ5D)	M
Sustained financial balance	M
4 HOUR TARGET	H
CDU reducing use of acute admissions	H

This matrix shows how the strategic intervention contributes to each programme measure.

There is a rapid 24/7 response to urgent care needs. The service model integrates fully with the development of Local Care Network (LCN) Hubs delivering more of urgent care closer to a patient's home, particularly aiming to be the choice to go to for minor injuries and illnesses. Emergency Department (ED) specialists are able to be reached for advice and also can book urgent appointments with GPs for patients who do present at an Urgent Care Centre or ED inappropriately. Clear sign-posting and agreed 'bundles of care' ensure patients receive the right services in the right place. 111 plays an enhanced role in navigating and coordinating an appropriate response to urgent (and not so urgent) needs. LAS has access to patient information and is able to route to the right service for non-blue light calls, including LCNs.

Urgent care in the community is enhanced through the Rapid Access Service (Home Ward and Specialist Response clinics located in hospitals) which particularly aims to support elderly frail patients and those others with LTCs, complex health and mental health needs to avoid the need to present at an Emergency Department. This means fewer vulnerable patients need be spending time in Emergency Departments or admitted to wards whilst awaiting diagnosis, as well as supporting speedier discharge for patients who do need to attend EDs. This may increase life expectancy for those who are frail or with certain LTCs.

Fewer patients from care homes are presenting at A&E and are assessed and treated at home through the 'Home Ward' team (Rapid Access Service).

Within EDs, improved streaming and flow, managed by an experienced Band 6 Nurse and GP provision at the 'front door' ensures patients are seen within the London Quality Standards targets and avoidable admissions are increased. This is enhanced by Clinical Decision Units with beds, able to hold, assess and treat patients without admitting to wards, improving patient experience, avoiding admission and returning home faster. In place are links with 24 hr social care and the voluntary sector able to support the patient on discharge/return home where needed and reduce likelihood of re-attendance with the same urgent need.

Complex needs – including alcohol and mental health related admissions – are more effectively managed to avoid admissions through integrated planning and working between community and specialist services. There is likely to be a reduction in frequent attenders.

Investment in services providing urgent care in the community will impact patient outcomes and shift urgent care activity away from UCCs and EDs.

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Maternity

Key Impacts

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	L
COPD mortality	N/A
Cancer mortality	N/A
CVD mortality	N/A
Smoking cessation	M
Excess weight (children / adults)	M
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	N/A
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	M
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H
Health-related quality of life for people with long-term conditions (EQ5D)	L
Sustained financial balance	M

This matrix shows how this strategic intervention contributes to each programme measure.

The strategic vision for maternity services is to place the needs of women and their families at the centre of maternity care. The model of care which is midwifery –led continuity of care includes neonatal care and early years up to 9 months. There are a number of key elements within the maternity service model which support the delivery of these overall programme measures.

Specifically:

- To develop maternity services and a workforce that promote healthy lifestyles which have a positive effect on the health outcomes for mother and child and the wider family.
- To work in conjunction with primary care and others to improve awareness of problems in pregnancy and the impact on outcomes caused by a range of lifestyle choices.
- Promoting early access to maternity services through a focus on hard to reach groups and supporting early identification of risk and consequent care plan development.
- Developing continuity of midwife-led care and reviewing maternity catchment areas in order to optimise integration with other services in particular health visiting, primary care, social care and children's centres.
- The service model enhances specialist maternity services for high risk women or women with complex health needs including perinatal and post-natal mental health.
- Midwives will become part of the team around the child moving from maternity to community based services and will include a postnatal overlap and transition to health visiting and primary care linking into the broader locality / community network to support new parents and babies.
- Improved access to postnatal services will also support a reduction in neonatal admissions.
- improved continuity of care and community alignment will help to ensure timely identification, referral and access to specialist services.
- Developing an approach to meet the required standards for consultant cover , particularly for high risk women that provides the maximum quality and safety for women and babies in hospital during and following delivery.

Normalising birth and supporting women to achieve the best possible outcomes for themselves and their babies is the focus of the maternity strategy. The successful implementation of the strategy will have an overall positive impact in improving the life chances and healthy life expectancy for local people.

Children and young people

Key Impacts

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	N/A
COPD mortality	N/A
Cancer mortality	N/A
CVD mortality	N/A
Smoking cessation	L-M
Excess weight (children / adults)	M
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	N/A
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	M
Mental health and CAHMs admissions	M

At the core of the children and young persons strategy is building community resilience and child-centred services. The service model particularly aims to deliver: early intervention; health care promotion and prevention delivered through Children's Centres and GP (Local Care Network) Hubs; improved access 'no wrong door'; effective assessment and coordination for children with Long term Conditions and Complex needs. These and a more effective interface between community and acute/specialist services will be impacting positively on life expectancy and healthy life expectancy.

Tackling 'Toxic Stress' and promoting emotional as well as physical well-being helps protect the child from adversity and reduces potential mental health conditions. The strategy presents a positive focus on mental health of the child and ensures their support networks help enable this. Up skilling the workforce across a number of system developments with regards to mental health will see an impact on the number of children and young people presenting to CAHMs services. Providing ill children and their parents/carers with psychological support in hospital and at home will improve healthy life expectancy and health-related quality of life.

