

South East London: Sustainability and Transformation Plan

21 October 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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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

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

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.

We continue to work at:

- Leadership and governance development, including development of a MOU
- A single reporting structure bringing transparency across the system
- The establishment of a 'single version of the truth' setting out our challenges, including our financial challenge.

We have committed to improving services for our residents within the resources available to us. We recognise 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

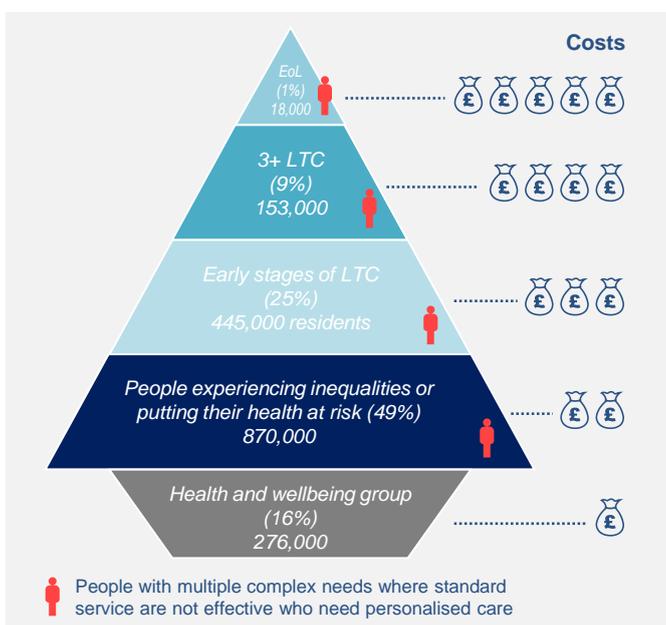
Locally, we face many of the challenges that are experienced nationally. The three gaps that are identified in the *Five Year Forward View* are found in south east London, and our plan will seek to address these.

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 imperative to prevent our challenges getting worse.



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.

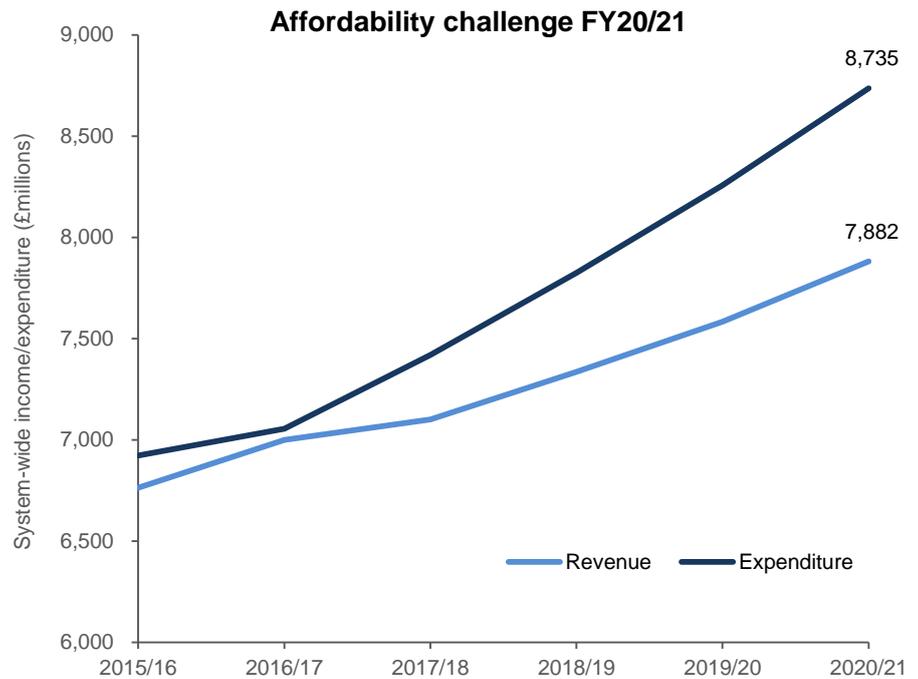
We are facing a financial challenge of £934m over four years

Based on plans, the ‘do nothing’ affordability challenge faced by the south east London health economy was forecast to be £854m by 2020/21. Excluding specialised commissioning, the affordability is forecast to grow from £159m in 2015/16 to £651m by 2020/21¹. NHS England (Specialised) have estimated an additional indicative £190m five year affordability challenge for specialised commissioning, alongside an additional challenge of £12m for London Ambulance Service.

Since these plans were developed, financial performance across the footprint has deteriorated by c. £80m across a number of organisations leading to an additional affordability pressure. Taking this into account the affordability challenge grows to £934m by 2020/21.

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 £189m relative to the 2020/21 baseline, reducing the planned ‘status quo’ affordability challenge to £727m. Similarly BAU QIPPs for commissioners are expected to



deliver system savings of £73m.

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.

Alongside this, the footprint has a ‘do nothing’ capital expenditure requirement of £1.1bn over the period to 2020/21. Of this, £983m is funded from identified sources. The approval process is underway for the remaining £153m required.

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 £132m² 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 challenge includes the requirement for Clinical Commissioning Groups to achieve a 1% surplus each year (one of the business rules set by NHS England).

² 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 comprehensively 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 a shift in focus to prevention, as well as, fully operational federations and networks developed to support other practices, and improved 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 consolidated centres. We are starting with orthopaedics before considering 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 and evaluation quick wins in HR back office, finance back office, procurement unit cost reduction and temporary staff. Over the next five years we will continue to explore opportunities to expand the program.

4 **Developing sustainable specialised services**

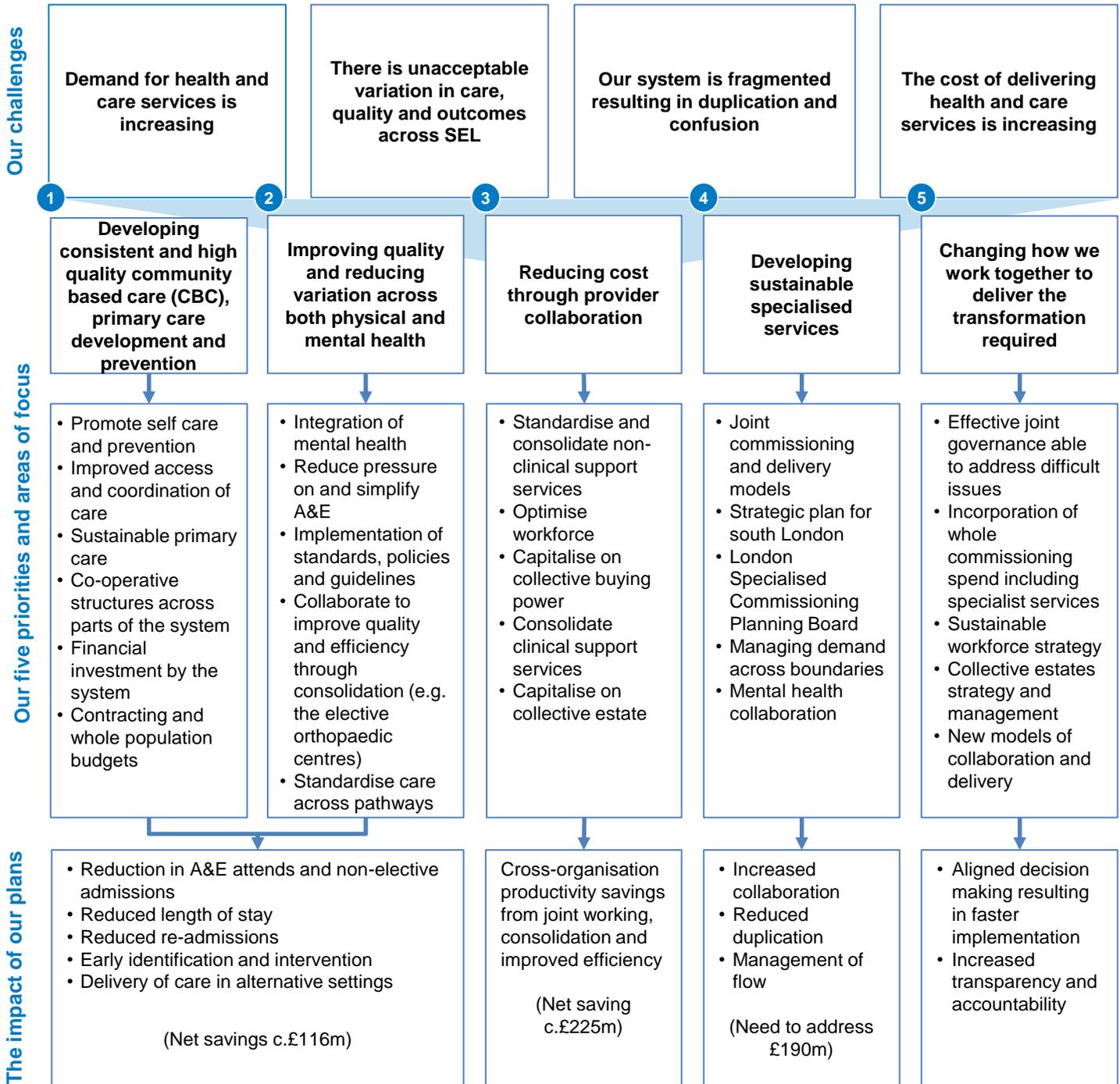
We wish to develop a sustainable, world class destination for specialised services that meet the needs of patients both locally and across England. Specialised services represent £850m of spend across SEL and are a significant part of the health economy, providing services at a local, regional and national 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 will review pathways, align services, and explore consolidation to support quality improvement and better value for money, especially in drugs and devices. 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 transformation required**

To deliver this plan we must establish the right governance, secure appropriate resources and address system incentives. 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 through the creation of a MOU and regular leadership events. 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.



