Our Healthier
South East London
Improving health and care together

NHS

South East London Sustainability and Transformation Plan - Summary

Introduction

In December 2015, health and care systems were asked to come together to create their own ambitious local blueprint for implementing the Five year Forward View, covering up to March 2021, known as Sustainability and Transformation Plans (STPs). In south east London we submitted our latest version of this plan to NHS England in October 2016. This is a summary of our October submission.

The STP is the "umbrella" plan for south east London and draws extensively on the Our Healthier South East London (OHSEL) strategy which has been in development since 2013.The STP process has broadened the OHSEL plan and has taken it much further by bringing organisations together to establish a place-based leadership and decision-making structure. This means that all the NHS organisations in south east London are working together and with local councils to make plans and decisions that will ensure the sustainability of our services into the future.

Our commitments

Over the next five years we will:

- Support people to be in control of their health and have a greater say in their own care
- Help people to live independently and know what to do when things go wrong
- Help communities to support each other
- Make sure primary care services are consistently excellent and have an increased focus on prevention
- Reduce variation in outcomes and address inequalities by raising the standards in our health services
- Develop joined up care so that people receive the support they need when they need it
- Deliver services that meet the same high quality standards whenever and wherever care is provided
- Spend our money wisely, to deliver better outcomes and avoid waste

Our challenge

In south east London, we have some very good health services. People are living longer and many people are healthier. But we also have some services that could be better. We have services that people find hard to access. Some people do not get the help they need to keep themselves and their families healthy.

We are trying to address a number of challenges, many of them common to other areas and some specific to south east London:

- **Ill health** - the way in which NHS services are provided today does not take account of changes in the population since the health service was created. People are living longer than ever before and there have been huge advances in medicine and treatments for various conditions. The NHS is now treating many more people than ever before, and many more people are living with long term conditions such as diabetes, high blood pressure and mental illnesses.

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

- **Outcomes** - Too often, the quality of care that patients receive and the outcome of their treatment depend on when and where they access health services. For example, we do not always provide the recommended level of cover by senior doctors in services dealing with emergency care, maternity or children.
- **Experience** - While patients are very happy with some services, surveys tell us that their experience of the NHS is inconsistent and that they do not always receive the care they want. Some patients find it difficult to get a GP appointment or feel that they do not have enough information about their condition. Too often, planned operations are cancelled.
- **Local needs** - South east London has a diverse and mobile population, with extremes of deprivation and wealth. A high proportion of our 1.67 million people live in areas that are among the most deprived in England, while a smaller proportion live in the most affluent areas. Four of the six boroughs (Lambeth, Southwark, Lewisham and Greenwich) rank amongst the 15% most deprived local authority areas in the country.
- **Finance** - Although NHS funding currently increases in line with inflation each year, the costs of providing care are rising much faster. This is because the NHS is now treating more people with more complex conditions than ever before, while the costs of medicines are increasing. All major political parties have made it clear that sustained and substantial increases in NHS funding are unlikely for the foreseeable future, which means that we need to do things differently if we are to deliver the best possible care for patients in the years ahead. If demand continues to rise as projected, and we do not change our approach to delivering care, the number of beds needed would be enough to fill a new hospital – something not affordable or possible. Our priorities must focus on managing the increase in demand by changing the way we work.

What will this actually mean?
Some examples of what we are doing and of our plans are:

1. Making it easier to see a GP

We are expanding the foundation stone of the NHS – the services offered by local GPs.

- An extra £7.5 million a year will ensure that people in south east London can book a GP appointment at a time of their choosing, including a huge expansion of time slots at evenings and weekends.
- Southwark and Lambeth have already extended evenings and weekend services, with an extra 87,000 more appointments a year in Southwark and over 82,000 in Lambeth. With extra funding, all boroughs will offer appointments 8am to 8pm, seven days a week, by 2019.
- From 2018, all practices will offer online as well as telephone booking, and will allow every single patient to manage their prescription and medical records online.
- From next April, this will be supported by new care teams of family doctors, nurses, pharmacists and other specialists. These will help vulnerable patients to stay healthy and have more control over their day-to-day health and care.
- A home care service provides intensive medical care in people's homes, where most say they prefer to be treated. This has supported more than 3,000 patients over the last year, including 500 who would otherwise have been taken to hospital. The number of patients with chronic obstructive pulmonary disease being taken to A&E has fallen by more than twice the London average of three per cent.

2. Focusing on prevention

We want to focus on wellbeing and to work with people to support them to manage their own health.