An integrated paediatric assessment and coordination process, linked to safeguarding processes and the Single Plan for children with disabilities/special learning needs will improve access and outcomes for children and young people with long term conditions and complex needs. Specialist Paediatric Assessment Units (PAU) will improve outcomes and reduce unnecessary admissions in to acute services for children with urgent care needs. GPs will be able to access Paediatric consultancy and advice to deal with urgent needs locally.

Community Child Health Teams manage LTC pathways, providing Out of Hours support, easy access to Paediatric Specialists and paediatric specialist nursing in the community, improving time in hospital and supporting improved quality of life, parental support and therefore mental health and emotional well-being of children. This is supported through a strong link into education and the role Local authorities, public health, and health visitors play in supporting a child's health needs. Services designed around the child and their support network promotes more informed life style choices This directly feeds into smoking cessation, excess weight, and alcohol related admissions within the cohort.

An effectively designed and coordinated community-acute / specialist interface model around PAU and Community Child Health Teams with paediatric team ownership from "front door" will avoid unnecessary admission and improve outcomes across secondary care. This will also speed up discharge ensuring the step down interface between secondary care and community will be efficient and effective. This will be supported by inreach to children with long term conditions in hospital from Community Child Health Teams ensuring services are centred around the child on discharge.

The model will support delivery of the London Quality Standards including specialist paediatric decision-making and cover for Emergency departments.

Ultimately with the reduction in avoidable acute admissions this aims to help to support a sustained financial balance.

Cancer

Key Impacts

The matrix below shows how each of the strategic interventions for the Strategy contribute to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	M
Gap in life expectancy	M
COPD mortality	L
Cancer mortality	H
CVD mortality	L
Smoking cessation	M
Excess weight (children / adults)	L
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	M
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	M
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	M
Delivering the London Quality Standards and other agreed quality standards	L*
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	M

The vision of the Cancer Clinical Leadership Group is to make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience. To support this vision, an initial model has been designed that will focus effort in areas where the greatest improvement of outcomes can be made, in particular:

- The approach to early detection and treatment is a fundamental driver of the system objective to reduce avoidable cancer mortality and increase overall life expectancy
- Enhanced and coordinated care and support services within the community will have a significant impact on emergency admissions and emergency attendances, particularly at end of life
- The focus on transition from treatment living with cancer and the effects of cancer will also make a contribution to reducing the amount of time people spend in hospital and the proportion of older people living independently at home following discharge from hospital
- Enhanced support to patients, families and carers will support the ambition of increasing the number of people having a positive experience of hospital care
- Education and training within the workforce (including social care providers and voluntary services) will help support prevention objectives, in particular for smoking cessation.

* Cancer has no specific London Quality Standards, but is following the recommendations in the Five Year Cancer Commissioning Strategy for London

Supporting Strategies

When the strategic opportunities and scope of the Clinical Leadership Groups were agreed, it was acknowledged that there would be some overlap and interplay between the groups and further that there would be a need for cross-cutting supporting strategies to enable the delivery of interventions defined through the groups.

Supporting strategies will be a fundamental part of the development of the strategy after the 20 June NHS England submission and successful implementation of any resulting system changes. Discussions at Clinical Leadership Group workshops and the Partnership Group stakeholder meetings have identified a number of common supporting strategies. Including:

- IT and Information
- Workforce
- Commissioning Models
- Communications and Engagement
- Organisational Design and Change Management
- Estates
- Transport

Further development post 20 June submission

- Establish a governance model for the supporting strategies
- Clearly define and scope the supporting strategies
- Create work and engagement plans for taking forward the development of the strategies

Priority Supporting Strategies

Priority Supporting Strategy	Overview
IT and Information	To drive a consistent and accessible approach to IT and information across all providers including: • Shared definitions and standards • Sharing of patient data and health information across providers • Use of a virtual patient record
Workforce	To develop a new workforce model that meets the needs of an increasingly community based model of prevention and care including: • Use of multi-disciplinary teams, at the right time in the right place • 24/7 care with an appropriate range of skills • Addressing recruitment and retention issues • Supporting cultural and behavioural change to reflect the emphasis on public health and self care
Commissioning Models	To develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system, including: • Commissioning and providing for outcomes • Development of incentives and contractual levers for change, including quality improvement • Effective co-commissioning to reduce complexity and ensure consistency of approach
Communications and Engagement	To develop the existing Communications and Engagement workstream to support all aspects of the programme over the coming months including: • Coordination of local and south east London-wide engagement on the strategy, including potential impacts on the health system • Communication with stakeholders, patients, local people and staff • Development of proposals for campaign approach to engage patients and local people in the strategy and management of their own health
Estates	To an Estates workstream with particular focus on: • Supporting Locality Care Networks through enabling the bringing together of staff and services • Promoting co-location of services where appropriate • Establishing primary care estate for the 21st Century

Implementation work already underway (1 / 2)

Much of the content in this draft has focused on the future state service models that will be in place by years three to five of the Strategy. However we understand the urgency to change services and significant work is already underway that will deliver foundational elements of the Strategy during years one and two.