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?	✓	✓	✓	✓
How will you develop the workforce you need to deliver?	✓	✓	✓	✓
How will you achieve and maintain financial balance?	✓	✓	✓	✓

We are building digital solutions into our plans. These are described across our priorities and in our Local Digital Roadmap

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;

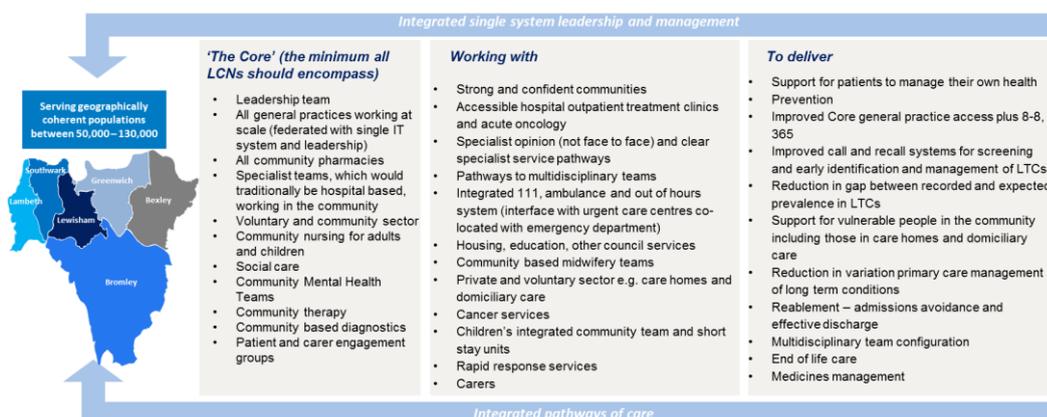
- Responsive services providing access from 8am – 8pm seven days a week;
- Secondary and tertiary prevention focussed on the physical health and wellbeing of people with enduring and significant mental health problems;
- Proactive secondary prevention, equitable and timely access, effective coordination;
- A systematic risk stratification and problem solving approach that addresses both physical and mental health.

Drawing on others from across the health, social care and the voluntary sector, 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 approximately £62m 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 improved access, resilience, development and care design recently outlined in the General Practice Forward View. We will aim to use national funding distributed according to the areas of greatest need to support delivery of agreed local and Pan London objectives and support sustainable and vibrant primary care. Some of this investment will generate savings in CBC but we anticipate that the main area of financial benefit will be in relation to unplanned and emergency care. 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. Our high impact schemes are shown below:

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 across SEL to drive a radical step change. We will support whole system approaches for issues such as obesity, mental health, diabetes, smoking and alcohol. One major initiative is the Healthier You: NHS National Diabetes Prevention Programme (NHS DPP), an evidence based behavioural intervention programme for individuals identified as being at high risk of developing Type 2 diabetes. In partnership with the Health Innovation Network, we aim to deliver over 4,000 places across South London CCGs and boroughs in 2016/17.
- *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 long term health conditions. 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 intervention and brief advice (IBA).* The Health Innovation Network will support the roll out IBA across health settings, social care and the criminal justice system, along with minimum standards which set out how staff can deliver.
- *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

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. 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 have established a workstream to support and facilitate this and 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 Forward 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:

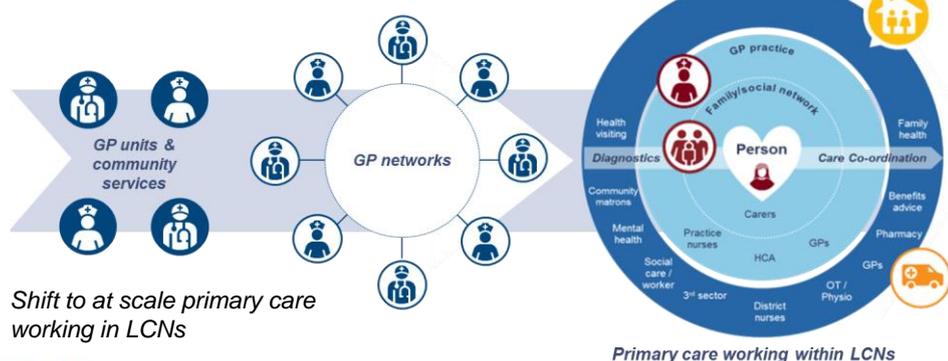
- To adopt the most effective approaches to screening for mental and physical health and call and recall;
- To work together to achieve the Primary Care Standards for London, including improved access;
- To develop and recruit to new roles, such as clinical pharmacists and care navigators;
- To achieve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

Enablers

Our Estate will be planned and organised around LCNs. Borough-based LCN hubs will be established to ensure that services are working well together – primary, community and secondary care – around the needs of the patient.

Our strategy is that LCN hubs are located within our better quality estate in each borough. While specific services will vary, they will house a range of health, social care and other services 7 days per week. Some hubs may operate as virtual hubs across a number of existing good quality facilities, GP practices and hospital sites.

Hubs will be fit-for-purpose, flexible, adaptable, accessible and be able to facilitate the shift out of the acute hospitals into the community. Where there is an absence of good quality estate, we will need to invest, potentially funding through proceeds from disposals and through accessing Estates & Technology Transformation Fund.



The Local Digital Roadmap (LDR) outlines SEL's digital ambition

At a high level 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

Achieving financial sustainability and improving outcomes will require us to introduce new models of care that are fully enabled by technology. Our plans will:

- Reduce our reliance on traditional face to face models of care in primary care and outpatient settings in favour of digital alternatives.
- Streamline referral, access to diagnostic services and the delivery of care in our hospitals by making the processes of care delivery paperless at the point of care
- Ensure that every interaction with the patient counts by making greater use of algorithmic decision support tools for clinicians working in all care settings
- Improve our ability to provide co-ordinated, proactive, care delivery to the most vulnerable people by consolidating and connecting up the many electronic record systems that exist today.

Many of our patients will continue to receive care from a number of different health and care providers some of which operate outside our local geography and if we are to move from existing models of face-to-face care, we will also need to make it easy for patients to make greater use of digital services. To this end, we will work with other STP footprints in London to '*connect the capital*'. Pursuing this common goal will allow us to (both) simplify and connect up our existing systems infrastructure in a way that supports the way that care is delivered to our patients. We have agreed to work across SEL to share information between the Local Care Record and Connect Care systems and have submitted an estates, technology and transformation bid to fund this work.

Moving forward in this way locally provides the pace required that will support the clinical transformation in SEL. In parallel we will look to collaborate with other STP footprints with the aim of interoperability. This may

mean establishing collective governance and utilising national funding sources where we can:

- At a local level, we will invest in technology leadership and support for change management. We will seek to exploit nationally and regionally provided technology services wherever we can.
- Working regionally, we will seek to connect the patient 'once', and to connect clinicians to all of the data that they need to deliver safe and well co-ordinated care.

We have devised realistic two year targets to within the LDR:

Within 1 year

- To have simplified the process of administering information sharing through the use of the pan-London data controller.
- To have connected our systems to a pan-London information exchange architecture and to have enabled the electronic sharing of electronic documents. Whilst this will deliver immediate clinical benefits it will also reduce postage costs.
- To be fully utilising e referral and demonstrating improvements in cancer treatment targets.
- To have developed a partnership model for informatics delivery that makes best use of specialist technology skills both within and across STP footprints.

Within 2 years

- To have enabled real time information exchange to support the care of people at the end of their lives and in so doing save (our share) of £150m savings potentially achieved through reductions in unwanted admissions to hospital.
- To have connected the patient and allowed them to exchange information via connected digital apps of their choice.
- To have universally deployed digital alternatives to face to face care in primary care and outpatient settings.

Our CBC plan includes a focused plan around prevention

Prevention has become a central tenet of national (and international) health and social care policy, recognised through the NHS Five Year Forward view with its call for a 'radical upgrade in prevention and public health'. The shift to prevention offers the opportunity to develop a shared approach across the STP footprint to invest in prevention to realise multiple benefits in relation to patient care, quality of life, health outcomes, health inequalities, and NHS financial sustainability.

These benefits and policy drivers have been recognised by leaders in SEL. Prevention and community based care (CBC) form the foundation of the SEL STP. Although there is a reduction in the national Public Health Grant allocations, local leaders have recognised that there will need to be concerted work together to deliver on our prevention priorities in a financially challenging climate, with particular focus on 6 prevention priorities shaped and delivered in line with Public Health England (PHE) and Healthy London Partnership (HLP) recommendations.

1. Smoking

The STP commits to a radical step change in community-based prevention, including the commitment that Local Care Networks (LCNs) will take holistic action on smoking. Collectively, SEL is delivering a strong tobacco control offer and is committed to the implementation of "Making Every Contact Count" as an opportunity to develop a consistent approach across the footprint. SEL will look to ensure that at national level, PHE and at regional level the HLP have developed a number of recommendations to support STP areas to develop systemic approaches to smoking prevention and to support the shift towards ensuring that those that most benefit from smoking cessation specialist support have better outcomes. At an SEL level, partners will build on the work of the SEL Illegal Tobacco Network and will work to ensure all SEL hospitals are smoke free.

