Our Healthier South East London
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NHS

South East London: Sustainability and Transformation Plan

30 June 2016

Key information details
Name of footprint and no: South east London; no. 30
Region: South east London (Bexley; Bromley; Greenwich; Lambeth; Lewisham; Southwark)
Nominated lead of the footprint including organisation/function: Amanda Pritchard, Chief Executive, Guy's and St Thomas' NHS FT
Organisations within footprints:
CCGs: Bexley; Bromley; Greenwich; Lambeth; Lewisham; Southwark
LAs: Bexley; Bromley; Greenwich; Lambeth; Lewisham; Southwark
Providers: Guy's and St Thomas' NHS FT; King's College Hospital NHS FT; Lewisham and Greenwich NHS Trust; South London and Maudsley NHS FT; Oxleas NHS FT; Bromley Healthcare CIC; and primary care providers
Dartford and Gravesham NHS Trust are an associate organisation, but formally sit outside of the footprint.

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Our commitments

Over the next five years we will:

- Support people to be in control of their physical and mental 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 sustainable and 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.

Introduction

In south east London (SEL) we have a history of partnership working. This includes collaborations between commissioners and providers, across health and social care, with the voluntary sector and citizens and with education and research institutions and networks. The six south east London CCGs have in place a well-established collaborative approach, and work with all of London's 32 CCGs and NHS England to enable transformation across the capital, including through the Healthy London Partnership (HLP). Providers work together as part of formal and informal clinical networks, including specialised services supported by our King's Health Partner's (KHP) Academic Health Science Centre. Organisations in the footprint also contribute to and use resources developed by support infrastructures such as the Health innovation Network (HIN) and Collaboration for Leadership in Applied Health Research and Care (CLARHC). The provider landscape is changing as we welcome the development of 15 at scale primary care federations covering all of south east London.

Although CCGs were developing a transformation strategy previously, the STP process has broadened this and has taken it much further by bringing organisations together to establish a place based leadership and decision making structure (that is, one which focuses on the population of SEL rather than the individual organisations). The aim of this is to collectively identify our priorities and to help ensure that health and care services are built around the needs of residents. This plan outlines our collective understanding of the challenges we face and sets out our approach and actions to address them.

To date, we have established:

- A single responsible officer supported by a quartet leadership drawn from local government, commissioners, providers and clinical leadership, and a strategic planning board to provide direction and oversight;
- Collaborative oversight and decision making bodies at various levels;
- A single reporting structure bringing transparency across the system;
- A 'single version of the truth' setting out our challenges, including our financial challenge.

Working collaboratively is not without challenge. We have committed to improving services for our residents within the resources available to us, and there will be a need for an effective decision making processes in order to do this effectively. We recognise that that the status quo is unsustainable and, in order to deliver the transformation required, we need to change how we work together to overcome barriers to delivering our shared priorities.

Our challenges and priorities

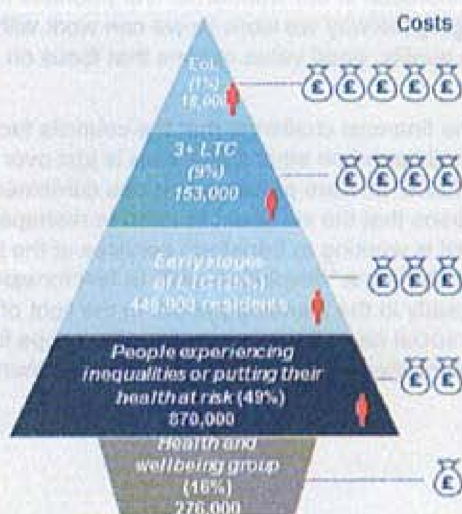
Locally, we face many of the challenges that are experienced nationally. The three gaps that are identified in the *Five Year Forward View* are found in south east London, and our plan will seek to address these.

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 an imperative to prevent our challenges getting worse.



Note: the financial graphic represents spend per patient

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

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 placed based approach to commissioning and contracting of care we will not optimise value.

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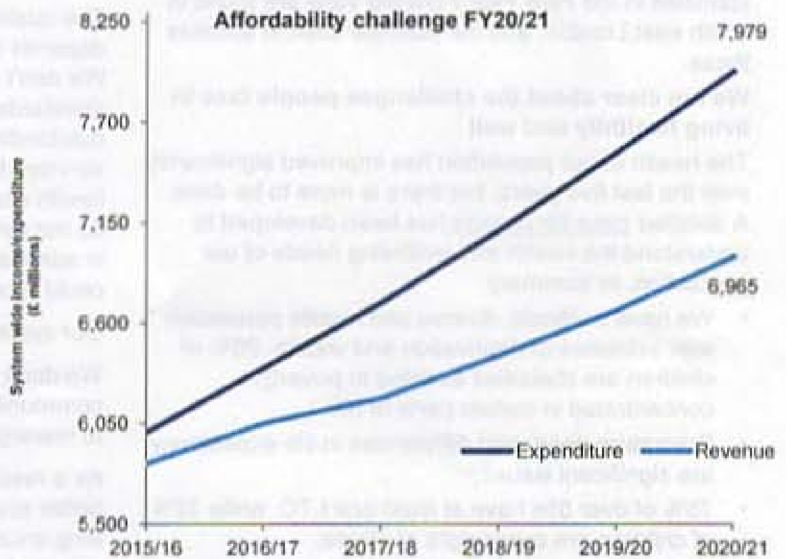
We are facing a financial challenge of £1,015m over five years

The 'do nothing' affordability challenge faced by the south east London health economy is forecast to be £1,015m by 2020/21. Excluding specialised commissioning, the affordability is forecast to grow from £157m in 2015/16 to £825m by 2020/21[1]. NHS England (Specialised) have estimated an additional indicative £190m five year affordability challenge for specialised commissioning.

The drivers of the affordability gap are a growing population that accesses health care more often, and are – positively – 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). The upshot of this is that not only is the system responding to greater throughput, but also that the sum cost of activity is growing faster than allocations.



Even without significant service transformation, our providers are expected to make substantial efficiencies to reduce this challenge. By considering previous cost reduction programmes undertaken by local organisations, we believe that 'business as usual' efficiencies of 1.6% per annum can be achieved in this way. These equate to savings of £339m, reducing the 'status quo' affordability challenge to £676m.

Taking into consideration growth assumptions over the next 5 years, we have calculated the increase in bed capacity that would be needed. 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. Across the six boroughs, the overall spend on adult social care is just over £576m. By 2020 the boroughs will need to contain cost pressures of £132m[2] and are planning to make combined budget reductions in their adult social care budgets of £110m. 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. In the light of the complex patient and service user pathways across health and social care, there is considerable scope for achieving a substantial quantum of these savings through collaborative work across the OHSEL partnership.

[1] This arises from the aggregate impact of demographic change, legislative change (principally the Care Act) and inflation, which will add a further £132m.

We have identified five priorities to make our health and care system sustainable in the near, medium and long term

By transforming our health and social care in south east London, we will optimise the value of our collective action, reward providers for the quality and outcomes they achieve and reduce demand to sustainable levels. To comprehensibly address these we must prioritise the areas that we think will have the greatest impact to our system. Based on our knowledge of our local challenges, and as a result of engagement across the system, we have identified the following five priorities:

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

Investment in CBC is essential to transform our system and move towards lower cost, higher value care delivery. Over the next five years we will continue to support the development of local care networks (LCNs) to establish coherent, multi-disciplinary networks that work at scale to improve access as well as manage the mental and physical health of their populations. This will include fully operational federations and networks developed to support other practices, and improve resilience in their local area; adopting population based budgets and risk-based contracts; and fully integrating IM&T across organisations and pathways. Fully operational LCNs will deliver our new model of care and the full vision of the Primary Care Strategic Commissioning Framework (SCF) - adopting population based budgets and risk based contracts, supported by sustainable at scale delivery of primary care and enabled by fit for purpose estate and integrated IM&T across their organisations and the pathways they deliver.

2 Improving quality and reducing variation across both physical and mental health

We have identified a range of initiatives across our system to improve consistency and standards by working collaboratively. Our main areas of focus are:

- reducing pressure on A&E by providing high quality alternatives (through CBC), simplifying access and developing a truly integrated offer;
- collaborating to improve value within planned care pathways, including the development of centres of excellence. We are starting with orthopaedics before expanding to other specialties;
- integrating mental health across health and care services adopting the mind/body approach.

3 Reducing cost through provider collaboration

Our acute and mental health providers have identified opportunities for reducing the costs of delivering care in five priority areas; clinical and non-clinical support services, workforce, procurement and estates. Our immediate step is developing business cases for each opportunity and delivering quick wins in areas such as payroll, workforce and non-clinical sourcing. Over the next five years we will continue to look for opportunities in other areas.