- We are working to 'make every contact count' with patients, working with patients holistically to support them – including on obesity, mental health, smoking, alcohol and managing long-term conditions.
- We will use targeted interventions to support people, like social prescribing, weight management, and health coaching.
- One major initiative is the *Healthier You: NHS National Diabetes Prevention Programme* (NHS DPP), an evidence-based behavioural intervention programme for people identified as being at high risk of developing Type 2 diabetes. In partnership with the Health Innovation Network, we aim to deliver over 4,000 places across South London CCGs and boroughs in 2016/17.
- We want to work with people to understand and manage potentially harmful drinking through structured, brief advice. The Health Innovation Network will support the roll out of *Alcohol Intervention and Brief Advice (*IBA) across health settings, social care and the criminal justice system.
- We will continue to work to encourage residents to stop smoking, including increasing maternity smoking cessation services and continuing the award-winning work of the South East London Illegal Tobacco Network (SELITN).

3. Improving cancer treatment and diagnosis

We want to improve the speed and accuracy of cancer diagnosis, then guarantee each patient a single plan that will explain every part of their care and when they will get it.

- Once a doctor raises the possibility of cancer, no patient will have to wait more than 62 days until they receive definitive treatment and a comprehensive plan, setting out what they can expect from their care and when.
- A dedicated oncology phone line will help direct patients, carers and GPs find the right facility for each stage of their treatment.
- Every patient will be contacted by a member of staff whose job it will be to help them understand their cancer care. Patients will also be able to see a dedicated clinical nurse specialist or other expert for advice and support around the clock.
- A new £160 million purpose-built Cancer Centre at Guy's Hospital was opened in September 2016 to provide state-of-the-art facilities for cancer diagnosis, treatment and research. It brings different services under one roof for the first time; previously these were provided in 13 different locations spread across eight buildings.
- The centre will use its specialist focus to cut paperwork, reducing the times that cancer patients wait between different stages of their treatment. More patients will have the opportunity to benefit from the most advanced treatments and take part in cutting-edge trials.
- A second, smaller cancer centre is being developed as part of the £30 million redevelopment at Queen Mary's Sidcup. This will provide 16,000 radiotherapy and 4,600 chemotherapy treatments a year from early 2017, so patients can be be treated closer to their homes rather than having to make the trip to central London.
- We will also increase cancer screening rates and train more GPs, nurses and other staff to help patients to prevent the onset of cancer by staying healthy.

4. Developing world-class orthopaedic care

We aim to ensure that patients receive the same standard of planned orthopaedic care whenever and wherever they are treated. At the moment, results vary too much across south east London, too many procedures are cancelled and there are unnecessary delays. We are planning to consult local people on proposals to develop two new specialist orthopaedic centres which would bring together routine and complex planned care, currently provided in seven locations across south east London. Having these dedicated centres means:

- We can offer more procedures, and patients would receive a higher standard of care because they would be able to see the most expert doctors in this field.
- Patients would also spend less time in hospital and there would be fewer cancelled operations. Because of this waiting times would fall and every orthopaedic patient every patient would be seen within 18 weeks.
- The centres would work closely with other sites to share their expertise and learning, ensuring that patients got better orthopaedic care across all of south east London.

5. Improving urgent and emergency care

- By 2017, there will be a single out-of-hours service and number (111) and access to a clinical hub, which also will let patients know about the different locations they can be treated.
- This will help to decrease the number of patients having to go straight to A&E by providing accessible alternatives before and on arrival, and meet the four-hour waiting time target so patients experience faster care for more urgent needs.
- By 2019, patients arriving at A&E will be admitted more quickly, and from next year they will all be seen by the best possible expert specialist for their needs

6. Integrating mental health services

We want to improve mental health in south east London, including the interaction between mental and physical health.

- We want to ensure that mental as well as physical health needs are identified and addressed – including training for non-clinical workforce to recognize and support mental health needs.
- We are working to ensure access to mental health support and liaison teams in A&E 24/7.
- We want to make sure that mental health patients who need inpatient care get the care they need, including access to a health-based place of safety (HBPoS) and no out-of-area placements for non-specialist care by 2021.

7. Supporting new mothers

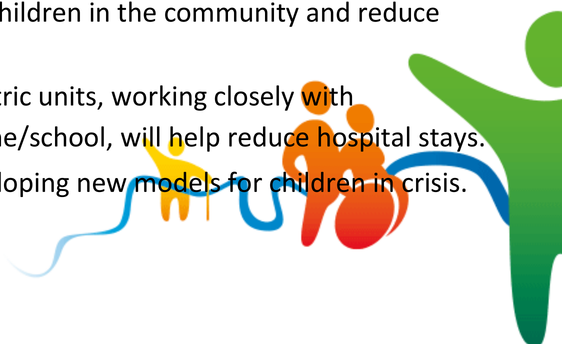
We want to provide simpler support to new mothers throughout pregnancy and make it easier for them to choose the right type of birth for them and their family.