2. Mental Health

The STP commits that SEL residents will be supported to have greater control over care of their mental health, and highlights the significance of mental health in meeting its commitments overall. There is some positive practice in individual boroughs, particularly around prevention with children, young people, families and the wider determinants of mental health. However, most mental health services are treatment rather than prevention focused and there is no systemic approach to early intervention or work with specific groups. This is an area of opportunity to collaborate at SEL level on developing consistent strategic approaches and workforce development; e.g. mental health first aid training.

3. Sexual Health

At SEL level, leaders have committed to: adopting an integrated sexual health tariff; providing an online service offer; shifting services to primary care; and targeting prevention and increased detection to groups with the highest rate of infections.

Contraceptive and screening services are widely available. Boroughs are increasingly using online services to empower residents to take a greater role in their own health and to support 'channel shift' for less complicated or asymptomatic cases to free up GUM services for more urgent and complicated care. We will explore opportunities across SEL to reduce duplication; e.g. combining websites and developing systemic approaches to effectively targeting services.

4. Alcohol

At an SEL level, partners have committed to implementing a pan-footprint alcohol identification and brief interventions offer across health and social care settings.

A range of alcohol-related prevention strategies are employed across SEL. There are support services available but the level of support is varied and embedded at different stages of pathways. There have been some positive developments, around use of wider powers to influence behaviour that SEL will consider systematising along with exploring opportunities to develop system-wide health messaging. We will look at how licensing can be supported to create an environment where alcohol licensing objectives are met as well as to promote sensible alcohol limits.

5. Obesity

There is commitment at SEL level to tackle obesity holistically through the Making Every Contact Count framework and through increased screening to identify individuals for targeted interventions such as social prescribing and weight management. Each borough offers varying degrees of obesity support but there are opportunities for a more consistent offer across SEL by systematising the use of wider powers, more effective partnership working and successful local programmes and health messaging. In particular, we will encourage a common approach to best practice to training, weight management and support for 'place shaping' to create a healthier physical environment. We will also encourage borough level Big Conversations across the SEL footprint with local communities who are most at risk of unhealthy weight.

6. Diabetes

As a National Diabetes Prevention Programme Pilot site, SEL already has a good offer for diabetes prevention in those identified with high risk. Prevention in this instance is consistently embedded into primary care, with strong examples of patient empowerment. We will look to build and enhance this work through shared learning across SEL and beyond to ensure consistency and to maximise the opportunities for multi-disciplinary team working and shared services. We will seek to ensure that there is a coherent offer to identify and provide appropriate evidence based interventions for people at risk of diabetes both through the NDPP and Health Checks.

Delivering on Prevention through Community Based Care

People in SEL are living longer, healthier lives than ever before. This should be celebrated, however, it is also putting our health and care services under increasing strain as people are living with more complex health issues, sometimes as a result of their lifestyle. There is pronounced social inequality in SEL, with approximately 49% of people in SEL impacted by inequalities and/or are putting their health at risk, and approximately 25% of people in SEL are in the early stages of suffering from a long term condition. Financial pressures mean that service transformation and increased capacity can only ever be part of the answer, with this in mind, the SEL STP focusses on prevention as a means of keeping people healthier for longer and reducing health inequalities. Specifically, public health authorities will work together with Local Care Networks to:

- Promote prevention, self-care, prevention and self-management by expanding accessible, proactive, preventative and self-management care for mental and physical health problems outside of hospital
- Deliver proactive primary prevention and demand management through secondary prevention, characterized by equitable and timely access and effective coordination
- Building strong and confident communities and involved, informed patients and carers

The shift to prevention is required to realise the multiple benefits in relation to patient care, quality of life, health outcomes, health inequalities, and NHS financial sustainability that Our Healthier South East London want to achieve.

Our Approach

With input from the Healthy London Partnership and Public Health England, and based on population need, SEL has identified 10 prevention areas that require focus:

1. Smoking and Tobacco Control
2. Mental health
3. Sexual health
4. Alcohol and substance misuse
5. Obesity and physical activity
6. Diabetes
7. Self-management
8. Health and the workplace
9. Dementia and ageing
10. Maternity and early years

We know that SEL has many examples of excellent prevention services, however demand on services is high and increasing. Therefore, our approach is to build on existing good practice by identifying and scaling up interventions that are already working locally to reduce demand, with additional improvements drawn from national and international examples of best practice. For many people, a GP is their first point of contact with the health system and someone with whom they have developed a long-term relationship of trust. For this reason, we see primary care as fundamental to the delivery of effective prevention services and will use the expanse of primary care in SEL to support the scaling up schemes that have been found to deliver benefits.

A detailed mapping exercise was undertaken to:

- understand current provision (and associated gaps);
- identify which schemes are likely to have the most significant impact in the priority areas; and
- identify those interventions that could potentially be scaled up to SEL level.

In SEL we acknowledge that although primary prevention is important, demand management through secondary prevention – for example supporting someone who recently been diagnosed with Type 2 to reverse the diagnosis through diet and exercise – is the key to the sustainability of services in the current financial climate. Therefore we aim to capitalise on all opportunities to improve demand management through secondary prevention.

The following section sets out the findings of the prevention profiling and the key elements of SEL's plan to improve the quality and consistency of prevention services across the footprint.

Delivery Overview – what we are doing now and the plans going forward

Based on current prevention profiling, the following table summarises the current offer across footprint prevention priorities and the high-level plans to improve service delivery across SEL. Please note that further analysis is required to identify the key areas of impact in term of reducing demand as outlined in the Prevention Delivery Plan (page 16).

	Current Provision	Moving forward
1. Smoking & Tobacco Control	SEL is delivering a strong tobacco control offer. Most boroughs offer stop smoking service, while well integrated with primary care, services could better address links with mental health.	At an SEL level, partners will continue the multifaceted approach including scaling up Making Every Contact Count (MECC) framework, increasing maternity smoking cessation services and continuing the SEL Illegal Tobacco Network.
2. Mental health	There is positive practice in individual boroughs, particularly around prevention with children, young people, families and wider determinants. As most services are treatment focused there is an opportunity to develop a systemic approach to early intervention or prevention for specific groups.	Collaboration at SEL level to develop consistent prevention and early identification approaches with attention for vulnerable groups. This will also include sharing digital platforms and workforce development; e.g. mental health first aid training.
3. Sexual health	Overall, SEL has a strong approach to sexual health prevention. Contraceptive and screening services are widely available and boroughs increasingly use online services to empower residents to take a greater role in their own health.	Continuing existing positive practice and using pan-SEL collaboration to optimise service delivery and reduce duplication; e.g. combining websites and developing systemic approaches to effectively targeting services.
4. Alcohol & Substance Misuse	While support services are available in each borough, the level of support is varied and embedded at different stages of pathways.	Focusing on the use of wider powers to influence behaviour, SEL will examine the opportunity to develop system-wide health messaging. SEL aims to improve outcomes and reduce spending by moving towards integrated commissioning across SEL (centred on prevention and early intervention).
5. Obesity & Physical activity	The SEL boroughs provide a variety of services for weight management and a number provide place based health promotion for children at schools. Several programmes exist that support people with making life style changes and provide (free) access to physical activity.	Commitment at SEL level to tackle obesity holistically through MECC and increased screening to support target interventions e.g. social prescribing and weight management.. Particular focus will be on integrating weight management with mental health services and making systematic use of wider programmes and health messaging. Moving towards standardised pathways and implementing the NHS 'let's get moving pathway' across SEL.
6. Diabetes	As a National Diabetes Prevention Programme Pilot (NDPP) site, SEL has a strong offer for diabetes prevention. Prevention approaches are consistently embedded into primary care, with strong examples of patient empowerment.	Continue the NDPP at a SEL level. We will look to build and enhance the programme through learning from each other, and elsewhere, to ensure consistency and maximise the opportunities for multi-disciplinary team working and shared services.
7. Self-management	Across SEL boroughs there is a variety of self-management support available, it is generally concentrated on reducing social isolation, health promotion in schools and targeted LTC self-management within primary care.	Over the next 5 years boroughs will share lessons and aim to create efficiencies by scaling practice and increase availability of effective self-management education and support.
8. Health and the workplace	Our Healthier South East London is developing a Healthier Workforce Strategy and internal commitments include the roll-out of the Healthy NHS programme. SEL is also supporting other businesses to adopt healthy workplace strategies.	To implement the Healthier Workforce Strategy and for example free health checks for staff, and integrate mental health in workplace prevention across SEL.
9. Dementia and ageing	There is good practice in SEL's offer for older residents with dementia, especially with regard to joined-up working across boroughs. For example, the Pilot Home Treatment Team (HTT) supports older adults with a mental health crisis across Lambeth, Southwark and Lewisham.	Continue current cross-borough practice and scaling the existing success of the Home Treatment Team across all six boroughs.
10. Maternity and early years	There are several programmes available across SEL that provide prevention for maternal health and nutrition, social and emotional development in the early years. SEL is working to improve the pathway for maternity smoking cessation services.	To implement the SEL business case on maternity smoking cessation services and widening Lambeth's experience with primary prevention with families in GP practices.