4 Developing sustainable specialised services

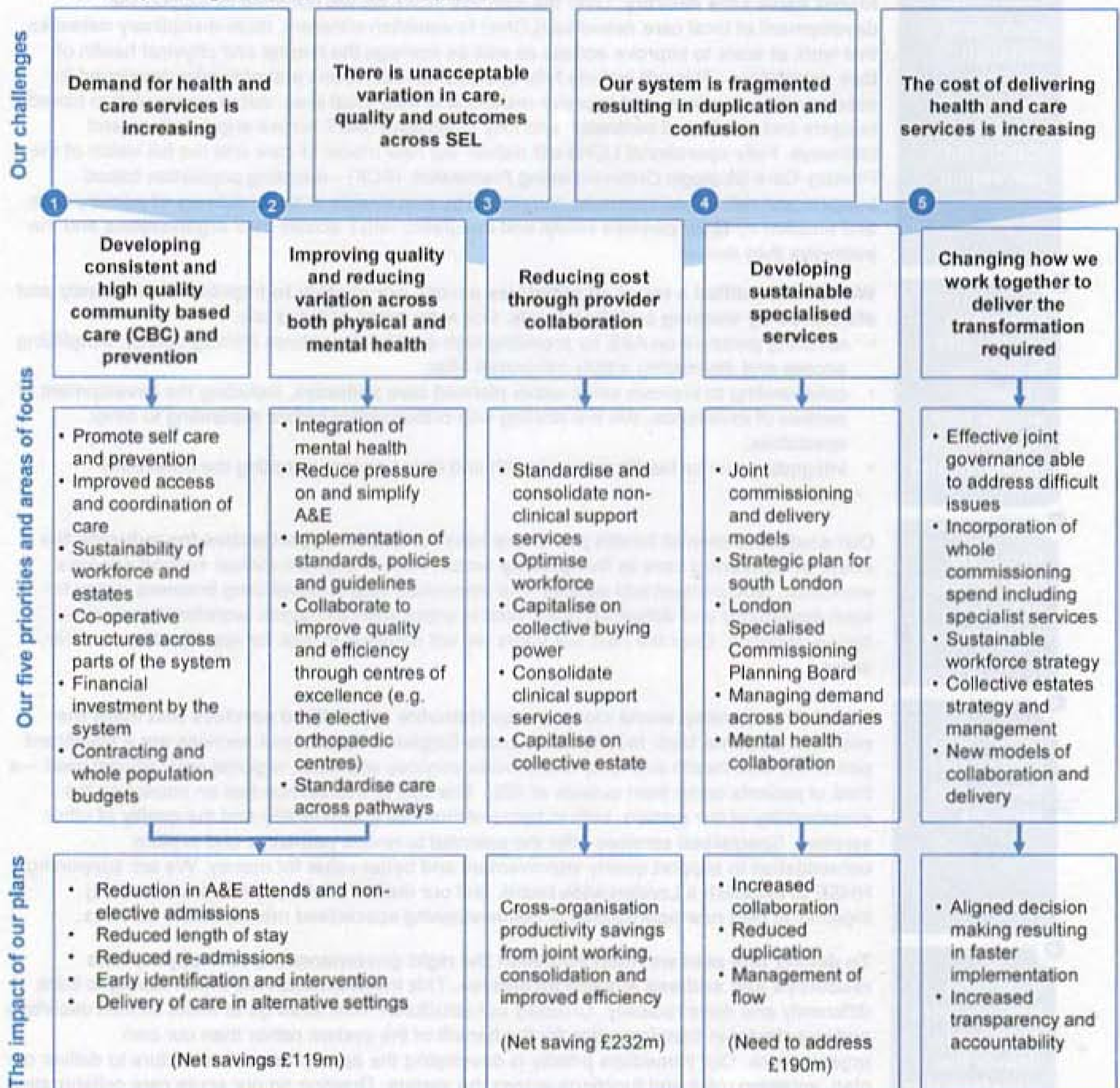
We wish to develop world class and sustainable specialised services that meet the needs of patients both locally and across England. Specialised services are a significant part of the SEL health economy and provide services at a local, regional and national level – a third of patients come from outside of SEL. The size of this service has an impact on the sustainability of our system, both in terms of financial sustainability and the quality of other services. Specialised services offer the potential to review pathways and explore consolidation to support quality improvement and better value for money. We are supporting NHSE to establish a London-wide board, and our mental health providers are working together to pilot new approaches to commissioning specialised mental health services.

5 Changing how we work together to deliver the transformatio n required

To deliver this plan we must establish the right governance, secure appropriate resources and address system incentives. This transformation will mean having to think differently and more radically. Crucially our structures must allow us to make difficult decisions and investment in transformation for the benefit of the system rather than our own organisations. Our immediate priority is developing the appropriate infrastructure to deliver our plan, agreeing roles and functions across the system. Drawing on our acute care collaboration Vanguard between Guy's and St Thomas' and Dartford and Gravesham we will build this capability into the SEL STP approach.

Plan on a page

We have worked collaboratively to develop our plan for south east London, and 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 and related areas of focus that we believe will have the greatest impact on our challenges and pressures to collectively address the three gaps of health, quality and finance while increasing value. 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.



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Together our local priorities align with the ten questions that nationally STPs must answer

Collectively, our priorities help address the ten questions posed by NHS England in the submission guidance. The questions cover the full range of health and care provision so, while our priorities address them all, they are supported by local organisational and collective plans that aim to address our challenges and meet national standards and requirements.

Each of our priorities have a different focus and, as a result, address different questions. The contribution of our priorities to address the questions is summarised below. Our fifth priority, how we will work collaboratively, will enable the delivery of our plans rather than directly addressing a question. As such it has not been included in the table below.

	1. Community based care	2. Quality and variation	3. Provider collaboration	4. Specialised services
How are you going to prevent ill health and moderate demand for healthcare?	✓	✓		
How are you engaging patients, communities and NHS staff?	✓	✓		✓
How will you support, invest in and improve general practice?	✓			
How will you implement new care models that address local challenges?	✓	✓	✓	✓
How will you achieve and maintain performance against core standards?		✓		
How will you achieve our 2020 ambitions on key clinical priorities?		✓		
How will you improve quality and safety?		✓	✓	✓
How will you deploy technology to accelerate change?	✓	✓	✓	✓
	We are building digital solutions into our plans. These are described across our priorities and in our Local Digital Roadmap			
How will you develop the workforce you need to deliver?	✓	✓	✓	✓
How will you achieve and maintain financial balance?	✓	✓	✓	✓
	We have set out how each of our priorities support our future financial sustainability both through reducing demand and costs. Our plans reflect the Carter Review and reflect organisations' efficiencies as well as collaborative opportunities.			

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, which offers the best value. Demand for secondary and acute care is rising.

We have developed and adopted a new 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.

Our work to form networks of CBC providers is already enabling us to take action in some major high impact areas and we are now looking to 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 our 23 Local Care Networks (LCNs), which will incorporate all 246 GP practices. There is no standard south east Londoner for us to model our service on. As such, we have built our LCNs around geographically coherent and self identifying communities, supported by scaled up general practice using natural boundaries within boroughs. LCNs share many of the features of multispecialty community providers (MCP) and will bring primary, community, specialist teams working in the community, mental health and social care colleagues together 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 LCN will adopt while flexing the service they provide for their local population. Each LCN is working towards:

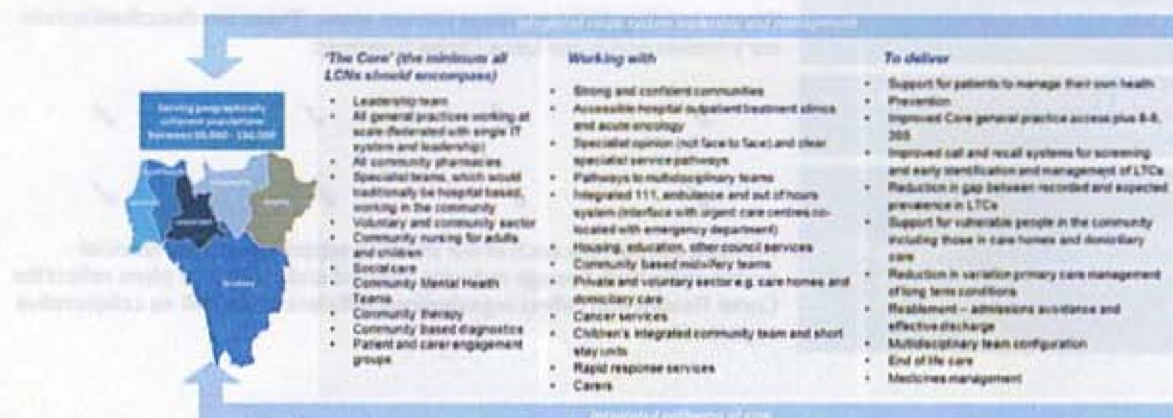
- Building strong and confident communities and involved, informed patients and carers who are supported to stay independent and self-manage;
- Delivery of consistently high standards of care, including the London Strategic Commissioning Framework Specifications, with clear outcome measures;
- Responsive services providing access from 8am – 8pm seven days a week;
- A focus on the physical health and wellbeing of people with enduring and significant mental health problems;
- Proactive primary and 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, LCNs will provide a full range of community based services. Ultimately, our ambition is that LCNs will be able to integrate the entire community based system, driving transformation in areas such as housing, as well as traditional players in health and care. Currently, 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.

LCNs 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.

Our target model (below) sets out the expectations of all LCNs, such as integration with social care and community mental health teams, and the need to work at scale to deliver the high impact scheme and sustainable change.



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 just over £60m to achieve the initiatives set out in the STP. 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 are assuming an ability to access the full range of transformation funding in order to ensure stabilisation (e.g. core Primary Care budget needed) and improvement, including the opportunities to support resilience, development and care design recently outlined in the General Practice Forward View. We will aim to use the PMS review to support delivery of agreed local and Pan London objectives. 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. We also anticipate there to be improved outcomes for patients, as well as the acute savings.

High impact schemes to be delivered by Local Care Networks

While the biggest change in the way care will be delivered will come from the ongoing shift to our future model of care, LCNs 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. LCNs will allow providers and residents to take decisions about models of care that represent best value from the resources they receive for their populations, by their ability to bring together providers to respond to aligned system incentives which reward them for the population outcomes they achieve together. The below schemes help to reduce acute demand, and improve quality by reducing variation. In particular they will focus on delivering excellent patient experience whilst reducing emergency admissions, length of stay and, ultimately per capita cost.

Accessible, timely care and assessment	*Access*: All LCNs will therefore offer extended hours to general practice (including 8-8) by drawing on the benefits of at scale working. • *Cancer*: Delivery of the recommendations made in the *Five Year Cancer Commissioning Strategy for London* which promotes an increase in screening and education. • *Population health management*: Through their population health responsibility LCNs will proactively target at risk patients, including those at risk of admission. This will include identification of those who are at risk and in receipt of social care services, and working in a multidisciplinary way to provide support and prevent escalation of need, including psychological and psychiatric needs.
Proactive and prevention focused care	• *Effective prevention*: There is a commitment to drive a radical step change. This includes taking a holistic approach for issues such as obesity, mental health, diabetes and smoking, Making Every Contact Count and increasing screening. NHS National Diabetes Prevention Programme offers those at risk of developing Type 2 diabetes a place on a programme to lower their risk through self care. It is delivered with the Health Innovation Network (HIN) across all south London CCGs and boroughs 4000 people are expected to attend the programme in South London in 2016/17. • *Re-commissioning of GUM/CaSH services* will include adoption of an integrated sexual health tariff, an online service offer; shift of basic services to primary care/pharmacy; referral for complex GUM/RSH and targeting those groups with highest rates of infections. • *Self management*: We are investing in innovative ways to empower self-management of health. This includes working with schools to raise awareness of mental and physical wellbeing as well as targeted programme to support patients with long term conditions • *Risk stratification*: We have implemented risk stratification and 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 • *Alcohol identification and brief intervention*. The Health Innovation Network will roll out alcohol Identification and Brief Interventions (IBA) across health settings, social care and the criminal justice system, along with minimum standards which set out how staff can deliver IBA. • *Illegal tobacco*. Continuing the award winning work of The South East London Illegal Tobacco Network (SELITN).
Co-ordinated and effective care planning which provides continuity (supported by multi-disciplinary working)	• *Mental health*: Integrated working with mental health and adult social care is among the core components of the model. • *Multi disciplinary team working*: A high-performing multi disciplinary team will include roles such as care navigators to coordinate care for higher-risk patients. • *Care homes*: Enhanced support to vulnerable people in care homes, extra care housing and those receiving domiciliary care.