Collaboration on the Strategy follows a principle of 'shared standards, local delivery'. In practice this means CCGs working together at the right scale: at borough, cross-borough or south east London level. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the Strategy.

Some examples of significant work already being implement are as follows:

- **Development of wider primary care, provided at scale** South east London CCGs are already working to transform local primary and community care:
  - The six boroughs have developed a model under which services will be provided at scale by 24 locality care networks supporting whole populations
  - This builds on the current pathfinder programme for developing new models of primary care under which there have been 12 applications, each with geographical coherence, with a coverage of more than 750,000 registered patients
  - Southwark CCG have been granted £950k from the Prime Minister's Challenge fund to provide extended access to primary care through neighbourhood working, supporting the implementation of the CCG's Primary and Community Care strategy
  - Lewisham CCG has transformed its Diabetes Pathway utilising various mechanisms to enhance diagnosis across Primary Care, including 'Peer2Peer support' which involves a dedicated clinical lead supporting practices by providing hands on in-practice advice and guidance. This has helped to strengthen and improve the number of patients taken through the 3Rs process (Register, Recall and Review) and the 9 Care Processes (NICE standard).
- **Developing a modern model of integrated care** There has been significant progress to date in the development of integrated care, delivered through south east London's Community Based Care programme. In addition to developing plans with local authorities under the Better Care Fund, CCGs have also achieved a number of other key milestones:
  - Bexley, Bromley and Greenwich CCG are all achieving top 10% performance for avoidable admissions through their local delivery of integrated care services
  - The development and scaling of the Southwark and Lambeth Integrated Care Programme (SLIC)
  - Greenwich achieving national pathfinder for Integrated Care.

Implementation work already underway (2 / 2)

Examples continued:

- **Improving and enhancing local urgent and emergency care** Locally driven work to improve urgent and emergency care including the redesign of Guys and St Thomas Emergency Department and Urgent Care Centre (UCC) in Lambeth and the successful transition of the 111 service to London Ambulance Service and subsequent achievement of all targets.

- **Transforming specialised services** The development of new cancer treatment centres at Guys Hospital and a cancer treatment centre at Queen Mary's Hospital Sidcup

- **Building resilient communities** South east London's CCGs are working with local authorities through Health and Wellbeing Strategies, to build and develop **resilient communities**, for example through the award winning Lambeth Living Well Collaborative

- **Partnership working across south east London** The Programme has a strong partnership approach, led by NHS commissioners and involving closely a wide range of local partners, including patients and communities, local authorities and NHS providers, to build agreement on priorities, strategic goals and outcomes. South east London's Partnership Group provides a strong and collective transformational leadership of the Strategy, with a shared recognition across all members of the scale of the challenge and also the level of organisational and cultural change needed

- **Clinical Commissioning Groups and membership organisations** The membership nature of CCGs enables change to be clinically led and rapidly delivered across the health system – for example rapid introduction of new referral protocols in relation to cancer waits.

Introduction to programme approach

- Since the start of September 2013, South East London commissioners have been working together to form a new commissioner-led, clinically-driven programme to address the challenges faced across the South East London health system in partnership with providers and the local authorities
- The South East London Commissioning Strategy Programme encompasses the South East London response to NHS England's requirement to produce a five year strategy. The strategy, key interventions and impact assessment have been completed at a high level and will be developed in greater depth and tested both in terms of impact modelling and testing with our stakeholders
- Implementation of the Strategy is underway. We can improve care to patients immediately and the Partnership will drive forward the changes
- The following pages set out the approach used to develop the strategy and next steps through which partners are working together to further develop and implement the Strategy through to 2019.

Programme principles and values

The approach has a strong focus on engagement, aiming to co-design with partners, including patients and local people. Initial thinking is being developed and amended through the engagement process.

Key principles and values for the programme include:

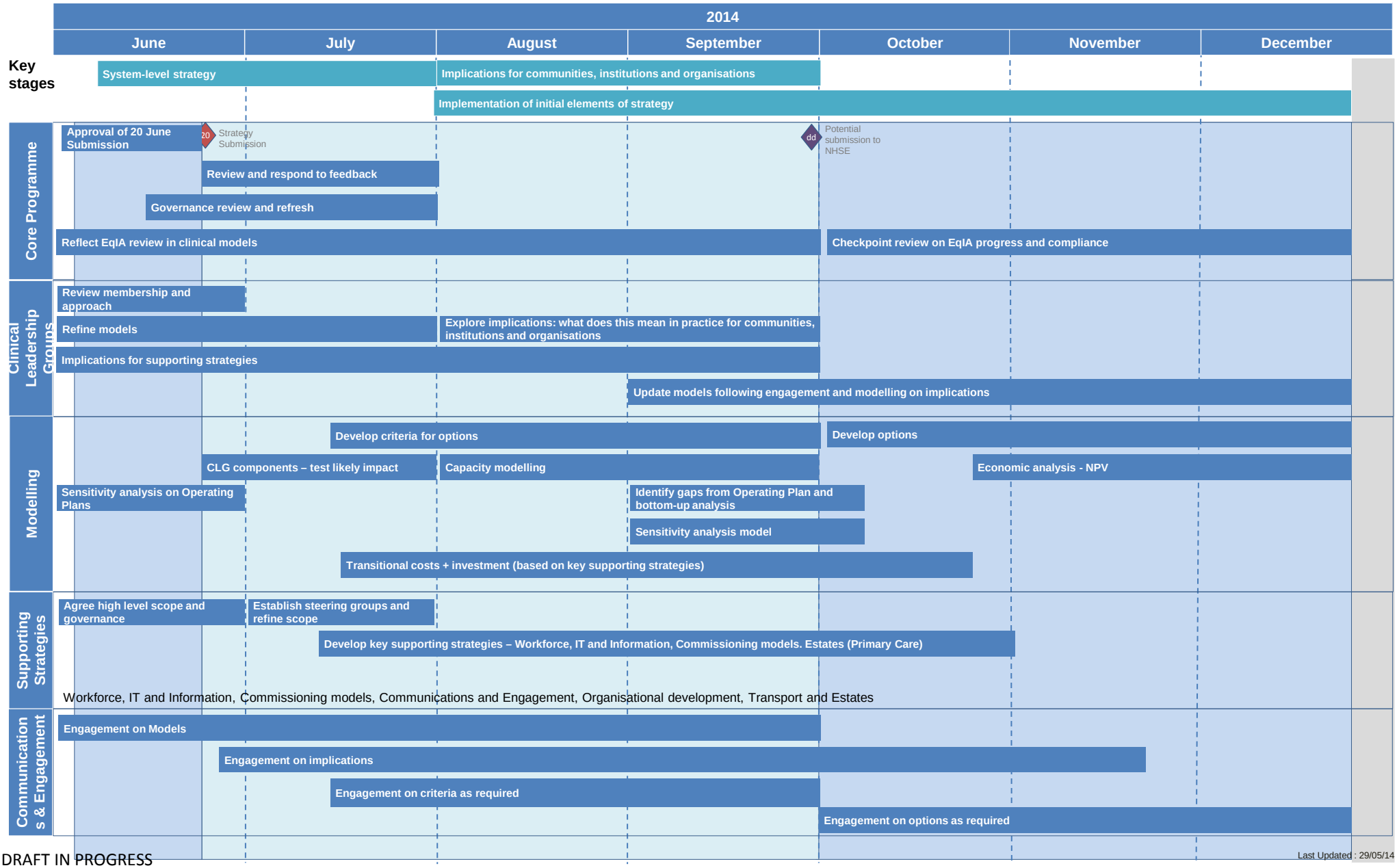
- Being based on local needs and aspirations, listening to local voices and building on work at borough level, whilst taking into account national and London policies
- Focusing on improving health and reducing inequalities
- Employing a strong partnership approach, led by NHS commissioners and involving closely a wide range of local partners, including patients and communities, local authorities and NHS partners, to build agreement on priorities, strategic goals and outcomes
- Creating solid foundations by ensuring all stakeholders have a common understanding of the scale of the challenge and then a shared vision and ambition for the next five years
- Being open and transparent throughout the process, from identification of need, to implementation of the strategy
- Engaging broadly, building on existing borough-level work with wider engagement activity to complement this as appropriate
- Working with the Health and Wellbeing Board in each borough.

Following these principles and values, the South East London strategy is building on the six individual CCG-level strategies developed locally with partners. CCGs are working collaboratively on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively.

Engagement is being undertaken throughout the process, primarily through existing borough-level engagement, but on a wider basis where this is helpful. Engagement to date has included developing the case for change, scope and vision, the ambition of the programme and is moving on to priorities and models of care as the programme develops.

Specific engagement will take into account equalities aspects and impacts on the nine statutorily protected groups, plus the needs of socially and economically deprived populations and of carers in south east London.

Plan for developing the strategy – to December 2014



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Last Updated : 29/05/14

Approach to strategy development – 2014 – 2019

Submission of the final strategy on 20 June is just the start of the development and implementation of a long term strategic vision and change for south east London:

- 20 June 2014 – Final Strategy submission to NHS England
- July to December 2014 – Work to review and refresh Strategy and set out impact of proposed interventions at an institutional and community level, with engagement on final strategy and implications as they develop
- 2015 – Business Case for any significant service change (if required) and formal consultation (if required)

Approach to engagement

The programme approach has a strong focus on engagement, aiming to co-design with partners, including patients and local people. Initial thinking is being developed and amended through the engagement process.