- By 2019, consultant obstetricians will be present on every labour ward from 8am until 7:30pm.
- In five years, every new mother will by week 10 of pregnancy be contacted by the midwife who will provide and manage her care and support before and after the birth.
- Women will receive better and earlier advice about what to expect during pregnancy and how to stay healthy, and their personal health risks will be assessed earlier.
- Standards of care will also improve, with a 20 per cent reduction in stillbirths by 2020.

8. Supporting children and young people

We want to get better at supporting families to keep children and young people physically and mentally well, by improving family resilience, developing more joined-up care in the community, and making sure that children and young people can access the right service quickly and effectively.

- We are developing children's integrated community teams to support children in the community and reduce hospital admissions in every borough.
- If children or young people do need to go to hospital, short stay paediatric units, working closely with community services to support children and young people back to home/school, will help reduce hospital stays.
- We are improving mental health support services for children and developing new models for children in crisis.



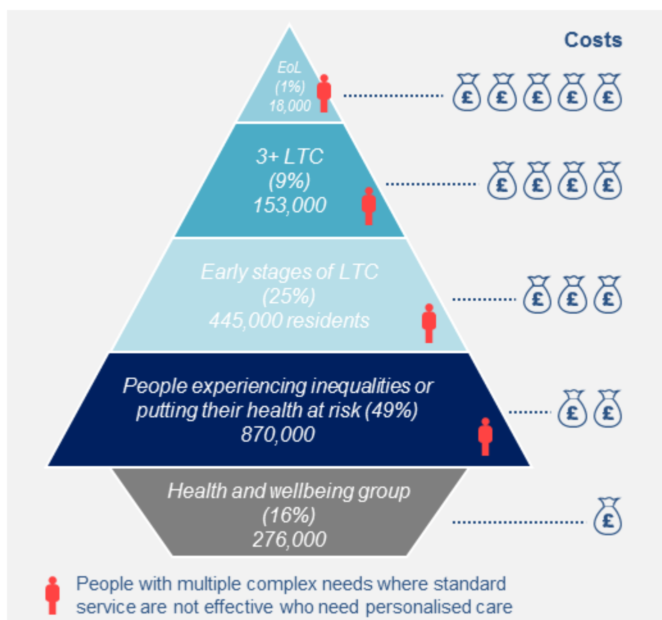
Our challenges and priorities

Locally, we face many of the challenges that are experienced nationally. The three gaps that are identified in the Five Year Forward View are found in south east London, and our plan will seek to address these.

We are clear about the challenges people face in living healthily and well
The health of our population has improved significantly over the last five years, but there is more to be done. A detailed case for change has been developed to understand the health and wellbeing needs of our population. In summary:

- We have a vibrant, diverse and mobile population with extremes of deprivation and wealth. 26% of children are classified as living in poverty, concentrated in certain parts of SEL;
- Premature death and differences in life expectancy are significant issues;
- 75% of over 55s have at least one LTC, while 32% of children are overweight or obese;
- We need to improve the health of the population overall. Keeping well, at all ages, is critically important.

We have developed a model (below) that segments our population into groups depending on their condition and level of risk, in terms of both physical and mental health. The 50% of our population who are affected by inequalities or are putting their health at risk is too high; ensuring more of our population are enabled to stay well is imperative to prevent our challenges getting worse.



Note: the financial graphic represents spend per patient

While we have made progress we can do more as a system to improve our care and quality gap

The quality of care that patients receive too often depends on when and where they access services. We don't consistently meet quality and performance standards, and some providers are not rated good or outstanding by regulators. We don't always deliver services that address people's mental and physical health needs in an integrated way. Our services often do not detect problems soon enough, which can result in admittance to hospital in crisis where earlier support could have produced a different outcome.

Our system is skewed towards hospital care

We don't invest enough in services based in the community which prevent illness or encourage people to manage their own physical and mental health.

As a result, people go to hospital when they could be better supported in the community, and can stay in too long once admitted. There is an opportunity here to provide better value care through our investment in the health and care system.

Our system is fragmented resulting in poor patient experience, duplication and confusion

Our system is made up of multiple organisations and professions which too often work within the confines of their own boundaries. This is reinforced through fragmented commissioning structures meaning that it is difficult to share resources. This impacts care and experience. Patients and carers find it frustrating to have to navigate different services and to provide the same information to different people. Patients often stay in hospital longer because joined up arrangements for their care in the community on and after discharge have not been put in place.