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Commissioning and contracting to achieve sustainable, modern and vibrant primary care

Our integrated model of care is organised around our populations rather than individual organisations. In many areas we are moving towards an MCP model. We recognise that to realise benefits we need to develop and adopt different ways of commissioning that emphasise value and population health.

It is not proposed to adopt a single commissioning model for south east London but instead enable CCGs to adopt models that suit their populations. It is expected that any contract will focus on:

- Provision of care on the basis of geographically coherent populations;
- Emphasising prevention, early intervention and proactive management, rather than activity;
- System outcomes and risk sharing across pathways
- The total cost through the whole patient;
- Integration between different types of providers.

CCGs have already started exploring different models and are committed to sharing learning. We are also working with LCNs and federations to establish appropriate legal forms to take on new contracts.

Delivering at scale primary care

At scale delivery of primary care, utilising the registered list is at the heart of effective LCNs. Our model retains the concept of list-based primary care, but empowers GPs to take advantage of the opportunities presented by working at scale within the 15 established federations.

We aim to establish a primary care offer that is proactive, accessible and coordinated. Transforming Primary Care for London provides the framework and structure for our plans.

Vibrant and sustainable general practice

We estimate that to 'do nothing' would require an additional 134 GPs and 82 nurses by 2021 at a cost to the health economy of approximately £17m. Supply forecasts predict a GP supply shortfall of 25% in this scenario. To address these pressures we are working with HEE and our local vision of the GP Froward View to:

- Develop roles such as care navigators and physician associates who can reduce some of the demands on GP time;
- Establish new ways of working across federations to reduce bureaucracy, administration and demand for clinical consultation;
- Create joint posts supporting multiple practices or working across health and social care.

Working collaboratively through federations

General practices are beginning to work together through federations, enabling them to share resources, such as staff and estates. Their key aims are:

- To adopt the most effective approaches to screening for mental and physical health and call and recall;
- To work together to achieve the Primary Care Standards for London, including improved access;
- To develop and recruit to new roles, such as clinical pharmacists and care navigators;
- To achieve economies of scale and efficiency that support the long term viability of primary care and create clinical capacity.

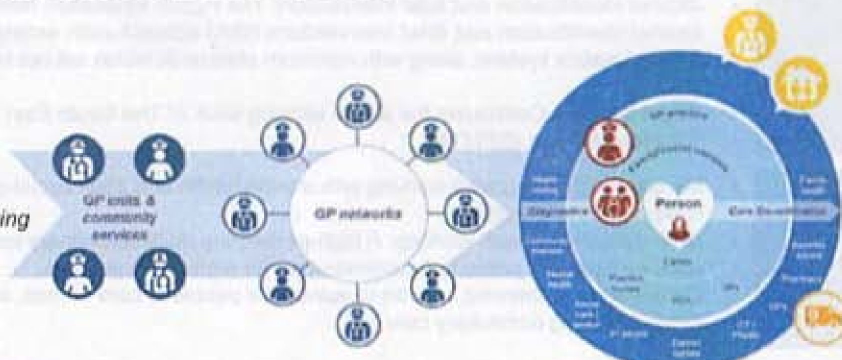
Enablers

Estate will be planned and organised around LCNs. We need to use existing estate differently, or acquire new estate, for instance through the development of hubs. Hubs will be a key change and will support the delivery of LCNs and, while specific services will vary, they will house a range of health, social care and other services 7 days per week. They should be fit-for-purpose, flexible, adaptable, accessible and be able to facilitate the shift out of the acute hospitals into the community. These changes will be delivered through accessing Estates & Technology Transformation Fund.

The Local Digital Roadmap (LDR) outlines the digital ambition for south east London. It focuses on:

- Being paper-free at the point of care by 2020;
- Digitally enabled self care empowering patients in the management of their care;
- Real-time data analytics at the point of care;
- Whole systems intelligence to support population health and effective commissioning and research.

Shift to at scale primary care working in LCNs



Primary care working within LCNs

Delivery plan for developing community based care

The table below shows our actions over the next five years. From 2019/20 we expect to have full coverage and to be realising benefit from our investment. An ongoing programme of organisational development will be needed to embed the cultures required to deliver this change.

	2016/17	2017/18	2018/19
Federations / alliances established	• All local GP practices have agreed to an alliance and recognised as a legal entity	• Commissioner offer made to the alliance and contract in place following due diligence • 3 to 5 year business plan developed	• Population based budgets and risk based contracts being established
LCN integrated system leadership and management	• Local Care Networks defined. LCN leadership team and management structure in place, with clear governance and decision making arrangements	• Enabling strategies embedded across networks • Integrated Care Provider, hosted by Oxleas, created to cover MH, CH, and adult social care	
Accessible care standards and associated high impact schemes implemented	• Reablement (including rapid response and supported discharge) across mental and physical health services	• Improved access to GP practice including 8 to 8, seven days a week available to all patients in SEL • Able to share medical records across federations • Single telephone triage and booking across federations • Same day access to specialist advice and clinics	
Proactive care standards and associated high impact schemes implemented	• Active risk stratification • Enhanced support to vulnerable people in care homes, extra care housing and those receiving domiciliary care	• Asset mapping and social prescribing • patient liaison across networks addressing mental and physical health needs • Training in motivational skills and health coaching • Enhanced call and recall and screening for hard to reach groups including those with severe mental illness	• Local communities/ stakeholders actively and routinely involved • Health and wellbeing champions across networks • Primary prevention and enhanced public health programmes
Coordinated care standards and associated high impact schemes implemented	• Active care registers within GP practices	• Identifying people at risk of developing LTCs including mental health conditions	• Patient/carer education programmes
Continuity of care standards and associated high impact schemes implemented		• All patients have a named GP • Flexible appointment lengths according to patient need commissioned • Assigned care professional in final year of life • Multi-disciplinary teams established within networks	

Improving quality and reducing variation

To improve care and reduce demand we need to reduce variation. Our programme is developing initiatives across key areas of our system where consistency is required and standards can be improved by working together.

Many of the improvements in our health and care system will come from changes in community based care, but we also need to reduce variation in our main pathways of care. 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.

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	A benefit of investing in CBC will be a reduction in demand for A&E through increased access to community support and population health management. However, when people do need to access services in a crisis it can be confusing. Our priority is integrating urgent and emergency care, providing accessible alternatives and signposting people to these and supporting people appropriately when they have to access A&E. In other areas such as cancer and mental health we are exploring options for care navigators and improving the acute oncology pathway to reduce demand on A&E.
Collaborate to improve quality and efficiency through centres of excellence	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 and 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 reductions in acute service utilisation demonstrated in 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 SMI 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.

There is extensive work being undertaken to improve pathways. As such, this section focuses on our plans which we believe have the most significant impact on addressing our three gaps.

If we do not change our approach to delivering care, projected demand would increase to the point that we would need a new hospital and a significant increase in workforce. Throughout this process we have therefore focused on managing this increase in demand by changing the way we work so we can work within our current infrastructure; reconfiguration will not manifest through a radical change in estate.

Reducing pressure on A&E and simplifying urgent and emergency care services

Demand for urgent care services continues to increase, putting pressure on our infrastructure and resources. This is a result of a fragmented system and a lack of suitable alternative settings.

By 2018 we will have established an *integrated urgent care system*, bringing together the whole system, including a reprocured 111 service (which will go live in June 2017). This will include a single out of hours number and access to a clinical hub, and will promote the use of alternative services in the community, including district nurses and community pharmacy. There's an appreciation in SEL, and across the region, of the limited information links between U&E Care, Integrated Urgent Care (IUC) and the London Ambulance Service (LAS). Solutions are required to integrate these services digitally . Healthy London Partnerships (HLP) has developed Patient Relationship Manager (PRM) which is one possible solution to enabling integrated urgent care. This is explained in our supporting Local Digital Roadmap strategy.

We *are creating and promoting effective alternatives to A&E by enhancing the capacity and capability of community based care*. This includes pharmacy and extended access in primary care, and are working to reduce ambulance conveyance to emergency departments through improved integration and the development of new models. We will have improved access to GP practices, including 8 to 8 seven days a week. It is currently anticipated that all patients within SEL will have access to this service by 2017/18. We are integrating community based care provision to support patients to manage their condition and to build links with settings such as care homes to reduce avoidable admissions by 2017. This will be supported by alternative contracts which incentivise prevention.

Avoiding high end need is through crisis intervention. As such, we are *developing models in primary and community care to reduce emergency department attends* such as specialist advice and ambulatory 'hot clinics'. We already have extended primary care services in Lambeth and Southwark, which have created approximately 200,000 appointments per annum, primarily focused on urgent and same day appointments, and enable proactive care for their frail adult population to reduce avoidable admissions to hospital.

When people do come to A&E, we are *improving and managing care and signposting* users to alternative settings. We are increasing access to specialists in A&E including access to frailty, paediatric and mental health experts and in 2017 all co-located UCC/A&Es will have enhanced front door streaming in place. CORE 24 would be a minimum standard for psychiatric liaison, though there are recognized financial hurdles that need to be worked through.

We will ensure that those who *experience a mental health crisis (including children) are addressed appropriately* wherever they enter the system, through interventions including:

- Specific drug and alcohol services on site to avoid patients absconding and re-attending;
- Improved services for under 18s, including specialist input at an early stage to avoid long waits for children and building on the NICE guidance with recommendations for transformation of services from the recent 'Improving the care of children and young people with mental health crisis in London';
- Parallel medical and psychological assessments for patients;
- Providing better and earlier mental health recognition and onward referral at the front door of the emergency department, exploring options to achieve the four hour wait target for mental health;
- By September 2016, options for a pan-London section 136 care pathway will have been developed in response to the Crisis Care Concordat.