Engagement is being undertaken through a number of complementary activities, including the following:

- Using existing borough-level channels and planned activities, supplemented by engagement on a wider basis where this is helpful. Initial engagement included developing the emerging and draft case for change, testing emerging strategic opportunities across south east London and the scope and vision and the ambition of the programme. The focus of engagement is moving onto priorities and proposed models of care as the programme develops.
- Patient and Public Participation:
  - Healthwatch representatives and local patient and public voices have been recruited and are members of each of the seven clinical leadership groups, working with clinicians and social care leads from organisations across south east London on clinical design activities for service improvements and proposed models of care
  - Healthwatch representatives and local patient and public voices are members of the Partnership Group, Clinical Executive Group and the Clinical Commissioning Board, shaping the overall strategy
- An early Equalities Impact Assessment:
  - to ensure that the strategy has considered, from the outset, the potential impact on those protected under the Equality Act 2010 and the additional south east London groups
  - to ensure that plans for further engagement – locally and more widely – are targeted appropriately to reach local people and communities whose voices are seldom heard
- Engagement events:
  - Wider engagement events across south east London or between boroughs with voluntary and stakeholder organisations, patients and local people.
  - Participating in events organised by south east London-based voluntary organisations and other stakeholders where the aim or content is relevant to the development of the strategy.
- Market research:
  - Independent survey with a representative sample of local populations to gain deeper insight into local people's views.

Engagement to date

In line with the engagement approach set out on the previous page, engagement to date includes:

- Understanding feedback from the 'Call to Action' engagement activities across all six CCGs from 2013 and using this to inform the emerging draft case for change
- Understanding feedback on local strategies during 2013 and 2014 and using this to inform the developing draft strategy
- Testing early thinking on the emerging draft case for change with the independently-chaired South East London CCG Stakeholder Reference Group (SRG) in December 2013. Using feedback from this group to inform development of local engagement plans and associated resources for engagement on the full draft case for change and the emerging strategic opportunities across south east London
- Sharing the emerging case for change through the CCGs' existing engagement forums and with NHS providers and local authorities via the programme's Partnership Group. Using feedback to inform development of resources for engagement on the full draft case for change and the emerging strategic opportunities across south east London
- Sharing the full draft the case for change, the emerging strategic opportunities across south east London and the draft vision and ambition through south east London's CCGs', NHS providers' and local authorities' existing engagement forums, SRG membership, Healthwatches, Clinical Executive Group and Partnership Group membership from February 2014
- Publishing plain English and technical summary versions of the draft case for change and emerging strategic opportunities across south east London for on-line engagement with local people and clinicians via all six CCGs' websites from March 2014.
- Regular updates on the strategy development at local public meetings of CCGs' Governing Bodies and Health and Well-Being Boards.
- Updating CCGs' GP memberships with regular briefings on the clinical developments and progress with the strategy.
- Recruiting patient and public voices for direct involvement in the development and shaping of the strategy

Patient and public participation

The following arrangements have been put in place to enable active participation of patients and local people in the clinical design and shaping of the overall strategy:

- **Clinical Leadership Groups** – A Healthwatch representative plus three additional patient/public voices on each of the seven Clinical Leadership Groups to participate in the work for planning service improvements and proposed models of care.
- **Clinical Executive Group, Partnership Group and Clinical Commissioning Board** – A Healthwatch representative plus two patient and public voices to participate in each group on shaping the overall strategy for south east London.
- **Patient and Public Advisory Group (PPAG)** – establishing this group as a collective forum bringing together the strategy's patient and public voices, Healthwatch representatives and other local stakeholders with an interest in the strategy to share messages from different groups and to provide peer support, as well as to advise the strategy on public-facing communications and wider engagement. It is anticipated that PPAG will report to the Clinical Executive Group. Its work is complementary to the independent advisory role to the strategy of the South East London CCG Stakeholder Reference Group.

The programme team is providing further support for representatives and patient and public voices:

- Provision of a high level role description outlining how participants will contribute to groups, clarifying the level of commitment expected by participants and the support available to them in their role
- Ensuring participants are adequately briefed for meetings and workshops – including overview of programme in advance of first meeting, collecting and disseminating their feedback more widely within the programme as appropriate and supporting them, as required, to feedback to their constituent groups and communities.
- Establishing additional support arrangements for participants including mentors.
- Supporting the work of the Patient and Public Advisory Group in communicating the role and work of patient and public voices more widely

These arrangements will be reviewed at the end June 2014 as we move into a further phase of significant engagement and start looking at the impact of proposed interventions on individual organisations and institutions.

Equalities impact assessment

One of the aims of the South East London Commissioning Strategy is to improve health and reduce health inequalities. Ensuring that the health and care needs of seldom heard groups are adequately met is a key element of this strategy.

To support programme engagement activities and to fulfil the need to ensure that we demonstrate that we have considered the potential impact on those protected under the Equality Act 2010, with specific regard given to the general equality duty/public sector equality duty, the South East London Commissioning Strategy Programme has appointed an external partner to undertake an early independent Equality Impact Assessment. During strategy development the Equalities Impact Assessment will:

- Explore how elements of the strategy support or hinder the achievement of the three limbs of the general duty of the Equality Act, namely the elimination of unlawful discrimination, harassment and victimisation; the advancement of equality of opportunity between different groups; and the fostering of good relations between different groups.
- Review the work undertaken to date at a local and collective level to identify:
    - Whether the programme has considered and understood the potential effects of the commissioners' strategy on different equality groups at key stages and assured that we have undertaken work to ensure that there is either no adverse impact or that we have identified a plan to address and to mitigate any adverse impact
    - Whether the programme has considered and identified enhancements to any benefits that could or might accrue to the nine statutorily protected groups (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, marriage and civil partnership - but only in respect of eliminating unlawful discrimination), plus two locally added groups (carers, deprivation – social and economic) as a result of the commissioners' strategy
    - How communities and protected groups and the additional groups of the six boroughs within South East London are likely to be affected by the strategy
    - What plans for further engagement should be put in place during the further development work on the impact of the strategy including traditionally under-represented groups.