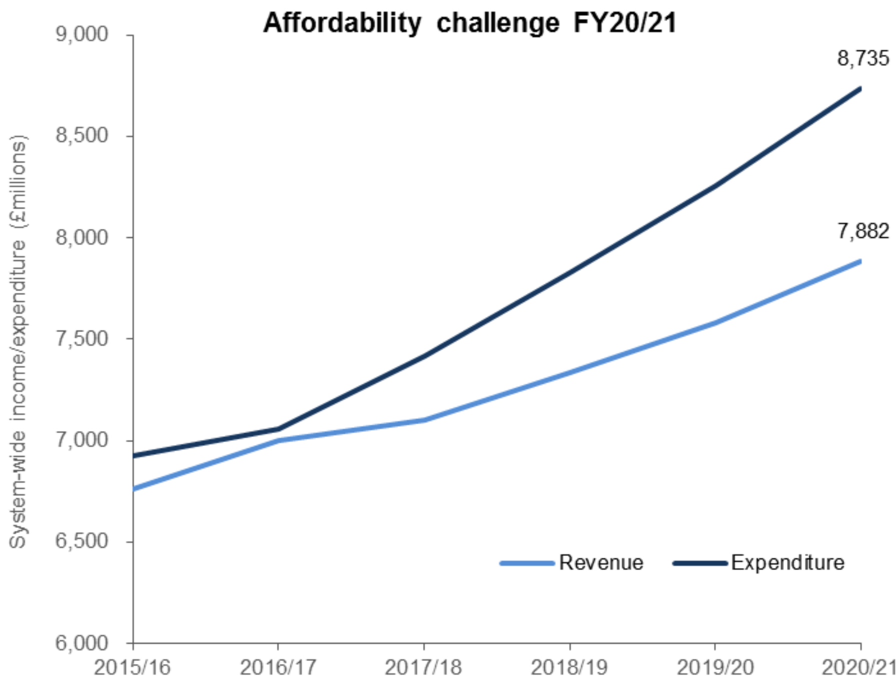
Our services are under increasing pressure

All services in our system are facing increasing pressure to deliver high quality care within a constrained financial climate. We are delivering in partnership with councils who face unprecedented pressures on resources. In some cases they are looking to save over 30% of current expenditure over the next 3-4 years.

Recruitment and retention of our workforce has become increasingly challenging and our estates are not always fit for purpose. Our use of data and information management and technology (IM&T) doesn't currently enable our vision.

Without a place-based approach to commissioning and contracting of care we will not optimise value.

We are facing a financial challenge of £934m over four years



Based on plans and forecasts, we think that if we do not change the way we work, we will need £934m more in 5 years than we are funded for. This is because of increasing demand and costs with a growing population that accesses health care more often, and people who are living longer but often with one or more long term conditions. Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked).

If we do not change our approach to delivering care, the projected demand would increase so that the number of beds needed would be enough to fill a new hospital site, something which is not possible or affordable. It would also require a significant increase in our workforce.

Our priorities must therefore focus on managing this increase in demand by changing the way we work so we can work within our current infrastructure. This will be by providing alternative high quality, good value options that focus on outcomes for our population.

In addition to the NHS challenge outlined in the chart above, the financial challenge that the councils face over the period to 2020 is £242m. This means that the six councils need to reshape social care services to lower costs and raise productivity. Each council is working to transform services at the local level with health sector partners. Lewisham, for instance, is conducting a "devolution pilot" to fast forward a number of initiatives so as to test some of the savings options early in the planning period. Working together will help Councils and the NHS be more efficient and make sure services are sustainable.

Plan summary – 'plan on a page'

We have worked collaboratively to develop our plan for south east London. Where there is a benefit to the system and to our residents we will deliver collaboratively, whilst much will be continued to be delivered locally. Our STP doesn't capture everything that we are doing as a health and care economy. Instead it focuses **on five priority areas** (listed below) and related areas of focus that we believe will have the greatest impact to collectively address the three gaps of health, quality and finance. The delivery of these plans will be supported by a new cross-organisational governance that will allow us to overcome difficulties and collectively manage the transformation required.

Our challenges

- Demand for health and care services is increasing
- There is unacceptable variation in care, quality and outcomes across SEL
- Our system is fragmented resulting in duplication and confusion
- The cost of delivering health and care services is increasing

Our five priorities and areas of focus

1. Developing consistent and high quality community based care (CBC), primary care development and prevention	2. Improving quality and reducing variation across both physical and mental health	3. Improving productivity and quality through provider collaboration	4. Developing sustainable specialised services	5. Changing how we work together to deliver the transformation required
• Promote self care and prevention • Improved access and coordination of care • Sustainable primary care • Co-operative structures across parts of the system • Financial investment by the system • Contracting and whole population budgets	• Integration of mental health • Reduce pressure on and simplify A&E • Implementation of standards, policies and guidelines • Collaborate to improve quality and efficiency through consolidation (e.g. the elective orthopaedic centres) • Standardise care across pathways	• Standardise and consolidate non-clinical support services • Optimise workforce • Capitalise on collective buying power • Consolidate clinical support services • Capitalise on collective estate	• Joint commissioning and delivery models • Strategic plan for south London • London Specialised Commissioning Planning Board • Managing demand across boundaries • Mental health collaboration	• Effective joint governance able to address difficult issues • Incorporation of whole commissioning spend including specialist services • Sustainable workforce strategy • Collective estates strategy and management • New models of collaboration and delivery