In addition to the 10 priority areas, SEL also aims to improve standards of care for AF and musculoskeletal health and improve the prevention, early detection and management of hypertension :

- **Atrial fibrillation and hypertension:** AF and hypertension are mostly addressed as part of general health screenings with lifestyle support and medication in primary care. In some boroughs people with AF are supported in specific pathways as secondary prevention against stroke. Under the STP, the stroke prevention pathways will be shared across the borough and increasing use of self-management and pharmacists to monitor hypertension to reduce demand for primary and secondary services. We will also link to the pan London-wide high blood pressure group, supported by the Healthier London Partnership, to share good practice and maximise opportunities for whole system approaches to improve the prevention, detection and management of high blood pressure.
- **Falls and musculoskeletal health :** Community services carry out most preventive action for the frail and older population, often taking a holistic approach addressing physical strength, the home environment and engaging with carers. Moving forward, OHSEL will develop a *Frailty Strategy* and has recently started work to standardise the MSK orthopedics pathway across SEL.

High Impact Areas

South East London Public Health authorities and CCG's will come together under the auspices of the OHSEL partnership to focus their attention on five high impact areas. This approach builds upon a strong existing track record of local collaboration. The 'high impact areas' are defined as the areas in which prevention will have the biggest impact on public health outcomes and demand for services and where the added value of the pan-SEL collaboration will be greatest in terms of creating efficiencies in service delivery and achieving outcomes. The proposed areas and actions are (to be signed-off by Dec 2016):

Area	Key actions (detailed to be developed as per delivery plan on following page)
Smoking & Tobacco Control	<ul style="list-style-type: none"> • Develop systemic approaches to smoking prevention • Continue and enhance the SEL Illegal Tobacco Network
Mental health	<ul style="list-style-type: none"> • Develop consistent prevention and early identification approaches with attention for vulnerable groups. • Sharing digital platforms and workforce development; e.g. mental health first aid training.
Alcohol & Substance Misuse	<ul style="list-style-type: none"> • Systemise use of wider powers to influence behaviour • Develop system-wide health messaging
Obesity & Physical Activity	<ul style="list-style-type: none"> • Implementing the Making Every Contact Counts framework consistently across the boroughs • Increased screening to support target interventions such as social prescribing and weight management programmes. • Integrating weight management with mental health services.
Diabetes	<ul style="list-style-type: none"> • Enhance the NDPP through learning from each other and elsewhere • Integrate public health within CBC multi-disciplinary team working and shared services.

In addition to improving patient outcomes, prevention and (in particular) demand management through secondary prevention can deliver significant financial benefits over time for the local health economies. These savings will primarily benefit health commissioners in the form of reduced A&E attendances and reduced hospital admissions. Because of pressure on budgets, local government is not currently incentivised, nor financially able to invest in public health, despite it being the right thing to do to improve outcomes and deliver the required financial savings in the long-term.

In the short term, we will, ensuring funding is distributed appropriately to optimise the clinical and financial benefits of preventive action. We recognise that increased investment can only do so much to increase prevention capacity. Therefore, using the STP as a vehicle, we will realign commissioning incentives for the NHS and local government, ensuring that resources flow to the area of the health economy where it will have the biggest impact, irrespective of commissioner. At minimum, this means sharing the risk and reward of commissioning prevention schemes between health and local authorities. We are also exploring the option of joint commissioning and coalescing around a shared outcomes framework for prevention. Please see overleaf the SEL high impact prevention scheme delivery plan, outlining how this will be successfully implemented.

Delivery plan for prevention

The plan below has been developed to be outcome-driven, in order to deliver on our prevention milestones by 2021.

2016/17	17/18	18/19	19/20	20/21
<i>Define priorities and agree plan</i>	<i>Agree a shared prevention outcomes framework</i>	<i>Commission agreed high impact schemes</i>	<i>Evaluation of operational schemes</i>	<i>Review of impact and development of 2021 plan</i>

Prevention – Key Actions and Milestones					
Establishing Prevention as a STP workstream	<ul style="list-style-type: none"> Borough prevention mapping (Complete) Detailed analysis of scheme outcomes and benefits Directors of PH to agree 5 key priority areas by Dec 2016 DPHs/CBC Executive Leads and CCG Chief Officer/LA Chief Executives agree prevention priorities and PMO resource – by December 2016 Appoint prevention programme steering group and SRO by Dec 2016 Development of spread plan by January 2017 Health and Wellbeing Boards validate delivery plans – January 2017 	<ul style="list-style-type: none"> Shared outcomes for prevention framework developed – April 2017 DPH/CBC Executive Leads and CCG Chief Officer/LA Chief Executives sign off shared outcomes for prevention framework – April 2017 	<ul style="list-style-type: none"> Ongoing monitoring and review of high impact schemes 	<ul style="list-style-type: none"> Prevention review – April 2019 Ongoing monitoring – 	<ul style="list-style-type: none"> Ongoing monitoring Impact review 2021 plan development
High Impact Scheme Delivery	<ul style="list-style-type: none"> Priorities agreed – December 2016 	<ul style="list-style-type: none"> Develop high impact scheme commissioning specifications – May 2017 Commission high impact schemes – July 2017 	<ul style="list-style-type: none"> High impact schemes go live – April 2018 	<ul style="list-style-type: none"> High impact schemes operational – ongoing Service specifications revised and schemes recommissioned if appropriate – July 2019 	<ul style="list-style-type: none"> Consistent approach to high impact public health prevention implemented across SEL

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	<ul style="list-style-type: none"> All local GP practices have agreed to an alliance and recognised as a legal entity 	<ul style="list-style-type: none"> Commissioner offer made to the alliance and contract in place in five of six boroughs 3 to 5 year business plan developed 	<ul style="list-style-type: none"> Population based budgets and risk based contracts being established
LCN integrated system leadership and management	<ul style="list-style-type: none"> Local Care Networks defined. LCN leadership team and management structure in place, with clear governance and decision making arrangements Local Estates Strategies with bids and business cases for hub development 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Reablement (including rapid response and supported discharge) across mental and physical health services. 	<ul style="list-style-type: none"> 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 Same day access to specialist advice and clinics 	
Proactive care standards and associated high impact schemes implemented	<ul style="list-style-type: none"> Active risk stratification 	<ul style="list-style-type: none"> Asset mapping and social prescribing patient liaison across networks addressing mental & physical health needs Enhanced support to vulnerable people in care homes, extra care housing and those receiving domiciliary care Training in motivational skills and health coaching Enhanced call and recall and screening for hard to reach groups including those with severe mental illness 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Active care registers within GP practices 	<ul style="list-style-type: none"> Identifying people at risk of developing LTCs including mental health conditions 	<ul style="list-style-type: none"> Patient/carer education programmes
Continuity of care standards and associated high impact schemes implemented		<ul style="list-style-type: none"> 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 mental health crisis care services as well as the acute oncology pathway to reduce demand on A&E.

Collaborate to improve quality and efficiency through consolidation

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

Integrating mental health services

30% of people with a long-term condition also suffer from poor mental health 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 reproposed 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 or alternative models explored.

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 models 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. Work is underway to explore how technology and sharing of information can prevent A&E attendances and admissions supporting the transformation required as well as how to make patients active and in control through technology.

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 and achieving this by Q1 2018/19.

@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 consolidation

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 are considering a 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:

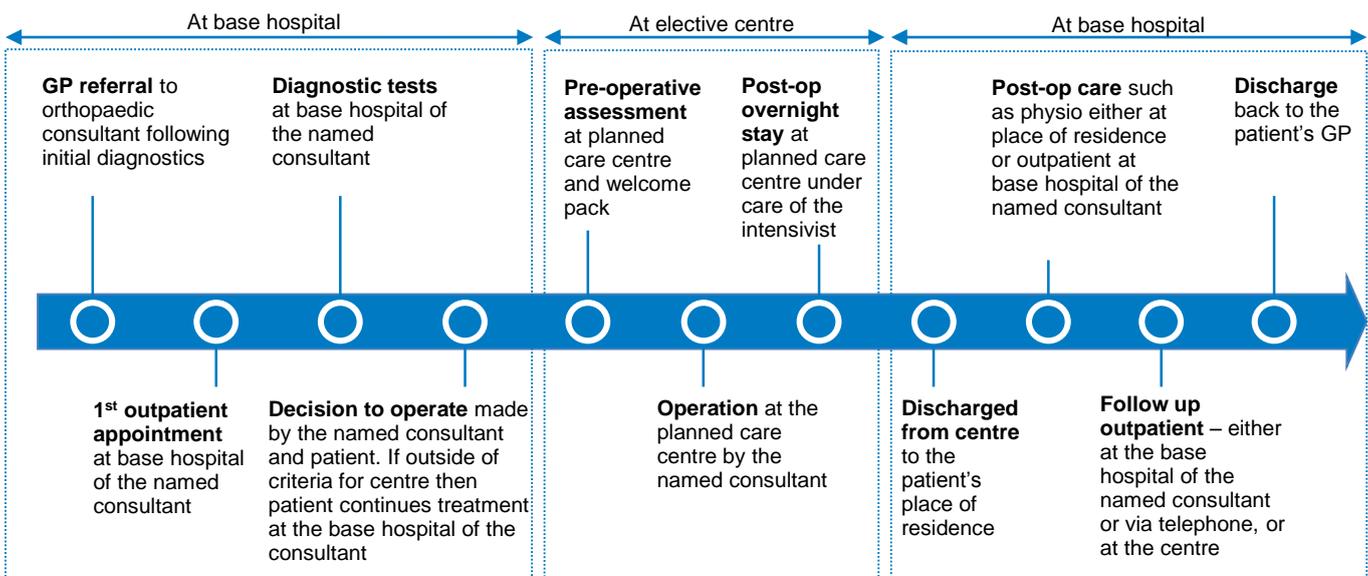
- Accurate and timely diagnosis utilising best practice in the assessment of elective orthopaedic conditions to enable rapid access for new and existing patients;
- Delivery of evidence-based treatments plans (where incidence rates make this possible) to enable improved treatment outcomes and the maximisation 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 pre consultation business case and clinical model enabling us to move towards consultation. 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 pre-consultation business case will be developed by November 2016 and be followed by a 14 week public consultation. This will enable the Committee in Common to decide whether to proceed in spring 2017.

