



DRAFT

South West London Five Year Forward Plan



Start well, live well, age well

October 2016

APPENDICES

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Appendix A - Approach to delivering national and other clinical priorities

i. Children - Emotional Health & Mental Wellbeing

Context

National context

The mental health and wellbeing of children is a key national priority with identified mental health outcomes by 2020. This is essential with the prevalence of mental health disorders in children and young people. One in ten children aged between 5 and 16 years has a clinically diagnosable mental health problem. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1-2% have severe Attention Deficit Hyperactivity Disorder (ADHD); (ONS 2004). A good start in life with positive parenting is crucial to good emotional health and mental well-being as well as building resilience factors (DH 2009, HMG 2011).

National priorities have been identified to address the treatment gap, access, crisis management and specific support for vulnerable groups (DH 2015). In 2014 the Children and Young People's Mental Health and Wellbeing Taskforce was set up to consider some of the greatest challenges facing mental health provision for children and young people such as: prevention, access, data and standards, support for vulnerable groups and addressing inequalities. At its foundation is the adoption of a co-ordinated whole-system-wide approach to manage these problems. With work aligned to the cross-Government Mental Health Outcomes Strategy, a joint approach with individuals and communities is also important to promote independence, quality service and choice. This includes working with people with learning disabilities, autism and/or behaviour that challenges, including people with a mental health condition (NHS 2015).

The Local Government Association (LGA), the Department of Health, Public Health England and wider partners are supporting local areas to transform services. 'Future in Mind' (2015) provides direction for local leadership across the health and social care system with a focus on partnership working to realise improvements in mental health services and outcomes. The inclusion of a CAMHS modelling tool will support NHS commissioners, local authority and key partners to plan and transform child and adolescent mental health services within their areas.

Local context

Performance against key mental health and wellbeing metrics currently varies substantially by CCG¹:

- Four CCGs have fewer admissions than the national average for hospital admission for mental health conditions, whilst two are above the average (including Croydon, which also has more admissions than the London average).
- There is a noticeable split in the number of hospital admissions as a result of self-harm across south west London. Three CCGs perform in line with the England aver-

¹ Public Health England (2015). Local Authority Child Health Profiles – London: <http://www.chimat.org.uk/profiles/scn>

age (412.1 per 100,000 children), whilst the other three are similar to the London average (230.5 per 100,000 children).

- Overall, the south west London average for percentage of school pupils – and looked after children – with social, emotional or mental health needs is in line with the London and England averages.

Consistently high performing CCGs are Kingston, Merton and Wandsworth, whilst Croydon and Sutton perform below the national average. That said, trends show that almost all CCGs are improving in a number of key areas, such as increasing assessments of emotional wellbeing of looked after children, a reduction in those considered ‘of concern’, and year-on-year reductions in self-harm hospital admissions.²

Key initiatives

Across south west London, CCGs have developed transformational plans for CAMHS which have been implemented from April 2016. These plans aimed to provide a holistic approach to emotional health and mental wellbeing for children across each of the boroughs.

As part of the STP we have drawn on these plans and other examples of best practice to identify areas where further attention and investment may be required. In particular, we have developed these initiatives based on the three areas of focus:

1. Prevention;
2. Crisis and waiting times for acute services; and
3. Transition support.

These are high level proposed initiatives, identified with a working group which included mental health commissioning leads and some provider representation. The detailed implementation planning in the next iteration of the STP will further refine, develop, and agree the initiatives with a broader range of stakeholders.

1. Prevention

Prevention is a key area where benefits could be realised for CAMHS in south west London. By developing and focusing on prevention at a population level, identification of at-risk children and the provision of support could be provided earlier. This could reduce the risk of children and young people developing difficulties later in life and reduce the need for higher acuity support.

A number of preventative initiatives have been identified within south west London but three key areas of current focus include **Targeted Mental Health in Schools, Providing skilled interventions that prevent the escalation of need for vulnerable and looked after children and Emotional and mental health support with alleged sexual abuse.**

Targeted Mental Health in Schools (TAMHS)

Issues such as domestic violence or divorce at home may start to impact children from a very early age and targeted interventions within schools - particularly primary schools - is a potential big hitter which could reach a wider range of children and result in lower acuity in the long term.

² Healthy London Partnership, Healthy London Partnership Children and Young People's Dashboard

TAMHS involves a holistic approach to support and identify children in schools. Specific actions could include:

- Linking schools with mental health services
- Providing school counselling
- Training staff in recognising children with disabilities
- Escalating Support to provide more intensive behavioural support in schools
- Involving mental health as part of the school curriculum.