The impact of our plans

Priorities 1 and 2	Priority 3	Priority 4	Priority 5
• Reduction in A&E attends and non-elective admissions • Reduced length of stay • Reduced re-admissions • Early identification and intervention • Delivery of care in alternative settings (Net savings c.£116m)	Cross-organisation productivity savings from joint working, consolidation and improved efficiency (Net saving c.£225m)	• Increased collaboration • Reduced duplication • Management of flow (Need to address £190m)	• Aligned decision making resulting in faster implementation • Increased transparency and accountability

Five priority areas

1. Developing consistent and high quality community-based care (CBC) and prevention

Our priority for the next five years is to expand accessible, proactive and preventative care for mental and physical health problems outside of hospital. We have developed a model of integrated community-based care that focuses on population health and wellbeing, supporting people to manage their conditions and increasing prevention and early intervention. We will support this through new contracting models and by ensuring that we have a sustainable workforce and appropriate estates.

Our new model of community based care
Over the next five years we will continue to invest in the development of local care networks which will incorporate all 246 GP practices. We have built these local care networks around geographically coherent communities, supported by scaled-up general practice using natural boundaries within boroughs. These networks share many of the features of multispecialty community providers (MCPs – a new nationally recognised model) and will bring together primary, community, specialist teams working in the community, mental health and social care colleagues to manage the health and care of local populations of between 50,000-100,000.

Our approach has been to establish a common set of standards that each network will adopt while flexing the service they provide for their local population. Each network is working towards:

- Building strong and confident communities and involved, informed patients and carers who are supported to stay independent and self-manage;
- Delivery of consistently high standards of care, including the London Strategic Commissioning Framework Specifications, with clear outcome measures;
- Responsive services providing access from 8am – 8pm seven days a week;
- Secondary and tertiary prevention focussed on the physical health and wellbeing of people with enduring and significant mental health problems;
- Proactive secondary prevention, equitable and timely access, effective coordination;
- A systematic risk stratification and problem solving approach that addresses both physical and mental health.

Drawing on others from across the health, social care and the voluntary sector, the networks will provide a full range of community based services. This includes the delivery of a number of high impact schemes including services such as improved step up / step down and admission avoidance for identified members of the population. Our ambition is that they will be able to integrate the entire community based system, even driving transformation in areas such as housing, as well as health and care. The local networks will also develop an integrated approach with acute providers identifying services which can be delivered locally, as well as making use of acute assets and expertise.

It is recognised that this transformation will require investment. CCGs are committed to directing funding towards improvements in community based care through increases in funding received by the system or as savings are achieved elsewhere.

Investing in community based care (CBC)

We know that, in order to realise savings in other parts of the system, we will need to invest approximately £62m to achieve the initiatives set out in our plans. Alongside this we will need to find ways to fund, non-recurrently and substantially, the organisational development that will be required to help professionals to work in new and different ways. We will aim to use national funding distributed according to the areas of greatest need to support delivery of agreed local and pan-London objectives and support sustainable and vibrant primary care. Some of this investment will generate savings in CBC but we anticipate that the main area of financial benefit will be in relation to unplanned and emergency care. One of our priorities with this area of focus is improved outcomes for patients, as well as the acute savings.

High impact schemes to be delivered by local care networks

We are already beginning to deliver against the high impact schemes, tailored to local populations, which enhance current provision to make an immediate difference to care. The schemes we have focused on help to reduce acute demand and improve quality, by reducing variation.

Access, timely care and assessment

- Extended general practice (8-8), through the local care networks
- Increasing cancer screening and education
- Identification of people 'at risk', including those at risk of admission, and working with them in a multidisciplinary way to provide support and avoid crisis, including mental health