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.

An Accountable Cancer Network in south east London

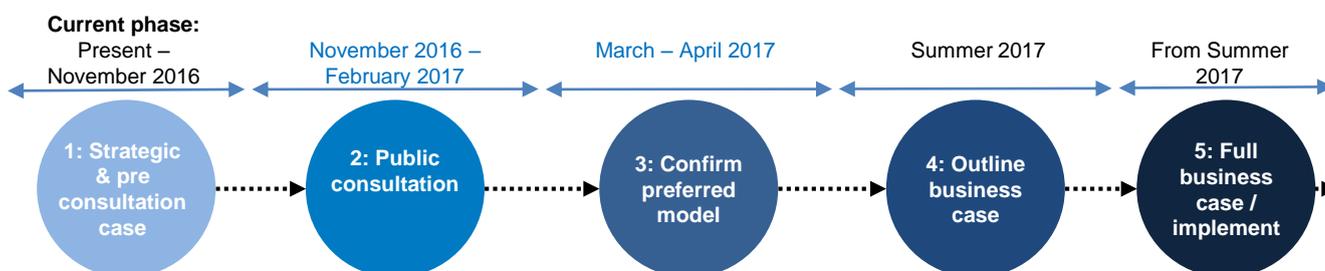
The three Trusts that provide cancer services are establishing an Accountable Cancer Network to provide a coordinated approach to the delivery of high quality cancer care across south east London working with commissioners. One of the key first priorities for the network is the sustainable delivery of 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 opened in September 2016. The centre will provide a consolidated a range of services previously located across SEL, helping to coordinate patient care; and will be a centre of excellence for cancer services, providing 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 early 2017.



Integrating mental health services

We want to improve mental health in South East London 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. SEL also has a large LGBT population, who also experience poorer mental health outcomes than the general population;
- 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:

<p>Community based care</p>	<ul style="list-style-type: none"> • 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 • Focus on integrated services to support people living with SMI, to increase and enhance their ability to live a life that encompasses meaningful work relationships and living conditions • 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
<p>Improving quality and reducing variation across both physical and mental health</p>	<ul style="list-style-type: none"> • Embed an integrated mind/body approach to support both the physical and mental health of patients and service users • Core 24 in place in 50% of SEL trusts by 2020/21 or sooner and alternative models agreed for remaining sites • 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 admissions and ceasing out of area treatments (OATs) • Ensure sufficient and appropriate capacity is available to meet future demand
<p>Improving productivity through provider collaboration</p>	<ul style="list-style-type: none"> • 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
<p>Optimising specialised services across south east and south London</p>	<ul style="list-style-type: none"> • 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.
<p>Standardised care across pathways</p>	<ul style="list-style-type: none"> • Improved access to appropriate mental health care supporting the implementation of the Mental Health Five Year Forward View • 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 winter 2016/17, 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 breast, bowel and cervical screening; and supporting locality teams to provide ongoing support post-discharge. In tandem, we have been working with general practice to promote the use of cancer care reviews for everyone diagnosed with cancer.
- *Improved coordination of care during the diagnosis and treatment phases:* streamlining care to ensure all patients have a holistic needs assessment and care plan from diagnosis to treatment, to support the sustained delivery of 62 day cancer waiting times standards and to ensure that patients are kept well informed and can access clinical nurse specialist or other key worker 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.
- Providing consistent alternative referral or conveyance pathways for agreed conditions (e.g. elder fallers, alcohol) for the ambulance service to utilise rather than conveying patient to A&E)
- *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 LD/ autism are supported in community settings with good quality, responsive services.
 - Ensure consistent transition planning for all children from aged 14 upwards to plan how they will live as independent adults wherever possible
 - Enhance crisis intervention for people with LD and/ or autism where people are at risk of being admitted to hospital to prevent admission
 - Develop proactive support for people with LD and/ or autism so that people can live independently in the community settings
 - Improve hospital care and discharge planning for people with LD and/ or autism.

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.

Specifically we aim to deliver the full implementation plan for the Mental Health Five Year Forward View for all ages, including:

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- Reduce suicide rates by 10% against the 2016/17 baseline;
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals;
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard;
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic

care and support;

- Eliminate out of area placements for non-specialist acute care by 2020/21;
- Increase access to evidence-based specialist perinatal mental health care, in line with the requirement to meet 100% of need by 2020/21, and ensure that care is in line with NICE recommendations; and
- Health and care commissioners should develop a pan-London multi-agency (including the police and ambulance service) case for change and model of care for child and adult mental health patients in crisis

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 Greenwich), 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.

Implementation of standards, policies and guidelines

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. In the immediate term South East London commissioners and providers have worked together to agree a Cancer Improvement Plan seeking to address earlier detection and faster diagnosis and treatment for people with suspected cancers. This includes action to improve access to diagnostic capacity within the first seven days of referral and the more consistent delivery of timed pathways of care for more patients.

We aim to 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;
- Support improved decision-making and patient choice;
- Review diagnostic capacity to ensure timely diagnosis and pathways of care;
- Create additional capacity with the opening of the new state of the art Comprehensive Cancer Centre at Guy's Hospital and new chemotherapy and radiotherapy facilities, closer to peoples homes in outer south east London, 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 £116m.

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.

All of the savings presented below 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.

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	52.0	(61.8)	(9.8)
Reduction in demand for and increasing efficiency of urgent and emergency care (adults)	70.6	(7.8)	62.7
Planned care transformation	40.7	(4.5)	36.2
Reduction in demand for and increasing efficiency of urgent and emergency care (children and young people)	7.6	(0.8)	6.8
Maternity care transformation	6.3	(0.7)	5.6
Cancer care transformation	16.8	(1.9)	15.0
Total	194.0	(77.6)	116.4

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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 Plan to achieve pan-London s136 pathway and HBPOS specification 	<ul style="list-style-type: none"> Priority 7-day standards in place for 50% of population Enhanced emergency department front door 	<ul style="list-style-type: none"> 7 day services in place for 95% of population Urgent and emergency care facilities spec compliant
Planned care	<ul style="list-style-type: none"> Elective care centres pre consultation business case and consultation GSTT and LGT meeting referral to treatment standard 	<ul style="list-style-type: none"> Elective care centres decision All providers meeting referral to treatment standard 	<ul style="list-style-type: none"> (If agreed) Elective care centres build and go live 	<ul style="list-style-type: none"> Elective care centres benefits realisation
Cancer	<ul style="list-style-type: none"> Support development of Accountable Clinical Network SE London Cancer Improvement Plan to address Cancer Waits Standards, including review of diagnostics demand and capacity Opening of Cancer Centres at Guy's and Queen Mary's Develop and implement training and education package for primary care to support earlier detection and improved support to people living with cancer as a long term condition 	<ul style="list-style-type: none"> 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 Delivery of timed cancer pathways to support achievement of faster diagnosis and 62 Day treatments cancer waiting times standards Roll out and evaluate primary care training and education package Recovery Package available to patients 	<ul style="list-style-type: none"> Implementation of consistent community based care offer to support those living with and beyond cancer including addressing mental health needs Full implementation of diagnosis provisions for NICE guidelines and GP access Implementation of breast, prostate and cancer patients access to stratified pathways of care 	<ul style="list-style-type: none"> Improved care coordination and streamlined patient flow through the system through implementation of care navigators
Children and young people	<ul style="list-style-type: none"> Development of SEL children and young people population planning network 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Strengthened primary care to support and treat children and young people

Milestones over the next five years, cont.

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
Maternity	<ul style="list-style-type: none"> • Maternity performance dashboard, • Standardised information on birth setting choices 	<ul style="list-style-type: none"> • Standardised maternity specification, including mental health • Saving Babies Lives care bundle implementation • Agreed obstetric consultant cover trajectory 	<ul style="list-style-type: none"> • Increased out of labour ward births • Local continuity of care ambition achieved • Promoting mental and physical wellbeing and identifying high risk women 	<ul style="list-style-type: none"> • Full access to local specialist perinatal mental health services • 20% reduction in stillbirths
Mental Health	<ul style="list-style-type: none"> • Identify gap and plan for delivery of Core 24 model • 3 of our 6 (50%) boroughs to have designated HBPOS in line with the specification requirements • Consistent acute and MH pathway developed across SEL • Opening of St. Thomas' ED including new MH facilities, finalise plans for PRU and QEH • Review drug and alcohol services demand, develop social care links • SEL plan developed for ceasing OATs across footprint • Develop training and education and measures for community workforce and commence 2 pilots 	<ul style="list-style-type: none"> • Determine appropriate model, workforce and wave 1 funding • Implementation of Acute and MH pathways across SEL • Evaluate outcomes of St. Thomas' MH facilities & review other SEL ED facilities • Revise models that can be applied across SEL with aim of having 50% of acute sites with appropriate models in place • Standardised care pathway developed for all OATs across SEL in place across half of SEL boroughs • Determine perinatal MH training 	<ul style="list-style-type: none"> • Continue implementation and wave 2 funding • Provider development programme continued • Up-skilling and recruitment of specialised staff • Testing new models and evaluating • Revise models that can be applied across SEL with aim of having 75% of acute sites with appropriate demand models in place • Implementation of plan and standardised care pathway achieved SEL wide • Funding to support development of specialist perinatal community teams 	<ul style="list-style-type: none"> • Bid for wave 3 funding – all models in place • All boroughs will have a designated HBPOS • By Q4 19/20 other agreed models implemented • 24/7 access to community crisis resolution teams and home treatment teams • Digital solutions • Commission community eating disorder teams

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 £225m through economies of scale and removing duplication, and we expect to see improved outcomes and quality. Opportunities for collaboration are outlined below:



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 through the appropriate engagement and decision-making mechanisms 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:

- A provider board chaired by a chief executive
- Memorandum of Understanding;
- 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.