Current initiatives in south west London

As part of the transformation mental health plans, several CCGs have identified specific TAMHS interventions. Wandsworth, for example, has started a whole school approach to mental health. They provide support for emotional well-being and mental health issues in 11 Wandsworth Primary schools and nine secondary schools³. Their actions have involved:

- A Promoting Alternative Thinking Strategies (PATHS) Curriculum to improve emotional and social competencies in primary school children
- Counselling in secondary schools
-

Merton also has a TAMHS initiative in place which provides links with mental health services in schools. This has been commissioned by schools and in 2014/15 the approximate spend was £232,000. This included providing:

- 0.18 WTE psychologists/psychotherapists/family therapists
- 3.9 WTE Primary mental health workers/music therapists.

Benefits

Benefits of this initiative have so far included:

- Improved academic achievement
- Reduction in [Strengths and Difficulties Questionnaire](#) (SDQ) score in primary schools
- Additional children seen by counsellors in secondary schools.

Required investments

As a high-level estimate, by scaling costs in Wandsworth across all south west London schools, the total potential maximum cost of implementing similar initiatives across south west London could be in the region of £2.8m⁴. There will also be potential workforce implications as teachers will need to be trained on emotional well-being and additional counsellors may be needed for schools.

There may be some financial benefits from existing & new TAMHS services through early intervention by reducing the demand for Tier 3 & 4 CAMHS services. However, the scale of potential benefits is unclear, and the net financial impact is likely to be a cost increase. It is therefore proposed that as part of the STP, CCGs, local authorities and education providers work together to build and expand upon their existing TAMHS plans and identify a risk stratification approach to target investment only at schools in those areas that are more deprived. These organisations will need to work together, along with the south west London Mental Health Group for Children, to develop a timeframe and plan for implementation.

³ Wandsworth Children and Young People's Transformation Plan 2015-16

⁴ Based on Department for Education: Local Authority and Regional Tables 2015 and applying costing information Wandsworth TAMHS initiatives.

Skilled interventions that prevent the escalation of need for vulnerable and looked after children

A large number of looked after children may require some CAMHS support in their lifetime, and this initiative aims to provide skilled interventions as a way to potentially reduce the need for children to access acute services. By providing this type of service, crisis issues may be prevented or there may be a reduced requirement for Tier 4 services.

The service would include⁵:

- A MDT team working with residential homes
- A team that includes psychologists, mental health nurses and psychotherapists
- A MDT team providing advice and support for foster carers
- Interventions that are closer to home.

Current initiatives in south west London

The service is currently not widely available in south west London, although some boroughs do already provide services to support looked after children.

Merton and Sutton and previously Kingston and Richmond, for example, have been part of the Multi Systemic Therapy pilots. This is now embedded in south west London and St George's Mental Health NHS Trust as a buy back service.

Benefits

As a result of this initiative it is expected that there would be:

- Better mental health well-being; this could lead to a slight reduction in A&E attendance
- Decrease in prison stays
- Decrease in teen pregnancy
- Appropriate rehabilitation, in the right setting.

Required investments

Investment will be required in additional workers as part of the MDT Team.

As part of the STP, local authorities and CCGs will need to work together, along with the south west London Mental Health Group for Children, to develop a timeframe and plan for implementation of this initiative.

Emotional and mental health support with alleged sexual abuse

There is a silent epidemic of sexual assault and abuse affecting the physical and mental health of our children and young people as well as their families and loved ones. It has been estimated that 9.4% of 11 to 17 year olds have experienced sexual abuse in the past year alone (including non-contact offences). In London, that is an estimated 61,470 children and young people, or roughly 1,860 per borough. Mental health support within London is addressing support services for this cohort of children and young people and their families.

Current initiatives in south west London

Across south west London, the acute providers are currently working to meet the minimum standards for access to required medical input and emotional support for children with alleged sexual abuse. In addition, south west London CCGs have commissioned emotional and psychological support services from NSPCC.

⁵ Derived from stakeholder input

Further plans are being developed to implement a Child Sexual Abuse Hub which is being supported by Home Office funding. This will include:

- A local Community paediatrician who will provide follow up and medical reviews including sexual health and safeguarding risk assessments, coordinated local borough support, and liaison with local social care team and police
- The provision of evidence based information for children and their families
- STI screening and CAMHS support.

Benefits

The majority of the benefits are clinical outcomes and include:

- Better patient experience
- Improved school attendance and educational outcomes
- Reduction in emotional and mental health needs requirements
- Reduction in crime
- Pathway improvement
- Cost savings for health, social care and judicial systems.

Investment

Investment will be required for additional workers including 1-2 Paediatricians and six FTE staff providing psychological/emotional well-being support⁶. These staff may be drawn from existing services, with some additional investment which is still to be fully modelled.

As part of this STP, we expect the south west London Mental Health Group for Children to review options for implementing this and funding required.

2. Crisis and Waiting Times for acute services

Crisis and waiting times is another area where significant gains could be made. The approximate NHSE Specialised Commissioning spend on specialised CAMHS services in south west London in 2014/15 was £4.7m, most of which corresponds to inpatient admissions. We will aim to remodel the current Tier 4 provision, working towards collaborative commissioning with NHSE specialist commissioning to develop a case for change that improves access, effectiveness and experience of care. We will seek to reduce the need for expensive (and sometimes distant and disconnected) inpatient care with community delivered models. HLP and Tier 4 commissioners are working this up for STP-level transformation plans.