By starting this assessment while the strategy is still in development, the outputs are being fed into the work of the Clinical Leadership Groups and the Communications and Engagement workstream from an early stage. In this way, it is already being used to shape the strategy, ensuring the equalities agenda is a key building block of the integrated system model and related service models for the south east London health system.

Introduction to programme governance

- The South East London Commissioning Strategy Programme governance has been designed to sit within the existing governance and decision making structures of the CCGs and NHSE. It provides formal forums to undertake the four key governance functions of the programme:
  - Senior joint forum for strategic direction and decision making (equivalent to a Programme Board) **– the Clinical Commissioning Board**
  - Collaborative forum for partnership working – **the South East London Partnership Group**
  - Clinical forum to guide design work – **the Clinical Executive Group**
  - Delivery focused forum to manage design and implementation activities – **the Implementation Executive Group.**
- These four functions are supported by a simple programme management structure to monitor and support clinical design and implementation activities
- The approach has been designed to ensure that current and future plans governed under the Strategy Programme are developed in collaboration with key stakeholders including the local community.

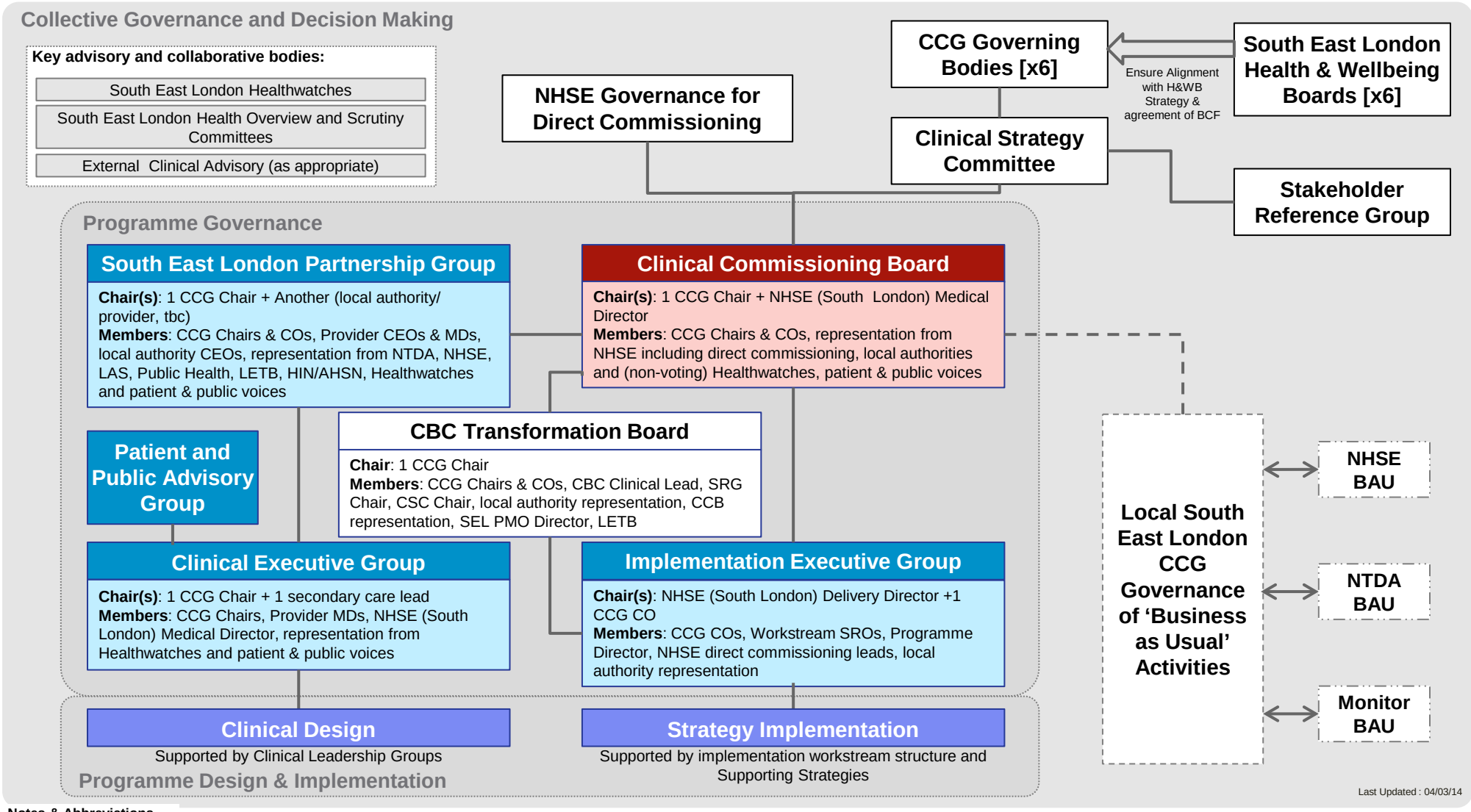
The following pages set out the principles, structure and key roles and functions for governance of the Strategy.