We are currently evaluating *short-stay paediatric units*, and developing a hospital at home and rapid response model to manage complex children out of hospital.

We are enhancing digital access to records and care plans as a key enabler to simplify and enhance our urgent care system. This includes shared access to care plans, interoperable IM&T across settings of care and the ability to share information across providers.

We are committed to achieving the London Quality Standards, with the aim to drive consistent, accessible and high quality services across London, including a focus on seven day working.

@home service in Lambeth and Southwark

The @home service operating in Lambeth and Southwark provides intensive medical care in people's homes to help reduce length of stay in hospital, or to avoid admissions altogether. Patients are supported by a multidisciplinary team including nurses, therapists, pharmacists, GPs and social workers. Over 3000 patients have been supported over the last year, and the @home concept has now been applied for children and young people, and for palliative care patients. Since November 2014, @home has also taken direct referrals from London Ambulance Service. By working in partnership, @home and the London Ambulance Service have been able to help support over 500 patients in their own homes who would otherwise need to be taken to hospital. In the last year, the number of admissions to hospital have flattened, while the number of patients with chronic obstructive pulmonary disease being taken to A&E has reduced significantly. It has fallen by 8% in Lambeth and 5% in Southwark, compared with a London average reduction of 3%.

Collaborate to improve quality and efficiency through centres of excellence

Our aim is to develop world class orthopaedic services that would deliver excellent patient outcomes and reflect the highest levels of productivity.

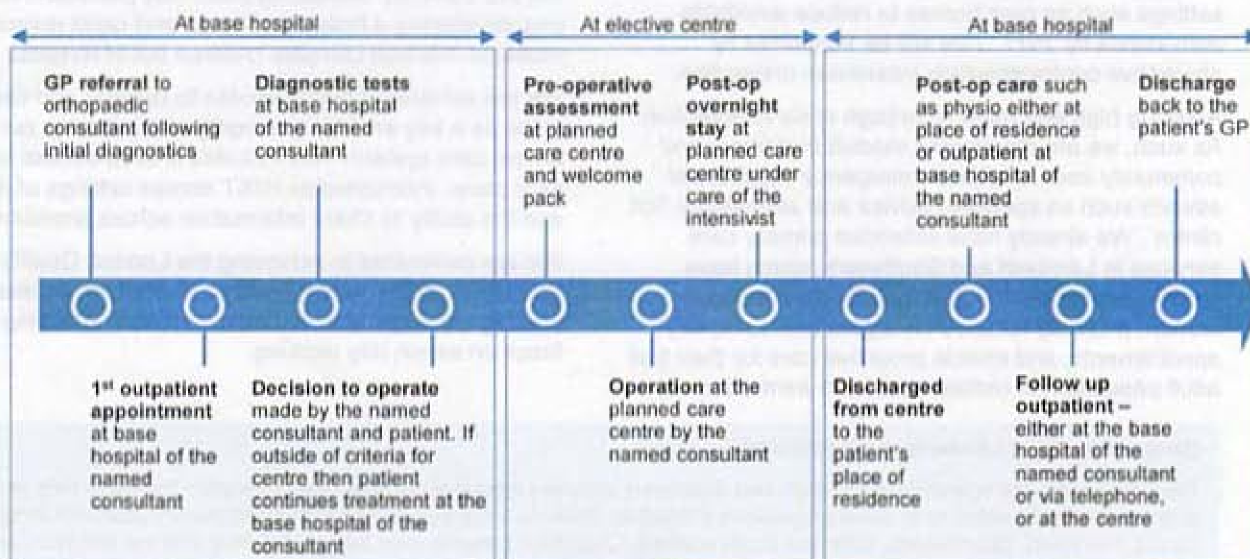
The *Getting it Right First Time* review suggested that consolidating elective orthopaedic services can deliver a number of benefits. In addition, this approach reflects a national drive to deliver specialist, complex and routine elective orthopaedic care through a networked model which provides an opportunity to improve outcomes, reduce complications and avoidable costs.

We plan to develop two elective orthopaedic centres. These will bring together routine and complex care onto single sites with ring-fenced facilities. This will minimise cancellations and ensure sufficient critical mass for certain procedures. The centres will work as part of a network and link with local hospitals and community based settings.

The overall service is expected to deliver:

- Accurate and timely diagnosis utilising best practice in the assessment of elective orthopaedic conditions to enable rapid access for new and existing patients;
- Delivery of evidence-based treatments plans (where incidence rates make this possible) to enable improved treatment outcomes and the maximisation of patients' functional ability through best practice multi-disciplinary management strategies including addressing patients' mental health needs at all stages;
- Appropriate shared care arrangements between specialities for the management of co-morbidities;
- Detailed audit of patient outcomes and experience, shared with colleagues in other centres, enabling the dissemination of best practice and appropriate;
- More complex operations, such as revision surgery, undertaken at suitably accredited units with the appropriate critical mass, by surgeons with a special interest in this field;
- The nine levers for productivity in elective care set out by Monitor.

The graphic below provides an example pathway of how the elective centres could work with base hospitals and how patients will move between base hospitals and the elective centre for outpatients, treatment and rehabilitation. Patients will still have choice of provider at the point of referral as activity is still owned by the base hospital.



In addition to consolidating acute provision we are further developing the pathway pre- and post-admission to ensure standardisation.

Timeline for establishing the elective orthopaedic centres

We are part way through the current phase of work which is in the context of the longer-term development of elective centres. The focus of this phase, to November 2016, is to develop the strategic case and clinical model enabling us to move towards consultation and/or implementation. The timeline for establishing the elective orthopaedic centres is summarised below and reflects national and regional guidance on NHS service change. It is expected that a strategic outline case and pre-consultation business case will be developed by November 2016 followed by a period of consultation if required.

The STP process has provided an opportunity to expedite the process by working as a system to collectively ensure that, where there is benefit to patients and the system, individual organisations would not be disadvantaged.

Opportunities for further collaboration

During 2016/17 we will identify additional opportunities for changing the way some planned care services are delivered. This will be prioritised in areas where there is the greatest potential benefit in terms of quality and cost. We will also align this work to the national Getting it Right First Time programme. Potential services will be assessed based on quality of care, sustainability (workforce), financial opportunity and deliverability. Based on work to date there is potential opportunity in a number of areas including ophthalmology.

An Accountable Cancer Network in south east London

The three Trusts that provide cancer services are establishing an Accountable Cancer Network to provide a coordinated approach to the delivery of high quality cancer care across south east London. One of the key first priorities for the network is the sustainable delivery of cancer waiting times standards. During 2016/17 two important new developments will support the delivery of better outcomes, access to services and improved patient experience for cancer patients.

Cancer Centres at Guy's and Queen Mary's

The new £160m purpose built Cancer Centre at Guy's Hospital will open in September 2016. The centre will be the centre of excellence for cancer services and will provide a state of the art facility for cancer diagnosis, treatment and research. Streamlined pathways will improve patient experience and focused research will accelerate the delivery of innovative treatments. The centre will provide a full suite of diagnostics and imaging to support the cancer pathway, as well as increased capacity with dedicated floors for outpatients, chemotherapy and radiotherapy.

The design of the centre has been patient focused with straightforward signposting, integrated services that holistically meet patient needs, and with access to therapies and supportive care alongside cancer treatment. To create a world class centre for cancer treatment and research, the centre will benchmark key metrics against other standalone cancer units in the UK and abroad. This will support the delivery of better outcomes, access to services and improved patient experience for cancer patients. In addition, a second smaller centre is being developed at Queen Mary's Sidcup to improve patient experiences of care by providing increased capacity for chemotherapy and, for the first time, radiotherapy treatment closer to home for patients in outer south east London from autumn 2016.

Integrating mental health services

We are looking at further opportunities for working at scale to improve mental health, including at the interaction between mental and physical health. There are specific areas where we know that we could do better in serving those with mental health disorders:

- All of our boroughs have higher than average levels of mental health need as indicated by the PRAMH formula;
- Those with serious mental illness (SMI) have reduced life expectancy of 13 years, usually due to higher risk of physical conditions;
- Analysis of the drivers of mental health need such as deprivation, population mobility, and ethnicity indicates that SEL has some of the highest levels of risk factors in the country. People from black and minority ethnic communities are more likely to be diagnosed with a serious mental illness and are over-represented in crisis services and the criminal justice system;
- Prevention, screening and early detection in those who are experiencing inequalities or putting their health at risk will be key to helping people to sustain good health and wellbeing.

We have identified a specific priority of integrating physical and mental health so that we consistently tackle the disparity in life expectancy of people with severe and enduring mental health problems and address the mental health and wellbeing of people with physical health problems and long term conditions and medically unexplained symptoms. The table below summarises our plans against our key priority areas:

Community based care	• Integrated mental and physical health in CBC by aligning services, developing multi-professional working, supporting people with housing and meaningful occupation including employment and increase training of teams within LCNs; • Building mental health into our approach for capitated budgets and risk sharing; • Incorporating mental health into our population health management approach; • Increase early access in primary care; • Tackling wider determinants of health in children and their families; • Improved services for people with dementia.
Improving quality and reducing variation across both physical and mental health	• Embed an integrated mind/body approach to support both the physical and mental health of patients and service users; • Deliver quality improvement methodologies across the provider landscape; • Improving timely access to specialist mental health support in the community; • Increase diagnosis rates for people with mental health conditions; • Develop access to crisis care for children and adults; • Explore how we can achieve the four hour target for mental health and ceasing OATs; • Ensure sufficient and appropriate capacity is available to meet future demand.
Improving productivity through provider collaboration	In addition to the collaborative productivity work across all SEL providers we are: • Establishing a pan-London procurement approach for mental health providers, and a shared approach to procurement of legal support across south London; • Implementing A joint approach across providers in south London to managing the budget for forensic provision and which could potentially be extended to specialised commissioning of mental health services for children and young people; • Collaborative approaches to estates planning to support new models of care and more integrated working.
Optimising specialised services across south east and south London	• We are trialling a new way to manage budgets for specialised services through our collaboration between the three south London mental health trusts to take on the specialised commissioning budget for adult secure services. We will assess how this approach could be extended to other areas.
Standardised care across pathways	• Ensure a standardised approach to Making Every Contact Count; • Encourage open and positive discussion about mental health and wellbeing across settings; • Promote excellence in relation to mental health across all services and conditions; • Increase early identification, including the use of screening, and early intervention for mental health needs.