Proactive care and prevention

- Working with patients to prevent ill health by focusing on issues such as obesity, mental health, diabetes, smoking and alcohol. For instance, using the *Healthier You: NHS National Diabetes Prevention Programme* (NHS DPP), an evidence-based behavioural intervention programme for individuals identified as being at high risk of developing Type 2 diabetes. In partnership with the Health Innovation Network, we aim to deliver over 4,000 places across South London CCGs and boroughs in 2016/17.
- A focus on sexual health and prevention
- Investing in innovative ways to empower self-management of long term health conditions, including working with schools and targeted programmes to support patients with long term conditions
- Proactive care planning to identify and target higher risk patients including those in the last year of life. Individuals identified will receive personalised care plans and tailored appointments depending on need
- The Health Innovation Network will support the roll out *Alcohol intervention and brief advice* IBA across health settings, social care and the criminal justice system, along with minimum standards which set out how staff can deliver.
- Continuing the award winning work of The South East London Illegal Tobacco Network (SELITN)

Co-ordinated and effective care planning

- Integrated working with mental health and adult social care
- A high-performing multi disciplinary team will include roles such as care navigators to coordinate care for higher-risk patients.
- Enhanced support to vulnerable people in care homes, extra care housing and those receiving domiciliary care.

2. Improving quality and reducing variation

The standard of care patients receive is not consistent. We don't always treat people early enough to have the best results and people's experience of care is variable and can be better. Many of the improvements in our health and care system will come from changes in community based care. We also need to reduce variation in our main pathways of care. To address this we will work collaboratively between organisations to make changes across our system that will improve value and outcomes for patients.

Reducing pressure on A&E and simplifying urgent and emergency care
Increased access to community support and population health management through our community-based care plans will reduce demand for A&E. However, when people do need to access services in a crisis it can be confusing. Our priorities are: integrating urgent and emergency care; providing accessible alternatives and signposting people to these; and supporting people appropriately when they have to access A&E. We are also exploring options for care navigators; improving mental health crisis care services; and reviewing the acute oncology pathway to reduce demand on A&E.

Collaborate to improve quality and efficiency through consolidation
We believe that greater efficiency and quality of care can be delivered by working collaboratively across organisations. In areas such as elective orthopaedics there is evidence that consolidating services can improve care at a lower cost. We are also establishing two cancer centres, one at Guy's and a smaller centre at Queen Mary's.

Integrating mental health services
30% of people with a long-term condition also suffer from poor mental health. People with severe mental illness do not always receive the best care for their physical health needs. We have undertaken pioneering work in this area, e.g. the 'three dimensions for diabetes' pilot (3D4D). We have initiated a programme of work to explore further options for improved integration, and to ensure physical health care for those with severe mental illness is optimised.

Standardise care across pathways
Where appropriate, we are developing standard approaches to managing similar conditions. This will include shared referral standards and protocols for managing patients.

Implementation of standards, policies and guidelines
We aspire to a high quality services and across our pathways we are committed to meeting national and regional standards, including as set out in the maternity review, the cancer taskforce report and the Mental Health Five Year Forward View. We will implement evidence based clinical standards of care consistently across providers. We are further expanding the Diabetes Prevention Programme.

3. Improving productivity and quality through provider collaboration

We can no longer rely on traditional cost improvement programmes within single organisations. Instead, we are working to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. Savings are estimated at £225m through economies of scale and removing duplication, and we expect these to bring improved outcomes and quality. We have five areas for collaboration.

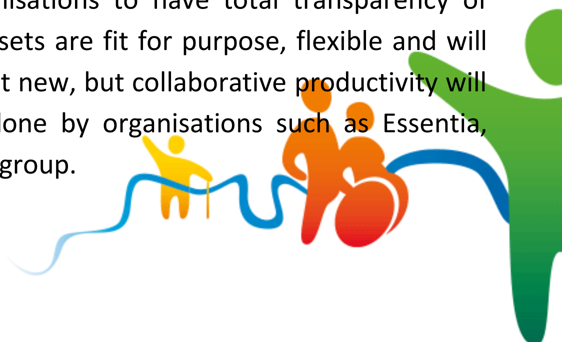
Standardise and consolidate non-clinical support services wherever possible
At present, non-clinical support services (such as HR, finance) are duplicated across trusts, tasks are repeated and there is significant variation in quality. The consolidation of non-clinical support functions will lead to savings through economies of scale, standardisation and simplification of processes, improved technologies and effective talent management. We aim to have established a new model for HR, IT, procurement and finance in the next three years.

Optimise the workforce be generating south east London-wide allegiance and alignment to staff banks and better management of agency contracts
We can achieve savings through collaborative working with the aim of: reducing demand for temporary staff; reducing agency rates; increasing supply of affordable temporary staff; and *w*orking with the London Ambulance Service so that, where appropriate, patients can be treated on scene and discharged e.g. training and educating paramedics into newly defined roles such as advanced practitioners. By 2021 we want to have built a large staff base by offering competitive rates and other non financial benefits.