Principles for programme governance

The governance approach is based on a number of overarching principles and assumptions:

- It must ensure the Commissioning Strategy is based on local needs and aspirations, listening to local voices and building on work at borough level, whilst taking into account national and London policies
- It must be open and transparent throughout the process, from identification of need, to implementation of the strategy, with opportunity for challenge by patients and the public
- Patient safety and quality must be at the heart of decision making
- Decisions should take into account patient, carer and community voice
- The roles, responsibilities and accountabilities of the CCGs, NHS England and all partner organisations must be explicitly defined
- There should be clear points of accountability for all deliverables
- Programme governance should provide assurance that the anticipated benefits of the programme will be delivered
- The core programme will be responsible for ensuring that contributing projects and programmes deliver the planned benefits of the programme in line with the critical path and overall timetable
- Duplication of effort should be minimised across the health system.

Structure and high-level memberships



Notes & Abbreviations

BCF = Better Care Fund
NHSE = NHS England
NTDA = NHS Trust Development Authority
LAS = London Ambulance Service
LETB = Local Education and Training Boards
HIN = Health Innovation Network
AHSN = Academic Health Science Networks
MD = Medical Director
BAU = 'Business as Usual'
CBC = Community Based Care
SRG = Stakeholder Reference Group
CSC = Clinical Strategy Committee

Key

Programme Decision Making	Existing Governance
Programme Governance	Advisory and Collaborative

Key roles and functions

The roles and functions of the South East London Commissioning Strategy Programme specific governance bodies are outlined below. The overall structure reflects initial planning guidance (NHSE, LGA, TDA and Monitor - 04 November 2013) including approach to joint working and units of planning. Structure and membership have been designed to best support the development of the Commissioning Strategy and it is likely that this will need to be revisited at key points in the programme lifecycle – in particular when the programme moves on to a delivery footing.

In South East London the function of the Strategic Planning Group is being delivered primarily through the Clinical Commissioning Board, supported by South East London Partnership Group and the Implementation Executive Group.

- The programme is led by the **Clinical Commissioning Board (CCB)**, which acts as the overall programme board. The CCB is commissioner-led and clinically-driven and steers and makes decisions on the development and delivery of the strategy. Members of the CCB have the authority to make decisions on the agreed scope of the programme on behalf of their respective organisations. All workstream SROs within the programme are accountable to the CCB for delivering their agreed share of the benefits of the programme
- The **South East London Partnership Group** is the strategic and partnership forum for the programme. The group is clinically-led and will frame and shape the commissioning strategy on behalf of the CCB, providing collective system leadership and oversight to the programme. Key programme decisions require the support of the Partnership Group
- The **Clinical Executive Group (CEG)** brings together clinical leaders from across South East London to frame and provide oversight of clinical design work by providing guidance and assurance to the individual clinical leadership groups and managing interdependencies across the group. It acts as a conduit for the management and escalation of clinical risks
- The **Implementation Executive Group (IEG)** is the executive group supporting the CCB, providing oversight to planning, implementation, benefits realisation and assurance. The IEG also steers the mobilisation workstream, and has a continuing responsibility to make recommendations to the CCB on the optimal structure and scope of the programme
- The **Public and Patient Advisory Group (PPAG)** is the collective forum for the strategy's patient and public voices: to share learning, provide peer support, facilitate wider engagement and disseminate messages and provide feedback on key programme materials
- The **Community Based Care (CBC) Transformation Board** acts as the programme board specifically for the CBC programme. The group provides leadership and oversight across the three key workstreams of Primary and Community Care, Integrated Care and Planned Care, ensuring alignment with the developing South East London Commissioning Strategy.

Programme design and delivery is undertaken by combination of contributing clinical groups, projects and programmes at varying points in their lifecycle, each requiring the appropriate treatment from a governance and operating perspective.

Collaboration and advice

The programme links to a number of existing advisory and collaborative bodies. Relationships have been established with these groups as appropriate as part of mobilisation and ongoing delivery.

- **Health and Wellbeing Boards (HWBs)** provide oversight, advice and input into the programme at borough level, focused on improvement of the health and wellbeing of their local populations, reducing health inequalities, and encouraging joined up working across commissioners. As well as being engaged and involved in the co-development of the Commissioning Strategy, ensuring alignment with local Health and Wellbeing Strategies, Health and Wellbeing Boards have agreed Better Care Fund plans
- **Health Overview and Scrutiny Committees (HOSCs)** will provide local scrutiny and review in line with statutory requirements under the Local Government Act 2000 and Health and Social Care Act 2012
- The programme links to the **South East London CCG Stakeholder Reference Group** for advice and oversight in relation to engagement on the development of the Commissioning Strategy, in order to ensure that the views of patients, service users, the public and their representatives are heard and acted upon
- The programme links to local **Healthwatch** teams in each borough to ensure that proposals developed as part of the Commissioning Strategy take account of the voices of consumers and those who use local health and social care services.