Standardise care across pathways

Where there is variation in standards of care we are working to ensure that this is reduced. This is through a combination of pathway redesign and standardisation, and interdisciplinary working to improve handovers.

Cancer

- *Education and training package for Local Care Networks:* By October 2016 we will have launched an education and training package in LCNs for GPs, nurses and allied health professionals. This will focus on: encouraging healthy lifestyle choices; earlier detection and uptake of screening; and supporting locality teams to provide ongoing support post-discharge.
- *Improved coordination of care during the diagnosis and treatment phases*: streamlining care to strengthen the pathway from diagnosis to treatment, to support the sustained delivery of cancer waiting times standards and to ensure that patients are kept well informed and can access advice and support.
- *Multidisciplinary Diagnostic Centre (MDC):* A pilot programme at Guy's Hospital aims to create a MDC to achieve timely diagnosis for patients with serious, non-specific symptoms. The pilot will be evaluated for its impact including speed of diagnosis, patient outcomes and the support offered to patients with non specific symptoms.
- *Acute Oncology Services (AOS):* By Q1 2017 we will have a single AOS phone line with linked e-prescribing systems that meet patient demand. This will triage patients, carers and GPs to the appropriate facility, enabled by sharing of relevant patient information between providers. Implementation of this will allow AOS to deliver effective and consistent emergency pathways and protocols across all sites. It will help reduce emergency admissions and attendance at A&E.

Mental health

- *Making Every Contact Count.* We will have a standardised approach to MECC to ensure earlier identification and intervention. Health aspects will be addressed in each contact, e.g. drug and alcohol use, anxiety, mood and psychotic symptoms, wellbeing, exercise, diet, cardiovascular risk factors, with clear onward pathways for issues identified.
- *Increase early identification and early intervention* for mental health needs, including through making mental health screening routine across all settings of care to promote appropriate care and timely referral where necessary.

Urgent and emergency care

- *Improve ambulance conveyance rates* through the establishment of a Clinical Hub with experienced clinicians who are operating the Hear and Treat service.
- *Redesigning urgent and emergency care pathways* to enable effective whole hospital responses to A&E demand, hospital flow from A&E to assessment and admission, plus the effective streaming and management within A&E.

Maternity

- *Creating continuity and promoting choice and mental and physical wellbeing* through the maternity pathways, and to provide clearer information about care choices and standardised information, including identifying more of those at high risk before 10 weeks and a named midwife for women. Access for all women to perinatal mental health services.

Learning disabilities and autism

The objectives of the south east London Transforming Care programme are to:

- Improve the way we identify and meet the needs of people with either learning disabilities, autism or both, through support in community settings with good quality, responsive services;
- Ensure consistent transition planning for all children from age 14 upwards to plan how they will live as independent adults wherever possible;
- Enhance crisis intervention for people are at risk of being admitted to hospital to prevent admission;
- Develop proactive support so that people can live independently in the community;
- Improve hospital care and discharge planning for people with learning disabilities, autism or both.

Implementation of standards, policies and guidelines

We aspire to a high quality services across our pathways. We are committed to meeting national and regional standards, including as set out in the national maternity review, the cancer taskforce report and the Mental Health Five Year Forward View. We will achieve this by implementing evidence based clinical standards of care consistently across providers.

Accident and Emergency (A&E)

In overall terms delivery of national waiting times standards for A&E has represented a real challenge over 2015/16.

For 2016/17 recovery trajectories have been agreed between commissioners and providers, driven by a joint commitment to securing an incremental improvement in performance over 2016/17, and underpinned by actions to support flexible, resilient and sustainable emergency care pathways. Recovery plans have been agreed on a provider specific basis and include a thematic approach to supporting improved performance, with the following key areas of short term focus:

- Ensuring appropriate capacity, both through a redesign of A&E departments where required (as at GSTT), and to ensure appropriate bed capacity is available to support effective flow;
- The effective management of demand, focused particularly on A&E diversion schemes;
- The implementation of discharge to assess models, alongside the provision of community based supported discharge, reablement and rehabilitation services;
- Dedicated service improvement and investment, in and out of hospital, to ensure the effective management and treatment of particular client groups, such as mental health, alcohol, frail elderly.

Over the medium term, the STP proposals for urgent and emergency care and the development of community based care will support sustainable, high quality and cost effective urgent and emergency care services.

18 week referral to treatment waiting times standard

Delivery of the 18 week referral to treatment waiting times standards for planned care is mixed, with GSTT and LGT meeting national waiting times standards at a provider level but with a history of challenge at KCH.

Recovery plans have been agreed at trust and specialty level with the following key areas of focus:

- Ensuring robust demand and capacity planning, focused on both immediate and future requirements;
- The redesign of planned care services, with a focus on developing virtual outpatient clinics, effective triage and assessment services and a shift to day case and outpatient rather than inpatient settings.

Work to ensure that demand is appropriately managed though the agreement of referral criteria, straight to test protocols for diagnostics, referral triage and the shift of follow up care to community based settings.

In addition to these existing RTT standards, the Mental Health Five Year Forward View envisages pathway development including access standards for mental health conditions and once those standards are clear, the implications for services across SEL will need to be understood and a process for ensuring that the standards can be achieved agreed.

Cancer

There is more to be done so that cancer services consistently meet national standards for all patients, particularly in terms of delivering on 62 day cancer waiting times to treatment and for those patients who transfer between local to specialist hospital services.

The 62-day waiting time standard is a key focus, particularly within the breast, lung and colorectal pathways. To resolve this we will implement:

- Joint data systems, including a joint waiting list;
- Care navigator roles that focus on the transfer of patients between providers;
- An Accountable Clinical Network to provide a coordinated approach to cancer with the sustainable delivery of national waiting times standards as a key first priority of the network;
- Create additional capacity with the opening of the Guy's Cancer Treatment Centre, new radiotherapy facilities at Queen Mary's Sidcup.

High quality acute provision

Only two of our providers are rated as good by the CQC and none are outstanding. We are committed to ensuring that all of our providers improve against this standard.

Savings associated with improving quality and reducing variation

The table below shows the financial impacts of implementing the initiatives described in this section.

The financial impacts have been estimated by considering potential changes in activity (i.e. managing growth in numbers of A&E attendances or reducing the average length of stay in hospital). These are based on a comprehensive benchmarking exercise. As a result, the performance implied has been demonstrated as achievable by other, similar areas.

The changes in activity have then been converted into financial savings (against the 'status quo' challenge) by costing them for each year over the five year period.

A proportion (40%) of the total potential savings has been assumed to be reinvested to achieve these (although this is expected to be applied disproportionately across the care areas). The net savings opportunity (against the 'status quo' challenge) across all care areas is therefore £119m.

The majority of investment is in community based care, reflecting the planned shift from acute and secondary to primary and community care and prevention. A substantial proportion of this is planned for the high impact interventions that are under development. While some savings are attributed directly to community based care many of the benefits are realised in other areas, particularly urgent and emergency care.

Area of anticipated saving	Estimated recurrent savings in 2020/21 (£m)	Recurrent investment costs in 2020/21 (£m)	Net recurrent savings in 2020/21 (£m)
Investment in **community based care**	50.4	(61.8)	(11.4)
Reduction in demand for and increasing efficiency of **urgent and emergency care (adults)**	71.5	(8.5)	63.0
Planned care transformation	40.7	(4.9)	35.8
Reduction in demand for and increasing efficiency of **urgent and emergency care (children and young people)**	13.0	(1.5)	11.5
Maternity care transformation	6.3	(0.8)	5.5
Cancer care transformation	16.8	(2.0)	14.8
Total	**198.7**	**(79.5)**	**119.2**

All of the savings presented above relate to the cost of provision of care throughout the system and are modelled consistently with the hypothetical 'status quo' scenario set out on page 2. As a result, some of the savings relate to avoiding demand or inflationary cost growth, while others relate to reductions in costs from the current position. All of these savings have been modelled in terms of costs of provider organisations (as opposed to the costs of commissioning care). These costs change at a marginal rate to reflect the fact that a proportion of costs (i.e. those associated with PFI estates) will not be releasable in any transformation.

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Milestones over the next five years

To deliver our plans set out above we have established workstreams centred around clinical areas. Each group is clinician led and has a senior responsible officer.

	2016/17	17/18	18/19	19/20
Urgent and emergency care	• Plan to achieve 7-day services developed with Healthy London Partnership in line with the London Quality Standards • Evaluation of short stay paediatric unit • Assess options for CORE 24 and CORE Comprehensive for larger teaching hospitals • Ensure mental health needs are identified and addressed as well as physical health needs	• Front door streaming at co-located sites • Rapid-response teams in place • Digital access to care plans • Integrated Urgent Care in place • Planning for 4 hour wait target for mental health and ceasing OATs	• Priority 7-day standards in place for 50% of population • Enhanced emergency department front door	• 7 day services in place for 95% of population • Urgent and emergency care facilities spec compliant
Planned care	• Elective care centres strategic outline case and consultation • Opportunities for further collaboration identified • GSTT and LGT meeting referral to treatment standard	• Elective care centres full business cases • All providers meeting referral to treatment standard	• Elective care centres build and go live	• Elective care centres benefits realisation
Cancer	• Support development of Accountable Clinical Network • Demand and capacity analysis to meet 62 day wait • Opening of Cancer Centres at Guy's and Queen Mary's	• Evaluate outcomes of multidisciplinary diagnostic centre pilot • Roll out of multidisciplinary diagnostic centre model across SEL • Go live of single Acute Oncology phone line for south east London	• Implementation of consistent community based care offer to support those living with and beyond cancer including addressing mental health needs	• Improved care coordination and streamlined patient flow through the system through implementation of care navigators
Children and young people	• Development of SEL children and young people population planning network	• Improving access to children and young people's mental health services trajectory to 2020 agreed • Children and young people performance dashboard • Taking a preventative approach, incorporating working more closely with other agencies to tackle the wider determinants of mental illness	• Integrated care models for children and young people with long term conditions • Building parenting and peer support in the community • Develop emotional literacy and resilience through school based support, alongside earlier identification and intervention	• Strengthened primary care to support and treat children and young people
Maternity	• Maternity performance dashboard, • Standardised information on birth setting choices	• Standardised maternity specification, including mental health • Saving Babies Lives care bundle implementation • Agreed obstetric consultant cover trajectory	• Increased out of labour ward births • Local continuity of care ambition achieved • Promoting mental and physical wellbeing and identifying high risk women	• Full access to local specialist perinatal mental health services • 20% reduction in stillbirths

Improving productivity and quality through provider collaboration

We can no longer rely on traditional cost improvement programmes within single organisations. Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

Savings are estimated at £232m through economies of scale and removing duplication, and we expect to see improved outcomes and quality.