Capitalise on our collective buying power with a south east London procurement hub
There is price variation, inefficiency and a large volume of waste in our procurement systems. Furthermore, there is a lack of data and proper analytics to support product decisions, with clinicians aligning patient outcome/cost with products. We think that (aligned with the Carter Review) supply chain management can be centralised while some responsibility is retained locally. We want to adopt a category by category approach to drive down price variation and common processes to reduce unnecessary waste and inefficiency.

Consolidate clinical support services to generate economies of scale and deliver consistent, high quality services
We have a number of common challenges across the clinical support services. There is variation in service and medicines costs; peaks and troughs of demand; and system and process inefficiencies which delay turnaround and reporting times, impacting patient outcomes. We plan to address these and achieve savings by reducing the drugs bill and improving pharmacy infrastructure services; workforce re-profiling and process improvements that make use of available technologies to create a leaner, multi-skilled workforce with improved retention rates; sharing equipment and contracts; and optimising purchase and use of consumables and reagents by using our collective power to negotiate.

Capitalise on the collective estate of south east London
There is currently underutilisation at some sites, and too high levels of activity at others. Lack of accurate data means strategic planning and decision making is difficult. In 2021, we want organisations to have total transparency of information informing a SEL wide estates strategy. We will work to ensure assets are fit for purpose, flexible and will fulfil future service requirements. The idea of collaboration within estates is not new, but collaborative productivity will allow it to happen on a new scale. This would build on important work done by organisations such as Essentia, Community Health Partnerships, NHS Property Services, and the OHSEL estates group.



4. Developing sustainable specialised services

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. They tend to be provided by hospitals that can recruit a team of staff with the appropriate level of expertise, often with research interests. There are nine providers of specialised services in south east London, and £850m spend. Most is spent with our two largest providers: Guys and St Thomas' (£410m) and King's College Hospital (£312m), with Lewisham and Greenwich accounting for £43m. South London and Maudsley (£41m) and Oxleas (£19m) provide specialised mental health services. One third of all activity comes from outside south east London, with the most significant flows from Kent and Medway and Surrey and Sussex. The growth in referrals from this wider region currently exceeds local growth. The size of specialised services in south east London has a direct impact on the sustainability of our system, both in terms of financial sustainability and the quality of other services. The potential impact to the south east London system of any change to these flows, decisions for repatriation or associated local developments cannot be underestimated.

Our aims for south east London

We are committed to delivering high quality and sustainable specialised services in south east London, both for our own population and for those that travel here to receive care. To achieve this, we, together with NHS England, are considering alternative ways to deliver and plan specialised services. We will:

- Reduce the number of people requiring specialised services by developing a whole system approach to provision and commissioning of services, maximising primary and secondary prevention;
- Ensure that the integration of physical and mental health is at the heart of our specialised service delivery;
- Build on our knowledge of patient flows and the relationship between services to determine new and innovative ways of commissioning and providing services to improve quality, safety and cost effectiveness;
- Eliminate unwarranted variation to ensure equity of access, outcomes and experience for all.

The majority of specialised service pathways for our population are delivered by the trusts within King's Health Partners (KHP) and St George's. As an Academic Health Sciences Centre, KHP is a key driver of specialised service development.
KHP work already underway seeks to address some of our local challenges, including strengthening haematology, cardiovascular, clinical neurosciences and children's services. There are significant opportunities to improve the coordination between specialist and local care through network models, and further optimize the specialist elements of these services with research and training across the specialist sites. Guy's and St Thomas' vanguard project with Dartford and Gravesham also includes a focus on paediatric, cardiac and vascular care pathways which will support and align with wider work on specialised services and improve outcomes for residents of east Kent.

This work could lead to some changes in service delivery so we will work closely with patients, service users and a wide range of other stakeholders to develop our proposals and determine how to deliver the best outcomes, experience and value to meet the needs of the people we serve. It also has further potential to address estates challenges through joint solutions.

Through reviewing our performance and quality issues and areas of highest spend, and our work with Kings Health Partners, we are suggesting three area of focus to explore further: pathway transformation, drugs and devices and improving value.

5. Changing how we work together to deliver the transformation required

The STP cannot take on the role of regulator, or substitute individual organisational governance arrangements that ensure they are meeting their statutory responsibilities. Delivery of our STP is therefore dependent on a shift in culture. A shift away from a focus on individual organisational achievement and towards shared ownership and accountability for improved health and social care outcomes for the population of SE London.

This is a collective endeavour and requires not just a clarity of vision but shared responsibility for delivering our plans. Such a change in relationship requires a true commitment from system leaders to work together differently and this will be formalised in a system-wide Memorandum of Understanding (MoU).

However, our ambitions for system transformation and integration of care will only be achieved if there is ownership of the challenges we face throughout our individual organisations. We need to empower health and social care staff to make change happen, beyond the shared programmes of work that are described in this document. This requires health and social care professionals to lead the process of change, whereby they identify opportunities to improve outcomes, efficiency and optimise the value of the care being provided to local people.