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 credible in the given timeframe. An investment strategy needs to be developed to understand the impact across individual organisations. 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 3 months

In the next 3-6 months we plan to:

- Establish a multi-disciplinary, multi-organisational provider board chaired by a CEO
- Agree with each SRO the resource requirement to develop investment ready business cases
- Develop a PMO and analytics function
- Establish a schedule and timeline for each initiative and develop the governance and sign off route for each programme
- Realise quick wins in payroll, clinical and non-clinical sourcing and category management

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.

We have agreed that insourcing will be pursued, as opposed to outsourcing, and further discussions are being held to choose the final model. 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.
- Working with the Ambulance Service in London to ensure appropriate workforce is in place so that, where appropriate, patients can be treated on scene and discharged e.g. training and educating paramedics into newly defined roles i.e. advanced practitioners

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, we will first create an outline business case, or 'Case for Change' that will describe how we intend to reduce agency spend and explore the idea of a shared bank. We also 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 led 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.

We intend to leverage existing pharmacy and medicines optimisation work, and integrate current initiatives into this area to drive the work forward.

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 total approximately £225m.

The largest savings stem from capitalising on our collective buying power, £62m, 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.

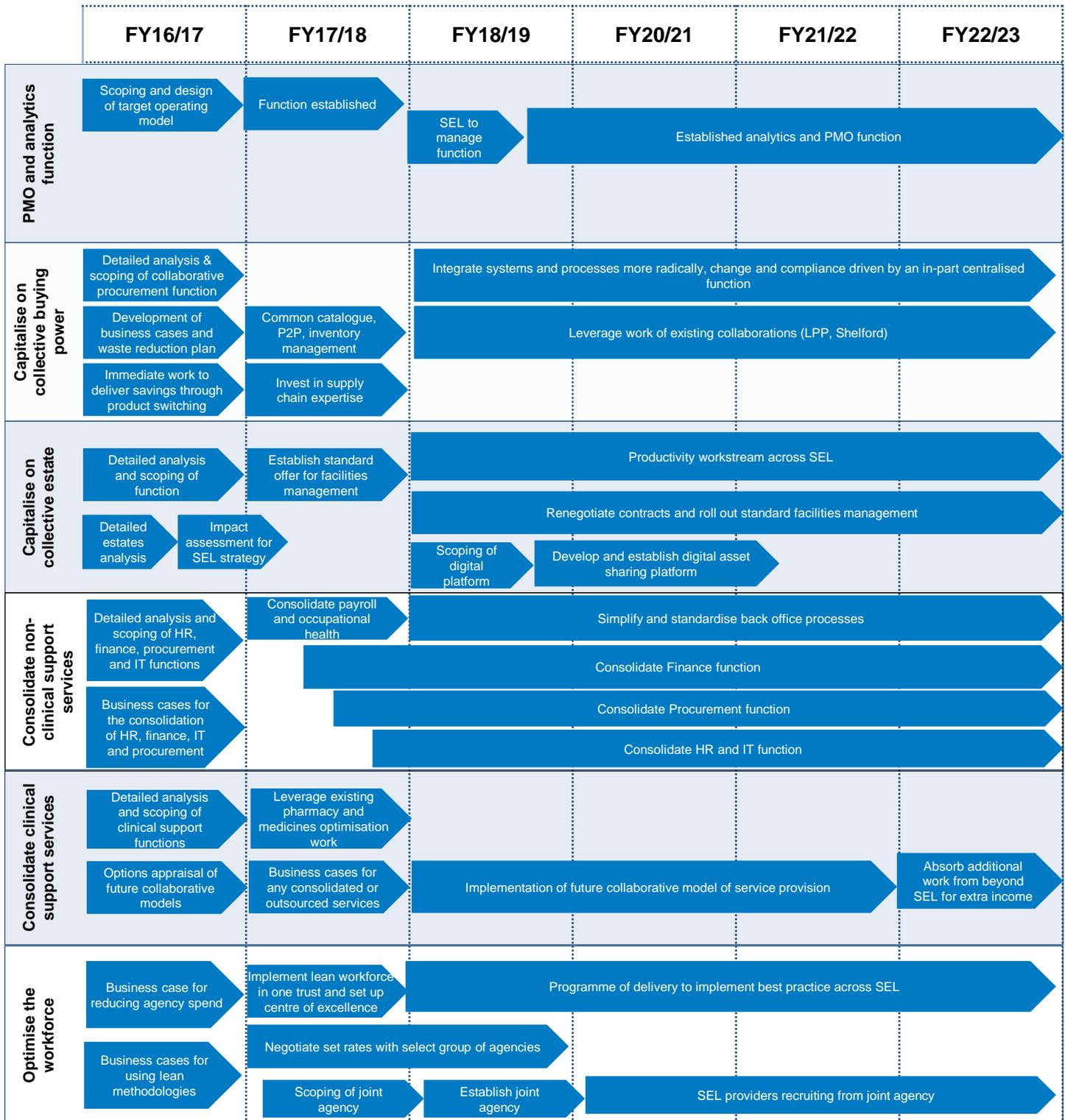
Further work is required to validate and refine these investment requirements prior to implementation of the proposed changes.

All of the savings presented below 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 £189m of BAU savings already achieved in the system. Work to confirm that there is no overlap with these existing programmes continues.

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	34.0	(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		£225.2	(35.4)	

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

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. They tend to be provided by hospitals that can recruit a team of staff with the appropriate level of expertise, often with research interests.

There are nine providers of specialised services in south east London, and £850m spend. Most is spent with our two largest providers: Guys and St Thomas' (£410m) and King's College Hospital (£312m), with Lewisham and Greenwich accounting for a further (£43m). South London and Maudsley (£41m) and Oxleas (£19m) provide specialised mental health services. The catchment for these specialised services stretches well beyond London - one third of all activity comes from outside south east London, with the most significant flows from Kent and Medway and Surrey and Sussex (particularly in renal dialysis, cardiac surgery and paediatric neurosurgery), while the growth in referrals from this wider region currently exceeds local growth. The size of specialised services in south east London has a direct impact on the sustainability of our system, both in terms of financial sustainability and the quality of other services. The potential impact to the south east London system of any change to these flows, decisions for repatriation or associated local developments cannot be underestimated.

The case for change in specialised services

We face a number of challenges in specialised services:

<p>We need to do more to manage demand and the rising costs of provision</p>	<p>At a national level we are seeing a rising demand for specialised services, driven by advances in science and an ageing population, which has prompted an increased demand for specialised care. We are also experiencing an increase in spending at a much greater rate than other parts of the NHS which is expected to continue, in a large part due to the increasing volume of expensive new drugs and new technologies.</p> <p>In south east London we are experiencing an increase in the number of patients coming to be treated from outside London.</p>
<p>We are not always joining up services and treating patients in the most appropriate place</p>	<p>Across London specialised services can be fragmented. There are gaps in provision and disconnects between specialised, non-specialised and local services, and treatment not being provided in the most appropriate place. In south east London we are faced with particular issues in mental health, with London patients being referred to beds/services outside of London while children and young people cannot always access age appropriate inpatient mental health services when they need them.</p>
<p>Services are not being delivered in the most efficient way</p>	<p>We also have a high level of services overlap in south London – most of which is in areas of high spend. The close proximity of similar services across south London offers opportunities for efficiencies, but attempts to create larger and more effective specialised units have often been contested.</p>
<p>The quality of our services varies and we are not always meeting our own standards</p>	<p>In south east London specifically, we have significant performance challenges and are not consistently achieving targets across acute specialised services. This includes issues with the 62 day cancer wait target, and a large number of patients waiting over 52 weeks in neurosurgery and orthopaedics.</p>

Our financial challenge

As well as addressing quality and performance challenges, we are considering ways in which we can address our projected financial gap in specialised services. In June, the 'do nothing' specialised commissioning financial challenge was estimated at a cumulative £190m over five years. Since then we have been developing a finance and activity model to refine, a greater level of detail, this provisional financial challenge associated with pan-London specialised commissioning. We are working with NHS England to reconcile the growth assumptions underpinning this model and agree the scale of the challenge. We are also working with our neighbours and surrounding regions as we plan initiatives to address our challenges.

Our aims for south east London

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

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

The majority of specialised service pathways for our population are delivered by the trusts within King's Health Partners (KHP) and St George's. As an Academic Health Sciences Centre, KHP is a key driver of specialised service development.