Opportunities for collaboration

Standardise and consolidate **non-clinical support services** wherever possible

Optimise the workforce by generating SEL-wide allegiance and alignment to staff banks and better management of agency contracts

Capitalise on our **collective buying power** with a SEL procurement hub

Consolidate **clinical support services** to generate economies of scale and deliver consistent, high quality services

Capitalise on the **collective estate** of SEL, rationalising services and point of delivery

We have outlined five areas for collaboration and have developed delivery roadmaps. These have been identified and agreed by trusts through constant engagement and clear governance to provide leadership and accountability.

Infrastructure to support delivery

This approach will only succeed if the right governance and infrastructure is established. We are putting the following in place to support delivery:

- Memorandum of Understanding;
- Terms of Reference;
- Stakeholder engagement and communication;
- Project management office and programme structure;
- Finance and risk: this change will require investment. We are exploring options for identifying transformation funding to support this work.

What the collaborative productivity programme has accomplished so far

The work to date has focused on developing the high-level opportunity areas into plans for delivery and collectively agreeing the potential savings. Governance and programme management arrangements are in place.

There are three key achievements and areas of consensus.

1. Defined cost bases

Trusts to have been collectively agreed the cost bases of the individual opportunity areas and workstreams. The programme can track the benefits delivered over time in a robust way from the outset.

2. Agreed savings opportunities

The scale of the opportunities are supported by accountable finance directors as achievable in the given timeframe. An investment strategy needs to be developed to understand the impact across individual organisations. In some cases detailed business cases will be required.

3. Formal commitment to the programme from all providers

There is consensus that the programme and encompassing research, analysis and engagement is at a point where we can move on to implementation.

Funding alone will not enable transformation. In some instances delegated authority from the centre may be required (e.g. estates disposals and receipts).

Our priorities for the next 6 months

In the next 6 months we plan to:

- Establish a high performing PMO and analytics function;
- Undertake specific baselining and further data gathering;
- Realise quick wins in payroll, clinical and non-clinical sourcing and category management and lean workforce approach;
- Develop detailed business cases for each opportunity area.

1. Standardise and consolidate non-clinical support services

At present, non-clinical support services are duplicated across trusts; tasks are repeated; there is significant variation in quality. Administrative activity impinges on clinical time and the technologies that are intended to increase productivity are not meeting their potential.

The consolidation of non-clinical support functions will lead to savings through:

- *Economies of scale:* beginning with the consolidation of highly transactional services to reduce headcount;
- *Standardisation and simplification of processes:* significantly reducing the level of variation across the trusts;
- *Improved technologies:* reducing required administrative effort and increasing clinical productivity;
- *Effective talent management*: providing staff who deliver non-clinical support functions with the scope and authority to re-engineer existing processes.

Five options have been identified – in-sourcing to an SEL entity, consolidation of all the functions to a single location, setting up an SEL owned Shared Services Centre, setting a joint venture with a private sector partner and outsourcing.

Once the preferred model has been chosen and in-scope processes are identified, we aim to have established a new model for HR, IT, Procurement and Finance in the next 3 years.

2. Optimise the workforce

Staff banks offer a more affordable and controllable way to service the demand for temporary staff than agencies. However, some staff are understandably tempted to work for agencies at higher rates, reducing the number of shifts that can be filled by the more affordable bank staff. Liaison analysis identified a £10.5m opportunity in this area.

Working as a collective enhances our position. We can achieve savings through:

- *Reducing demand for temporary staff:* one trust would undergo an intense productivity drive creating a centre of excellence who will share best practice across all trusts, beginning with the e-rostering system;
- *Reducing agency rates:* Collaborating to secure the best rate from a select group of agencies and a vendor management system to improve understanding of temporary staff spend
- *Increasing supply of affordable temporary staff:* by setting up a jointly owned agency, starting with high impact staff groups and expanding over time.

By 2021 we want to have built a large staff base by offering competitive rates and other non financial benefits. The commission would be re-distributed among trusts. There will be visibility of spend on bank and agency and this will be used to enter into joint negotiations with external agencies to achieve lower rates. Along with a cultural shift in framework compliance, a shortlist of preferred agencies will be chosen and rates fixed. Digital technology will be used to underpin the lean model of the organisation.

To achieve this vision, over the next 6 months we plan to create a data sharing agreement so that bank and agency data can be routinely shared. There will need to be alignment of Direct Engagement systems to ensure free flow of data. We will commission detailed baselining of spend in order to identify lowest rates.

3. Capitalise on our collective buying power

There is a lack of control and visibility over inventory and purchase order compliance. This has lead to price variation, inefficiency and a large volume of waste. Furthermore, there is a lack of data and proper analytics to support product decisions, with clinicians aligning patient outcome/cost with products.

Findings to date, (aligned with the Carter Review) indicate that some 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. The role and profile of the supply chain management function will be expanded to ensure effective management of supply within each trust. We will have the flexibility to align and fully exploit opportunities from other collaborative networks, in particular the Shelford Group, London Procurement Partnership and the Mental Health Trusts clustering network.

In order to achieve this vision we need to:

- *Reduce waste:* through the standardisation of processes, sharing of best practice, pro-actively challenging non-pay spend, increasing visibility over activity and driving compliance;
- *Drive down unit costs:* by leveraging the combined purchase volume and using the most competitive contract terms going forward. This will be enabled by using the best people from participating organisations and re-alignment of people, processes and technology.

4. Consolidate clinical support services

Challenges common across the clinical support services include: 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.

There are a range of future collaborative models which we are considering across different services, including pathology and radiology.

We plan to achieve savings by:

- *Reducing the drugs bill and improving pharmacy infrastructure services* through improving integration between primary and secondary care, improving use of e-prescribing and reducing medicine stock-holding;
- *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 or Managed Equipment Service contracts* by leveraging scale to negotiate better equipment contracts and investing in better equipment;
- *Optimising purchase and use of consumables and reagents* by using our collective purchasing power to negotiate better contracts and to reduce waste.

5. Capitalise on our collective estates

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.

This will be achieved through:

- *Reducing the level of under-utilised and non-clinical space:* by understanding the current state of all estate and increasing investing in digital technology to improve operational productivity and implementing digital delivery between all providers;
- *Reducing running costs:* through the development of a standard offer for facilities management and working as a collective to renegotiate large scale contracts;
- *Improving Productivity:* by investing in digital technology to improve operational productivity and implementing digital delivery such as telehealth.

Savings associated with improving productivity and quality through provider collaboration

The collaborative productivity savings have been split across the five opportunity areas. Within each of these opportunity areas each trust's general ledger has been used to cost the areas that may be impacted by the proposed changes.

Savings proportions and potential investment requirements for each of these areas have then been applied based on discussions with subject matter experts (both inside and outside the local health economy). These assumptions have subsequently been tested with Chief Financial Officers of organisations taking part in the programme.

The 2020/21 savings across all trusts are shown in the table below. They have been estimated to be just over £230m.

The largest savings stem from capitalising on our collective buying power, £68m, and optimising the workforce - £61m. Together, these opportunity areas contribute to over 50% of the total savings.

The non-recurrent investment required in order to achieve these savings has been estimated to be £35m. This investment requirement has been estimated individually for each option.

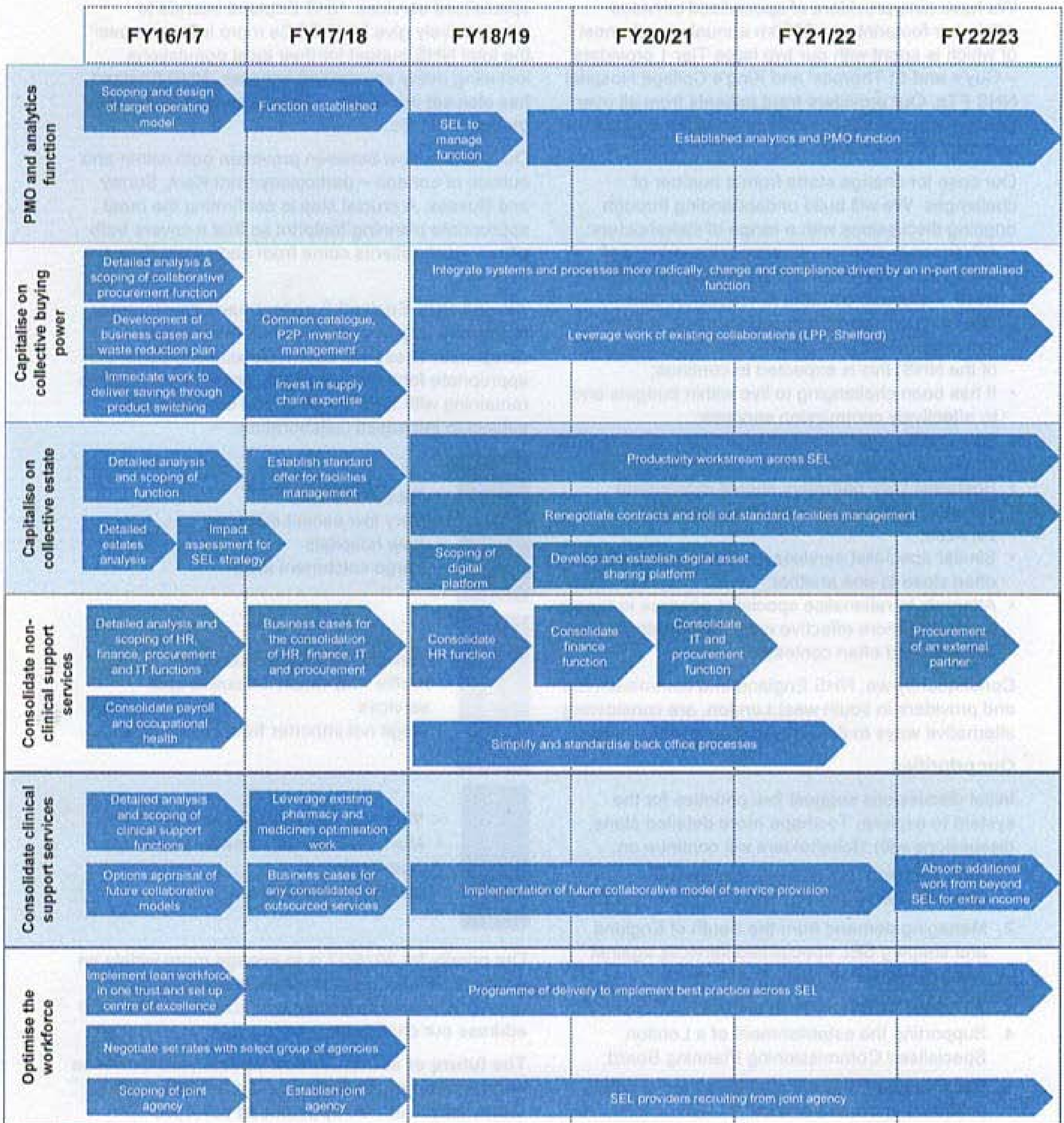
Further work is required to validate and refine these investment requirements prior to implementation of the proposed changes.