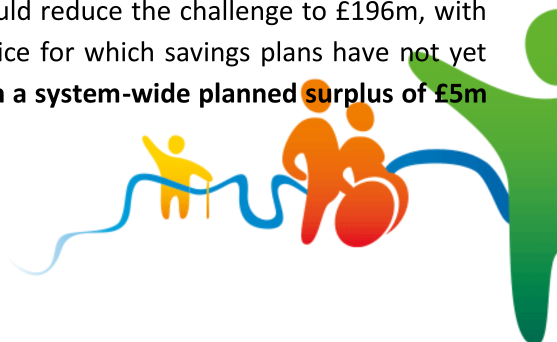
In recognising that the STP is not meant to be a regulatory body, we've begun to define our role in: delivering CIP/ QIPP plans; delivering performance plans; financial strategy. We have also looked at the existing governance structure and made some changes to reflect the new working, such as the formation of a productivity board to take forward this area of work.

Impact – bridging the financial challenge

The south east London health economy faces a considerable affordability challenge over the next five years. We think we will bridge this gap through:

- 'Business as usual' efficiencies, estimated to be £262m by 2020/21 (at 1.6% per annum across our five provider organisations and including commissioner BAU QIPPs)
- Collaborative productivity measures estimated to contribute savings of £225m over the five year period
- The implementation of Local Care Networks, along with other changes in services and proposed pathway redesign, should lead to considerable savings across a number of care areas - net savings of £116m are estimated due to this reduction in demand and variation. Within this, the largest savings relate to reductions in demand for urgent and emergency care, worth £63m by 2020/21.

Thus, bringing these savings together, reduces the affordability challenge for south east London to £250m. However, recent work to consider 2016/17 in-year performance has deteriorated this position to a deficit of £80m in 2020/21.
This does not include any additional funding from national bodies to support transformation. Indicative Sustainability and Transformation Funding of £134m has been announced by NHS England for south east London[1]. Early access to this amount is required to deliver the scale of transformation. This investment would reduce the challenge to £196m, with £202m related to specialised commissioning and the London Ambulance Service for which savings plans have not yet been developed. **If ongoing work is able to fully address these pressures, then a system-wide planned surplus of £5m (0.1% of total system revenue) would remain by 2020/21.**



Our Healthier South East London
Improving health and care together

NHS

Timelines and milestones

2016 2017 2018 2019 2020

5 year vision

CBC

Federations established across SEL
100% of population have increased access to primary care
Integrated MDTs in place across LCNs
New contracting models in place for LCN
Patient and carer training in place across all boroughs
Rapid response and supported discharge fully operational
100% compliant with proactive care specification
Same day access to specialist advice and clinics
Specification agreed for an enhanced primary care offer
Specification agreed for integrated community based care for C&YP
Cancer training in place for LCNs
100% compliant with continuity of care specification
Productivity workstream across SEL, standardised FM. Established digital asset sharing platform and re-negotiation of contracts
Consolidate and standardise back office processes
95% of population have access to 7 day urgent care services
Established analytics and PMO function
Integrate procurement systems and processes
Implementation of collaborative model of service provision
Fully compliant with U&EC facilities specification
Patients with LTCs share patient-held records across providers
CAMHS compliant with LQS
SSPAUs compliant with LQS

Acute collaboration

Business cases for preferred collaborative options
Common catalogue, P2P, inventory management
Establish SAM function
Final productivity report
Development of business cases for collaborative opportunities
Leverage existing pharmacy and medicines optimisation work
Enhanced ED front door including interface with mental health
Elective orthopaedic centres operational
Scoping and design of target operating model
Negotiate set rates with select group of agencies
Establish joint agency
Earlier access to midwifery antenatal support in place
Increased number of midwife led births at home / in birthing units
Detailed analysis and scoping of collaborative opportunities
Elective orthopaedic outline business case
Elective pathways review for scope to deliver benefits
Improved access to specialist advice through specialist clinics
Development of SEL estates strategy
Deliver savings through product switching
Integrated urgent care procurement complete
Implement lean workforce in one trust and set up centre of excellence
Elective orthopaedic strategic outline case and consultation
Specification in place for the management of oncological emergencies
Continued delivery of pathway review for paediatric oncology, neuro-rehab, HIV services, Tier 4 CAMHS
Establish governance and mechanisms for increased provider collaboration across mental health providers
Scoping of next phase of pathway review projects
Develop appropriate commissioning structure to address challenges
Cancer centre opens at GSTT
London specialist commissioning board established

Quality and variation
Specialised services

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England