KHP work already underway seeks to address some of our local challenges, including strengthening haematology, cardiovascular, clinical neurosciences and children's services. There are significant opportunities to improve the coordination between specialist and local

care through network models, and further optimize the specialist elements of these services with research and training across the specialist sites. Guy's and St Thomas' vanguard project with Dartford and Gravesham also includes a focus on paediatric, cardiac and vascular care pathways which will support and align with wider work on specialised services and improve outcomes for residents of east Kent.

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

We are also embarking on a trial across south London to test a new way of managing budgets for specialised mental health services. This would see the three mental health providers (SLaM, Oxleas and South West London 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.

Focus areas

Through reviewing our performance and quality issues and areas of highest spend, and our work with Kings Health Partners, we are suggesting three area of focus to explore further: Pathway transformation, Drugs and Devices and Improving Value.

In delivering these, we will take a collaborative approach to commissioning services on a STP or multi STP footprint. This will include planning and designing services together and providing financial incentives for pathway improvement, supported by the pooling or delegation of budgets as appropriate as well as reforms to the payment and contractual system. We will take this forward in 2016/17 through a collaborative commissioning approach to adult secure mental health services.

Pathway Transformation

i. Aligning services across south London

In south London we have eight acute specialised providers, including three large providers with contracts over £150m (Guy's and St Thomas', Kings College Hospital and St George's) which are geographically extremely close – the furthest distance between them is just 7 miles. There is considerable overlap in the services provided at these hospitals. Commissioners have initiated a programme of work to identify the future optimal configuration for these services to be clinically and financially sustainable and deliver the best patient journey. This work will also consider the patient flows into London from the South East.

ii. Pathway reviews

We are reviewing how we deliver the most effective and high performing services. The Specialised Commissioning Appendix sets out the areas of initial focus at a pan London and south east London level. The Priority areas are Paediatrics, Cardiovascular, Specialist Cancer, Renal, Neuro-rehabilitation, Neuro-surgery, Vascular Services, HIV, Adult secure mental health, CAMHS and Transforming Care Partnerships.

Drugs and Devices

We will work closely with clinical colleagues and partners to bring forward system-wide benefits to improve the value that the NHS gets from our significant investment in high cost drugs and devices. We will engage with patients and carer representatives on the CRGs on the medicines optimisation programme to improve the value and outcomes for patients.

Improving value

In line with the national commissioning intentions we will engage with important areas of work to drive improved value including fragile services, reducing variation and use of national CQUINs.

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.

A system wide delivery plan to underpin the STP plan is in progress via a series of workshops for SE and SW commissioner and provider teams (with the first 2 workshops scheduled for 2nd and 17th November). This will support agreement of early deliverables focussed on the clinical case for change, out of area patient flows, network models, activity growth, public engagement and potential for improved patient pathways.

Delivering our plan will require a change in how we work and what we do

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

This will require the space for new conversation to take place throughout the health and social care system:

- Conversations that are inclusive of staff and local people;
- Conversations that are honest and where necessary challenging; and
- Conversations that are compassionate and respectful of the very real day-to-day pressures faced by individuals and organisations working to improve the lives of people in SE London.

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

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

In recognising that the STP is not meant to be a regulatory body, we've begun to define our role.

STP Role in Delivering CIP/ QIPP Plans

- SEL STP will understand business as usual CIP/ QIPP plans and recognise that individual organisations will be responsible for delivering those alongside regulators.
- SEL STP will be responsible and take an active role in strategic coordination and designing areas collaboration, and be accountable for collaborative programmes.
- SEL STP will continue to explore opportunities for collaboration and seek opportunities to solve problems which are best tackled on a footprint- wide basis.

STP Role in Delivering Performance Plans

- SEL STP will understand business as usual supply and demand pressures on healthcare; individual organisations remain accountable to their regulator.
- SEL STP will provide a strategic coordination function to monitor our progress to meet performance targets.
- SEL STP will problem solve and explore opportunities to enhance our performance position where this makes sense on a footprint-wide basis.

STP Role in Financial Strategy

- SEL STP will maintain a financial model which will provide the strategic framework for planning and will work with organisations to build a collective understanding of this framework.
- Organisations are accountable for their own control totals; the SEL STP will monitor the collective control total which is the net sum of the in-scope organisational control totals.
- Monitoring the collective control total will be the responsibility of the quartet and the Strategic Planning Group; the monitoring role will allow system leaders (where required) to pursue further savings opportunities that are best tackled on a footprint-wide basis.

Fit-for-purpose governance needs to be developed so that the STP delivery phase has a solid foundation.

A number of proposed changes to the current OHSEL governance structure to make it more fit-for-purpose have been created. The changes are meant to be more practical and sustainable to allow for a joined-up approach to working collaboratively across the system.

The proposed changes are:

- There should be **distinct and defined roles** and responsibilities for the Strategic Planning Group (SPG) and the Quartet.
- The **SPG** sets the strategic direction, and will continue its role setting the overall direction for the STP and be the sign-off point for STP plans, the **Quartet** will be the body that meets monthly to keep executive oversight of the programme.
- CEO and CO's need to continue to meet regularly both with each other and on their own. As part of **this there should be a monthly provider CEO meeting.**

The provider productivity work has reached the stage where it needs a separate board constituted differently, perhaps with a chief executive chair. This programme board would oversee the entirety of the productivity programme.

Underneath that would be a project board for each of the five productivity workstreams. The project boards would be supported by a designated project manager for each area. The role of the Project Manager would need to include responsibility for driving the work forward on a day-to-day basis, regular reporting to the respective project board, risk management and benefits tracking.

- So that even resource is allocated to the system re-design work and the collaborative productivity work, it is proposed that like collaborative productivity, **system re-design also has a programme board** which sits across the various CLGs. The Clinical Executive Group (CEG) have fulfilled this role to an extent in the past, however, it's membership would likely need to change if it were to become the system re-design programme board. There may be value in retaining CEG for specialist clinical input, and having a differently constituted group to oversee the implementation of the system re-sign workstreams.
- It would be expected that both **programme boards monitor progress** and, where appropriate, **escalate issues and risks** to the Quartet and the SPG.
- PPAG would continue to provide patient voice.
- CEG, DoS and the Finance & Technical Group should provide specialist advice and perspectives (acknowledging that CEG could become the system re-design board).
- It is proposed that **communication and engagement be added** to the governance structure **as an enabler**. As we move into delivery, communications and engagement is increasingly important and needs to be deployed in a targeted way so as to support the delivery of the STP.

It is also proposed that there is stronger programme management infrastructure and processes to provide decision making governance groups with insight and equip them to take action. Examples are:

- **Governance groups will receive regular reports** on each element of the programme. The reports will clearly highlight where progress is being made or otherwise.
- **Cover notes** for papers and reports **highlight the decisions that need to be made**.
- **Clear change control processes need to be put in place**. Presently, executive groups, do not have clear oversight of the changes being made within CLGs and amongst the Finance Directors. Where changes are proposed by stakeholders, these will be recorded and escalated to the Quartet and the SPG within a report which highlights the financial and non-

financial implications of the proposed change. The Quartet and the SPG will then have the choice to approve the change.

Additional tools and key documents that will support a new governance structure have been identified to support the shift to implementation.

Delivery Plans

The only way the STP can be delivered is through the groups responsible for delivery (the CLGs and the enabling and productivity groups) having:

- Clear plans for delivery
- The right leadership, membership and resources
- The backing of constituent organisations

The STP Programme will continue to further develop the delivery plans with intervention detail. These will provide a view on how to obtain real progress across each intervention be reviewed by the Clinical Leadership Groups (CLGs) and other delivery group SROs.

Memorandum of Understanding

To begin the process of building greater integration between health and care as well as accountability across and within organisations, we're developing a system-wide MOU. The MOU will set out how providers and commissioners will work together as a SEL system to make decisions to improve patient care, outcomes and financial sustainability. Following feedback and iteration, each organisation will be asked to sign off the MOU and the principles of collaboration within.

The MOU framework includes:

1. The role of the STP and our forward financial strategy
2. Overarching principles of collaboration and decision making
3. Governance structure amendments and specific roles

A full draft of the MOU is included in the appendix;

Central monitoring via the PMO

The PMO will be able to track the implementation of delivery plans. The key measures that the PMO will gauge are:

- Pace of delivery
- Meeting milestones
- Risks by organisation to deliver

Monitoring through designed information systems

In parallel with tracking progress of meeting delivery plans, we will create information systems which monitor the financial and non-financial benefits the STP is set to achieve. Two examples below are tools for activity monitoring and financial monitoring.

Activity monitoring

To monitor the changes in activity that the clinical interventions are set to achieve, we have begun to create a balanced scorecard. The SEL balanced scorecard is founded on specific key performance indicators (KPIs), relative to the set of interventions identified in the STP.

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

As part of delivering the NHS Five Year Forward View, Dartford and Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust have been selected to be a "Vanguard" site to deliver new systems for acute care. Dartford & Gravesham faces challenges in terms of financial sustainability and the clinical sustainability of some of its services. It also recognises the need to plan for healthcare in the new town of Ebbsfleet which is rapidly expanding. DGT therefore sought a partnership with a major tertiary provider to test out how such a partnership could address these issues and ensure good quality and seamless services for local people through collaborative working without the cost, including opportunity cost, of a merger or acquisition.

DGT and GSTT are working collaboratively to develop a Foundation Healthcare Group model with the vision to develop a sustainable local hospital model without merger or acquisition activity that makes best use of scarce resource and can be replicated across the NHS. It will improve outcomes and access, reduce costs and meet challenges of increased demand.