Opportunity area	Option	2020/21 recurrent saving (£m)	Estimated non-recurrent investment[1] (£m)	Years to fully implement
Optimise the workforce	Joint agency	19.9	(6.8)	3
	Collaborative rate reduction	12.1	(1.0)	2
	Productivity	28.9	-	2
Capitalise on our collective buying power	Unit cost	40.5	(4.1)	2
	Waste reduction	27.7	(2.6)	5
Standardise and consolidate non-clinical support	Consolidation	38.2	(9.3)	3
Consolidate clinical support services	Pharmacy	24.7	(2.2)	3
	Other clinical support	13.0	(4.7)	4
Capitalise on the collective estate	Estates	26.8	(4.7)	5
	Total	**231.7**	**(35.4)**	

All of the savings presented above relate to the cost of provision throughout the system and are modelled consistently with the hypothetical 'status quo' scenario set out on page 2. They have been estimated alongside existing cost improvement programmes and are therefore considered additional to the £339m of savings already achieved in the system. Work to confirm that there is no overlap with these existing programmes continues.

Timeline

We have developed a high level timeline of activity over the next five years, which will enable the system to come together to work in a more collaborative way.



Optimising specialised services across south east and south London

We have nine providers of specialised services within our footprint and £850m annual spend, most of which is spent with our two large Tier 1 providers – Guy's and St Thomas' and King's College Hospital NHS FTs. Our providers treat patients from all over London and the wider south east (which account for one third of all activity).

Our case for change starts from a number of challenges. We will build understanding through ongoing discussions with a range of stakeholders:

- Advances in science, an increasing volume of expensive new drugs and an ageing population have increased demand for specialist care;
- Spending on specialised services has hence increased at a much greater rate than other parts of the NHS; this is expected to continue;
- It has been challenging to live within budgets and to effectively commission services;
- Demand for specialised services from outside SEL can have a significant impact on local capacity;
- Specialist care pathways should incorporate patients' local services and non specialist services;
- Similar specialist services in south London are often close to one another;
- Attempts to rationalise specialist services to create larger and more effective units have been slow to succeed and often contested.

Consequently we, NHS England and commissioners and providers in south west London, are considering alternative ways to deliver and plan these services.

Our priorities

Initial discussions suggest five priorities for the system to explore. To shape more detailed plans, discussions with stakeholders will continue on:

1. Joint planning and delivery models with commissioners and providers across boundaries;
2. Managing demand from the South of England and shaping SEL specialised services against local, regional and national patterns;
3. The alignment of services across south London;
4. Supporting the establishment of a London Specialised Commissioning Planning Board;
5. Collaboration between specialist mental health providers in South London.

Working collaboratively to manage, commission and deliver specialised services

NHS England currently commissions most specialised services. NHS England intends to progressively give local CCGs more influence over the total NHS budget for their local populations, including many specialised services. NHS England has also set out how it will plan services jointly with groups of CCGs.

Our patients flow between providers both within and outside of London – particularly from Kent, Surrey and Sussex. A crucial step is confirming the most appropriate planning footprint so that it covers both where most patients come from and where they are treated.

We and NHS England (London) have developed a framework to group services into three broad categories. These will inform discussions about the appropriate footprint with highly specialised services remaining with NHS England and the other two subject to increased collaboration.

Category	Characteristics
Highly specialised	• Rare conditions • Very low patient numbers • Few hospitals • Large catchment area
Specialised (1)	• Episodic specialised services • Profile may mean difficult to split services • Large net importer from other areas
Specialised (2)	• 'Pathway' specialised services • More discrete with smaller population base (c.3m) • Long term conditions

Our priority for 2016/17 is to engage more widely on a fully developed case for change and develop the appropriate commissioning structure to enable us to address our challenges.

The future of south London Specialised Services and developing a strategic plan for SEL and south west London specialised services

South London has some similar services being provided in close proximity, which presents both opportunities and challenges.

We have initiated a process to produce a strategic vision for South London Specialised Services.

STP leads, supported by local CCGs and the London Specialised Commissioning Team have met, and are developing a draft high level strategic plan which considers the long term sustainability of acute services at Guy's and St Thomas', King's College Hospital and St George's. All provider chief executives are involved with and committed to this work programme.

Establishing a London wide commissioning structure for specialised services

As patients flow across boundaries, and local and London plans need to align, a London Specialised Commissioning Planning Board has been established to strengthen focus across London. This Board is currently developing key priorities and plans, and how it will work in practice. In particular, the Board will engage with footprints outside of London:

Transforming specialised services in South East London

NHS England London Specialised Commissioning has established a programme of pathway reviews to address many of the challenges, while specialist providers in SEL have come together as King's Health Partners (KHP) to explore opportunities for maximising our collective strength. To support the pathway reviews, a set of strategic priorities have been developed:

1. Leverage best in class standards, processes and frameworks to undertake reviews of key strategic priority specialised services;
2. Establish co-planning and improve system wide strategic planning through strengthening governance;
3. Improve access for patients, through the consolidation of services, in line with the Five Year Forward View;
4. Improve the quality of patient care and ensure the continued achievement of constitutional standards in London to ensure excellence in clinical outcomes and patient experience;
5. Achieve financial sustainability of Tier 1 providers, and deliver longer term transformational QIPP.

Four projects are in development with further projects being scoped. These are; paediatric oncology, neuro-rehab, HIV services, Tier 4 CAMHS.

KHP comprises our three main foundation trusts (GSTT, KCHT and SLaM) and King's College London. 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 and children's services. There are significant opportunities to improve the coordination between specialist and local care through network models, and consolidate the specialist elements of these services with research and training across the specialist sites.

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 co-develop our proposals and determine how to deliver the most efficient and high performing services that meet the needs of the people we serve.

Collaboration between specialist mental health providers in south London

We are embarking on a trial across South London to test a new way of managing budgets for specialised services. This would see the three mental health providers (SLaM, Oxleas and South West London and St George's) collectively manage the relevant portion of the specialised commissioning budget.

The trial will support the transformation of adult secure services by improving pathways and delivering cost effective services as a result of improved estate management, governance and bed management.

2016/17 will act as a shadow year as we establish the appropriate governance and collaborative mechanisms.

A world class destination for specialised services

Excellence in clinical care, research and education is at the heart of SEL's specialised services offer. Our work to develop world-class specialist services is supported by KHP's five year plan for improving health and wellbeing locally and globally. This means that underpinning all of our work in SEL will be a focus on integrating mental and physical healthcare across all care pathways, delivering interventions to improve population health and providing better value healthcare through improved outcomes and innovative use of data and informatics.

Delivering our plan will require a change in how we work

To deliver our plan we must establish the right governance, secure appropriate resources and address system incentives. At the same time we must work with patients, the public and our workforce to embed our plans and, where necessary, change culture and behaviours.

Balancing system benefit and impact on individual organisations: A place based approach to planning and delivery will mean making decisions that whilst are for the benefit of patients and the system do not align with individual organisational aspirations. However, we will only succeed as a system if organisations commit to shared plans.

We now have a joint governance structure. However, we shall undoubtedly come across issues that will test our cohesion as a health and care system but we shall be anticipating these issues and approaching them head on. We are also developing a system-wide approach to manage conflict where changes have a patient and system benefit but bring short-term disadvantage to individual organisations.

Aligning transformation funding to the objectives of the STP: We are committed to aligning investment to the objectives of the STP and will build processes to ensure that investment across the system supports our collective vision.

Investing in shared planning and delivery: We have invested in establishing a central programme office with dedicated project leads to support the development of our plans to date and senior responsible officers for workstreams. Our next step is to ensure that a collaborative approach runs throughout the programme.

Aligning system incentives: Over time we will need to move away from reimbursement systems that incentivise activity to systems that drive population health and value and share risk. The journey to capitation and outcomes based systems will be complex and will need to be supported by contractual and policy changes from the centre, but will be key to delivering the five year vision.

Having an ongoing dialogue with our stakeholders: Engagement is an ongoing dialogue with our key stakeholders, patients and the public – a conversation we are committed to continuing across as many channels as possible. We want to build on our engagement to date and extend as required to address our key priorities and gaps. We want to ensure that we meet best practice and involve patients, the public and our partners at every stage of our work.

- Patients and the public will continue to be represented in all workstreams through Patient and Public Voices and Healthwatch.
- We have developed a clinical ambassadors programme to support engagement with these groups.
- A south east London JHOSC has been established and will continue as a key forum for scrutiny and engagement.
- Understanding the impact on groups protected by the Equality Act 2010 is ongoing throughout our programme. Implementation of our equalities findings is managed through a dedicated Equalities Steering Group which will include a three-stage equalities analysis against our elective care proposals.

A system-wide delivery plan: To deliver the transformation needed we will need to monitor our plans for delivery and hold each other to account for performance.