An external **Clinical Advisory Group** will be established, if and as required at later stages in the programme, to ensure that any proposed clinical changes are designed in a manner which ensures wide ranging clinical engagement in service design and alignment with national and London-wide quality standards; and that clinical services will be safe and sustainable both during transition and post implementation.

Introduction to programme risks

- The governance and assurance of the Strategy Programme is supported by a programme risk management framework and risk register
- The risk register captures the key risks to both the **development** and **implementation** of the Strategy, rating these based on impact and likelihood, and setting out mitigation controls and actions
- The following pages set out the highest priority risks to the development and implementation of the Strategy, plus associated mitigations. Full details of impact, likelihood and mitigation for each of the above can be found in the full risk register.

Key risks

Risks to development of the Strategy

The following high level risks have been identified to the development of the five year commissioning strategy. This list will be reviewed regularly through the Clinical Executive Group, Implementation Executive Group and Clinical Commissioning Board.

Title	Risk	Impact	Mitigations
A1. National Specialised Commissioning Timeline	• National timetable for specialised commissioning limits ability to consider whole pathways / maximise impact of local workstreams	• Strategy not able to move forward at required pace or level of quality / completeness. • Data and finance and activity plans for specialist and primary care commissioning may not be available within programme timescales • Impact of proposed Clinical Leadership Group changes on financials and activity cannot be effectively assessed	• Local workstreams continue further work after June to integrate and drive benefits • Close liaison with NHS England. Review and refresh of strategy as data becomes available • Exploration of opportunities for co-commissioning
A2. Provider Engagement	• One or more service providers is insufficiently engaged or subsequently disengages	• Full consequences of change in the local health system are not properly understood • Ability to deliver the proposed strategy could be compromised	• Engagement through CLGs, Clinical Executive and Partnership Group • CEG and CLG Chairs to work with Central team to reinforce importance of contribution
A3. Partner and Stakeholder Engagement	• Insufficient partner and stakeholder engagement	• Strategy not able to move forward at required pace and potential to challenge ability to deliver	• Engagement through CLGs, Clinical Executive and Partnership Group • Local engagement led by CCGs, complemented and supported by work of central team • Clinical leadership includes work with partners and stakeholders
A4. Patient/Public Resistance to Change	• Patients and local people tell us there is no need for change	• Further engagement required Possible challenge to legitimacy of strategy	• Continual engagement through CCGs and south east London –wide work. Clear and consistent messages from system leaders, particularly clinicians
A5. Strategy Development Resourcing	• Work on 5 year strategy and associated communications and engagement, in addition to business as usual activities could overstretch commissioning, finance and teams in both CCGs and NHSE.	• Potential impact on quality / schedule for the south east London strategy - or on delivery of operational imperatives	• Strategy resource levels benchmarked against programmes elsewhere • Resources and delivery reviewed regularly through Implementation Executive Group

Key risks

Risks to implementation of the Strategy

The following high level risks have been identified to the development of the five year commissioning strategy. This list will be reviewed regularly through the Clinical Executive Group, Implementation Executive Group and Clinical Commissioning Board.

Title	Risk	Impact	Mitigations
B1. Insufficient Impact of Change	• When implemented the impact of the strategy is insufficient to meet the need and ambition	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Collective modelling work and triangulation of strategies and plans across south east London
B2. Insufficient investment to deliver the change	• There is insufficient investment available to deliver the scale of change at the pace required	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Detailed planning and modelling to quantify investment needed and when • Use of non-recurrent funds to pump prime change • Including investment requirements in financial modelling
B3. Service Change not Fully Implemented	• Inability to implement sufficient service change	• The need and outcomes outlined in the case for change and strategy are not fulfilled. • Quality remains variable • System is unsustainable	• Supporting strategies to be implemented to enable service change implementation • Ownership by system leaders
B4. Financial Sustainability of Health System	• New service models in primary care and community services do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand	• Increased system costs through duplication of services and low productivity leading to poor patient and staff experience • Quality remains variable • System is unsustainable	• Clinical Executive Group and Partnership Group review integrated system model and all draft service models as a whole to ensure that any proposed changes to the health system are effectively balanced. • Impact of areas of early implementation (primary and community care, integrated care) reviewed in models as the develop.
B5. Patient/Public Resistance to Change	• If partners and stakeholders are not sufficiently engaged throughout the development of the five year strategy any proposed service change could be subject to significant local opposition	• Further engagement required Possible legal challenge Delays to implementation of changes • Leading to increased cost and delay	• Engagement activities will be undertaken with a broad range of partners and stakeholders throughout the development and implementation of the strategy • Dedicated communications and engagement enabling workstream to coordinate these activities.
B6. Information Systems	• Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in South East London	• Duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost	• Information Systems to identify and support improvements required to mitigate.
B7. Workforce	• Workforce requirements of new models of services cannot be met in a timely fashion	• Skills not available in right location to support new models of care • Insufficient capacity in system to support cultural change required to drive new behaviours	• Workforce strategy, with input from LETB to identify workforce impacts of proposed changes and develop plans for resolution