The Trusts are pursuing the Foundation Healthcare Group model to develop a collaborative model for hospital providers that offers better value and a set of organising principles than the current standalone model. International evidence suggests that the Group model could support the health economy to reduce the health and wellbeing, care and quality, and funding and efficiency gaps.

The vanguard will deliver:

A collaborative, non-acquisitive group model that will enable a DGH to be financially sustainable long term

A model that will enable smaller healthcare providers to gain benefits of scale needed to overcome financial and clinical challenges

A model which will enable smaller providers to benefit from a group brand, achieve economies of scale but retain local accountability and relationships

The Vanguard has identified a series of benefits that are being tested through clinical workstreams. The key benefits are:

Improved clinical outcomes and reduce unwarranted variation by using common governance to drive shared information and knowledge, collaboration, network building, pathways, assets and capabilities

Enhanced patient experience by localising care, improving access to services and clinicians and by creating a consistent and navigable experience

Increase in the safety / quality of services provided through timely sharing of patient and diagnostic information and the convergence of pathways

Greater resource sustainability through a new, replicable group model that will drive clinical and non-clinical efficiencies and scale economies..

The ability of the Vanguard to fully deliver the benefits of the group model is dependent upon access to capital to invest in the digital and imaging platform that will enable the clinicians to work together in a more effective way and to prevent patients from unnecessary travel and duplication.

Lewisham devolution pilot

Lewisham Health and Care Partners are working to achieve a sustainable and accessible health and care system which better supports the local population to maintain and improve their physical and mental wellbeing, and to live independently. As a devolution pilot, Lewisham is testing out the freedoms and flexibilities needed within estates and workforce specifically which could accelerate the achievement of that vision.

A key element of the Lewisham vision is the delivery of community based care through neighbourhood care hubs. As a devolution pilot, Lewisham is working with NHS Property Services, Community Health Partnerships, London partners and sub-regional strategic estates boards to identify what would help facilitate the release health and care estates across the borough and enable reinvestment locally to provide fit for purpose premises and make services more accessible.

Lewisham is also keen to develop new workforce approaches informed by the Buurtzorg model developed in the Netherlands. Working with Health Education England, Skills for Care and professional bodies amongst others, Lewisham's devolution pilot is focused on the development of enhanced and hybrid health and care roles which support integrated and holistic delivery.

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.

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. Based on plans, this was estimated to be £592m 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 £854m, reducing to £592m once efficiencies have been achieved at 1.6% per annum across our five provider organisations and including commissioner BAU QIPPs.

The green bars then demonstrate the impacts of collaborative productivity measures in reducing provider expenditure. In total these are estimated to contribute savings of £225m 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.

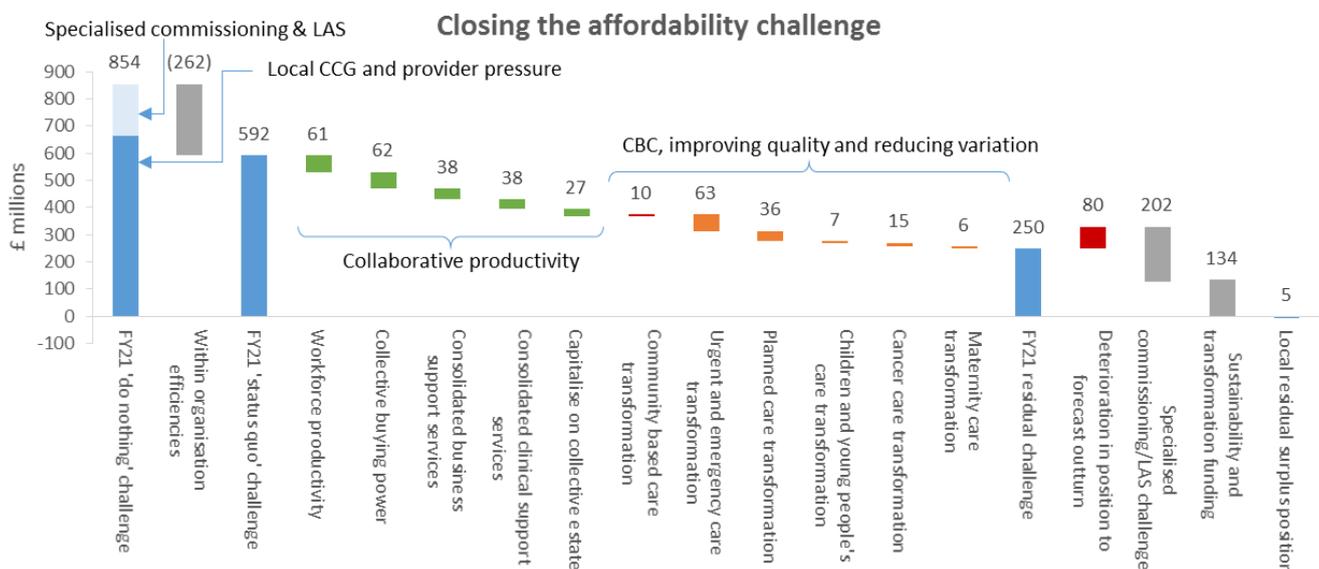
The red bar, then demonstrates how there will be a net investment of £10m for community based care. However the implementation of Local Care Networks, along with other changes in services and proposed pathway redesign, leads to considerable savings across a number of care areas (demonstrated in orange below). In total, net savings of £116m are estimated due to this reduction in demand and variation. Within this, the largest savings relate to reductions in demand for urgent and emergency care, worth £63m by 2020/21.

Thus, bringing these savings together, reduces the FY21 affordability challenge for south east London to £250m.

However, recent work to consider 2016/17 in-year performance has deteriorated this position to a deficit of £80m in 2020/21.

This does not include any additional funding from national bodies to support transformation. Indicative Sustainability and Transformation Funding of £134m has been announced by NHS England for south east London¹. Early access to this amount is required to deliver the scale of transformation. This investment would reduce the challenge to £196m, with £202m related to specialised commissioning and the London Ambulance Service for which savings plans have not yet been developed.

If ongoing work is able to fully address these pressures, then a system-wide planned surplus of £5m (0.1% of total system revenue) would remain by 2020/21.



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

Capital expenditure

There is recognition that the south east London STP, alongside the rest of the NHS, is operating within a constrained capital environment. As such, the capital expenditure required to deliver planned strategic changes across the sector has been limited where possible. The initiatives set out in this document mainly consist of changes to where care is delivered and efficiencies from consolidating corporate services. These opportunities require minimal investment to supplement existent capacity, equipment or real estate.

The table below outlines the forecast 'do nothing' capital expenditure for south east London, distinguishing between those schemes that are internally funded (i.e. from donations and cash reserves), those which are externally funded but already approved and those schemes for which approval is still being sought.

Currently, this 'do-nothing' capital expenditure forecast across south east London is £1,138m over the five years to 2020/21. Within this £153m is as-yet unapproved planned capital expenditure from 2016/17 to 2020/21, split between £100m for Guy's and St Thomas' NHS Foundation Trust and £53m for Lewisham & Greenwich NHS Trust. These unapproved capital expenditure schemes are very important for the continuation of provision of services within the footprint. In particular they include works that will allow Guy's and St Thomas' to meet national access standards and Lewisham & Greenwich to continue to provide endoscopy services.

The table below provides an overview of planned capital expenditure across the sector over the next five years.

£m	2016/17	2017/18	2018/19	2019/20	2020/21	5 year total
Internally funded	170	145	142	126	121	704
Externally funded but approved	143	75	30	25	8	280
Sub-total 'do nothing' capital expenditure	313	220	172	151	129	985
Awaiting DH approval	6	48	43	30	27	153
Total 'do nothing' capital expenditure	319	268	215	181	156	1,137

In addition to the above, there are a number of items of capital expenditure required in order to deliver the transformation schemes set out in this document. These include the following:

- Primary care estates transformation: £99m
- Primary care technology transformation: £23m
- Local digital roadmaps: £35m
- Elective orthopaedic centre consolidation: £12m
- **Additional 'do something' capital expenditure: £169m**

Business cases will be developed to support bids for funding the above capital expenditure.

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	<ul style="list-style-type: none"> • GPs to have formed federations or alliances and are recognised as a legal entity • Local care networks defined • Proactive and coordinated care: Active risk stratification and care registers within GP practices • Continuity of care standards achieved (Q1) • Accessible care including 8 to 8 in at least three boroughs and urgent care
Improving quality and reducing variation	<p>Development of a:</p> <ul style="list-style-type: none"> • Strategic outline case and consultation on Elective Orthopaedics • Cancer centre and education and training package developed • Front-door streaming specification finalised
Provider collaboration	<p>We have the potential to make the savings this year from our collective productivity programme through:</p> <ul style="list-style-type: none"> • 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
Specialised	<p>Development of:</p> <ul style="list-style-type: none"> • 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 £220m in addition to other efficiencies.

CCG	2016/17 planned QIPP savings (£m)	Provider	2016/17 planned CIP savings (£m)	2016/17 planned income CIPs (£m)
NHS Bexley CCG	8.5	GSTT	78.0	16.2
NHS Bromley CCG	8.6	KCHT	38.4	11.6
NHS Greenwich CCG	15.5	LGT	23.4	-
NHS Lambeth CCG	9.2	Oxleas	8.1	-
NHS Lewisham CCG	6.8	SLAM	22.4	8.4
NHS Southwark CCG	6.7	Total	170.3	36.2
Total	55.3			