We are developing a system-wide plan and delivery dashboard that will be reviewed by the SPG and STP Exec. We are also mapping roles and responsibilities across organisations so that responsibility for delivering our change is clear.

An employer of choice: Health and social care aspire to being employers of choice to secure recruitment and retention and to working with local education providers, including universities and apprenticeships, to ensure current and future staff are prepared for new ways of working.

Working collaboratively across London: Some of our challenges can only be addressed by working across London. We therefore work collaboratively with partners across the capital. Healthy London Partnership (HLP) was established in 2015 to undertake transformational change across London in areas that can either only be successfully tackled on a pan-London basis or which offer such economies of scale and reduced duplication and variation that warrant a 'once for London' approach. The current programmes of work cover areas such as prevention, mental health, primary care, urgent and emergency care, cancer, homelessness, mental health and enabler areas such as interoperability and personalisation, workforce and estates.

Clinically and professionally led change: It is essential that we keep health and social care professionals at the forefront of the changes we are making. This will involve clinicians and managers working together to define the change we need and see these through to fruition.

Measuring outcomes: Longer-term sustainability means focusing on the outcomes for the population. We have identified eight overarching outcomes that we aim to improve:

- Preventing people from dying prematurely and enabling them to live longer and healthier lives;
- Reducing differences in life expectancy and healthy life expectancy between communities;
- People are independent, in control of their health, and able to access personalised care to suit their needs;
- Health and care services enable people to live a good quality of life with their long term condition;
- Treatment is effective and delivers the best results for patients and service users;
- Delivering the right care, at right place, at the right time along the whole cycle of care;
- Commitment to people having a positive experience of care;
- Caring for people in a safe environment and protecting them from avoidable harm.

Adopting new models of collaboration and delivery: Our plans require deeper collaboration across providers. We will be able to take lessons from our local vanguards, pioneers and pilots to deliver our plans.

Acute care collaboration: Our vanguard between GSTT and Dartford and Gravesham

Guy's and St Thomas' NHS Foundation Trust are currently part of the Acute Care Collaboration vanguard. Dartford and Gravesham NHS Trust, although currently stable, is facing a range of serious challenges that, if not addressed, will start to impede its ability to continue to deliver sustainable, local services.

Clinical workstreams:

- To develop sustainable, local clinical services, including how small hospitals can access clinical expertise with a small population base;
- Develop networked clinical models that are replicable and will de-risk local hospital services and enable DGT and other small hospitals to continue to offer access to high quality care locally;
- Codify clinical pathways to increase their value whilst being more cost effective;
- Test the implications for the Group model.

Organisational design and governance workstream:

We are developing options to understand how best to create the Foundation Healthcare Group model without merger or acquisitions.

The accelerated options appraisal on organisational form will support the systematisation of the clinical model and enable standardisation of pathways.

Financial modelling must be prioritised in order to understand the economic and clinical benefits to understand the cost drivers. Wider system issues will be discussed with NHS Improvement.

Once the options have been identified, a process of agreeing the preferred model and then working through the relevant governance and the implications for both organisations will need to take place. This model will inform policy around the development of the Foundation Group; accreditation process and regulation of the Groups as well as developing a series of options that other Trusts may want to consider.

It is noted that even with this investment, the ability to fully deliver the benefits is dependent upon access to capital to invest in the digital and imaging platform.

Lewisham devolution pilot

Lewisham will run a pilot seeking to integrate physical and mental health services alongside social care. A detailed business case will be published in July setting out its detailed vision and plans. Currently the aim of the pilot is to explore:

- *Workforce*: develop new workforce models and enhanced roles to support new models of care, including joint health and care roles working with Health Education England, Skills for Care and professional bodies amongst others;
- *Estates*: working with NHS Property Services, Community Health Partnerships, London partners and sub-regional strategic estates boards to facilitate the release of primary care and hospital estates to support the development of new models of care and release relevant resources for transformation;
- *Aligned incentives and reimbursement, and funding structures*: flexibilities around tariffs and new payment models to support new models of care, beyond current flexibilities, multi-year funding cycle and accelerated roll out of Connect Care, our virtual patient record system, across all parts of Lewisham Health and Care system to support the planning and delivery of care.

The overall vision for devolution in Lewisham is consistent with our STP. During the pilot we will consider the lessons learnt and how they can be applied elsewhere in south east London.

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Bridging our financial gap

The south east London health economy faces a considerable affordability challenge over the next five years, even if reasonable 'business as usual' efficiencies are assumed to be achieved. This is estimated to be £676m by 2020/21 (see page 2).

We have carried out financial modelling to estimate the impact of our priorities. In particular this focuses on three main areas:

- Reducing demand through consistent and high quality community based care;
- Improving quality and reducing variation;
- Improving productivity and quality through provider collaboration.

At this stage, we have not modelled the financial impact of proposed changes to specialised services but we plan to carry that out over the coming months as plans develop further.

The graph below demonstrates how these changes may potentially address the affordability challenge in 2020/21. It starts from the 'do nothing' challenge of £1,015m, reducing to £676m once efficiencies have been achieved at 1.6% per annum across our five provider organisations.

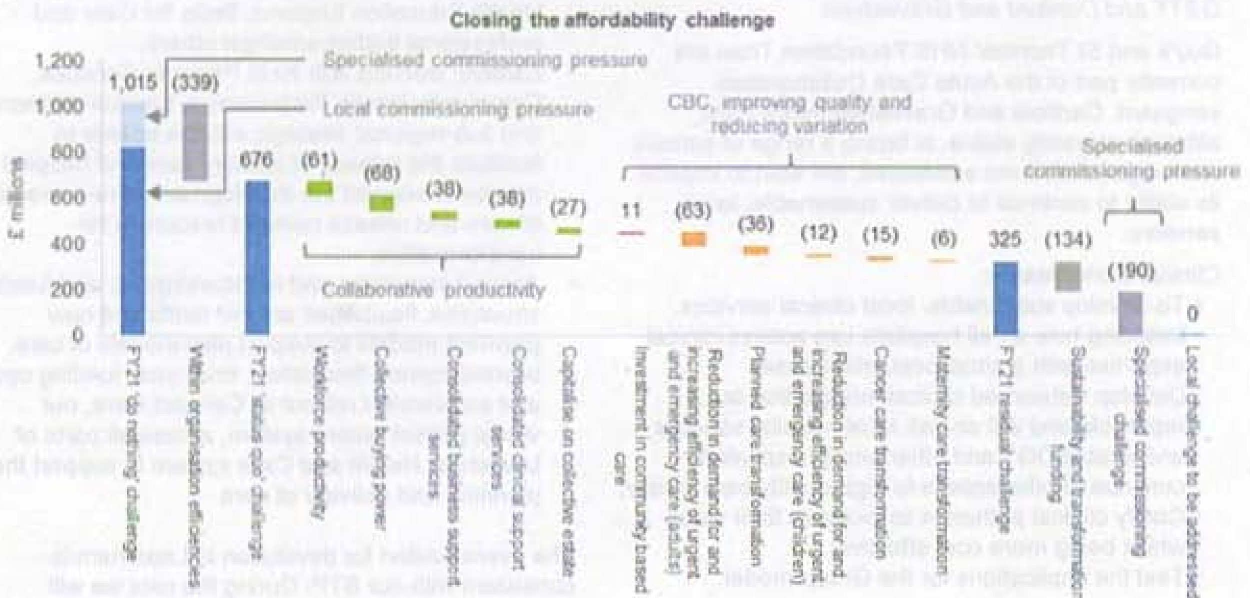
The green bars then demonstrate the impacts of collaborative productivity measures in reducing provider expenditure. In total these are estimated to contribute savings of £232m over the five year period. It is important to note that savings have also been estimated for Dartford & Gravesham NHS Trust who are included in the Collaborative Productivity programme but they have been excluded from this figure.

The red bar, then demonstrates how there will be a net investment of £11m for community based care. However the implementation of Local Care Networks, along with other changes in services and proposed pathway redesign, leads to considerable savings across a number of care areas (demonstrated in orange below). In total, net savings of £119m 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 FY21 affordability challenge for south east London to £324m.

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 £190m, with all of this relating to specialised commissioning for which savings plans have not yet been developed.

If ongoing work is able to fully address this specialised commissioning pressure, then this would address the entire affordability challenge across south east London by 2020/21.



[1] https://www.england.nhs.uk/wp-content/uploads/2016/05/STP-indic-allocs.pdf

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

Making progress in 2016/17

Although this is a five year plan we are taking action now. Our plans are already embedded within our ways of working and we have an established delivery structure. CCGs and providers are continuing to deliver challenging QIPP and CIP plans and we have identified a number of quick wins from our plans.

Community based care	• GPs to have formed federations or alliances and are recognised as a legal entity; • Local care networks defined; • Coordinated care: Active care registers within GP practices; • Continuity of care standards achieved (Q1); • Proactive care: Enhanced support to vulnerable people in care homes, extra care housing and those receiving domiciliary care; • Accessible care including 8 to 8 and urgent care.
Improving quality and reducing variation	Development of a: • Strategic outline case and potential consultation on Elective Orthopaedics; • Cancer centre and education and training package developed; • Front-door streaming specification finalised.
Provider collaboration	We have the potential to make the savings this year from our collective productivity programme through: • Clinical and non-clinical sourcing and category management initiatives to reduce non-pay unit cost; • Increasing productivity through lean workforce to deliver savings in outpatients; • Consolidation of payroll and occupational health services.
Specialised	Development of: • KHP strategic outline cases for cardio-vascular and haematology institutes and networks; • London Specialised Commissioning Board established and co-planning approach agreed; • Initiation of transforming specialised care pathways; • Outline Business Case for expansion of Evelina London Children's Hospital; • Shadow operation of adult secure services collaboration across South London mental health trusts.

Our forecast QIPP and CIP programmes outline planned savings of over £190m in addition to other efficiencies.

FY17 QIPP challenges

CCG	£000
Bexley	8,542
Bromley	8,600
Greenwich	15,480
Lambeth	9,151
Lewisham	8,745
Southwark	6,659
Total	**57,177**

FY17 CIP assumptions

Provider	£000
GSTT	43,813
KCHT	36,203
LGT	23,000
SLaM	20,730
Oxleas	8,000
Total	**131,746**

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