Review existing interventions

As part of the transformational plans for CAMHS, a number of crisis and waiting time interventions were proposed for each of the boroughs. These were implemented from April 2016 and the results of these initiatives are yet to be realised.

Current initiatives in south west London

The crisis and waiting time interventions that were included in the transformational plans include:

- A single point of access – streamlining CAMHS referrals to ensure access to the right service at the right time and in the right place, achieving the right outcomes (south west London wide)

⁶ Derived from stakeholder input

- A&E liaison service – re-designing psychiatric liaison model for south west London A&Es (south west London wide)
- MDT working – implementing a MDT team triage that focuses on risks, prioritising and safeguarding (Richmond)
- Work to eliminate Tier 3 waiting list - providing increased investment to provide more initial assessments (Croydon).

Benefits

The benefits of these initiatives are expected to be:

- Reduced waiting time for Tier 3 and Tier 4 services
- Reduced hospital inpatient admissions including self-harm admissions.

Economic evaluation of a case study indicated that investment in an uplifted model of all-age acute psychiatric liaison could be net cost-saving.

Required investment

These initiatives are already being implemented so no further investment is expected at present. Existing investment includes:

- Implementation of a single point of access
- Hiring psychiatric liaison workers and implementing MDT working
- Investing in more initial assessment capacity to reduce waiting times.

As part of this STP we expect the south west London Mental Health Group for Children to work together to review the results of these services and take forward the successful initiatives at a wider south west London level.

3. Transition Support

Transition support is a key issue for CAMHS services as there can often be difficulty with providing a seamless service for the child/young person. Many times the child simply does not understand which services they need to access or in some cases there may even be a bottleneck to access adult services.

Ready Steady Go

The ready steady go initiative is a set of tools and questionnaires that can be used to ensure the medical, psychological and vocational needs of a young person are addressed in a structured way. The initiative involves:

- Questionnaires which are used to prepare the patient for the adult service
- Training of staff to support children through the use of the tools and questionnaires.

Current initiatives in south west London

Ready Steady Go is not currently available in south west London. However, it should be noted that there are a number of other transition services which are available in south west London.

Benefit

As a result of this initiative it is expected that there could be:

- Improved patient experience
- Reduced inpatient admission.

Required investment

In order to achieve this initiative investment will be required in several areas including:

- The training of staff to implement the Ready Steady Go tools
- The development of the tools and questionnaires to support Ready Steady Go.

As part of this STP, we expect the south west London Mental Health Group for Children to work together with CCGs to develop a plan and timeline to implement this initiative across south west London.⁷

ii. Cancer

National Context

One in two people born after 1960 in the UK will develop cancer at some point in their lives. People are living longer, and more people will be diagnosed with cancer in their lifetime.

There is an urgent need to bolster both public health and NHS cancer services, and to work together closely to manage the needs and demands of the growing and ageing population. The expectations for prevention, earlier diagnosis, and improved access to diagnosis and treatments to improve cancer outcomes and experience are clearly outlined in national guidance and policy including the Independent Cancer Taskforce Report (Achieving World Class Cancer Outcomes - A Strategy for England 2015-2020). The report sets out the six strategic priorities over the next five years which could save 30,000 lives a year by 2020:

- Spearhead a radical upgrade in prevention and public health
- Drive a national ambition to achieve earlier diagnosis
- Establish patient experience on par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer
- Make the necessary investments required to deliver a modern, high-quality service
- Ensure commissioning, provision and accountability processes are fit-for-purpose.

In particular, the overall goals for Cancer included in the *Five Year Forward View* specifically focused on:

- Significantly improving one-year relative survival to achieve 75% by 2020 for all cancers combined (up from 69% currently)
- Patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP

Following the Taskforce report, a national implementation plan for taking forward the Taskforce recommendations has been published ('Achieving World-Class Cancer Outcomes: Taking the strategy forward', May 2016). Furthermore, the Macmillan report, 'Improving cancer services through primary care commissioning' (April 2016) has also

⁷ DH (2015) Future in Mind

HM Government (2011) No Health without Mental Health: Delivering better mental health outcomes for people of all ages

Master, W. and Kingdom, U. (2015)

NHS E, ADASS, LGA (2015) Building the Right support

ONS (2004) Mental Health of Children and Adolescents in Great Britain, 2004

Joint Commissioning Panel for Mental Health, (2012). Guidance for commissioners of liaison mental health services to acute hospitals

emphasised a number of these priorities including early diagnosis, living with and beyond cancer, patient experience and cancer education.

Furthermore, the national must-do's for 2016/17 as set in the *Five Year Forward View* included specific actions on achieving the 62 days Urgent GP referral to treatment Cancer waiting time standard and six week wait for referral to diagnostics. We have undertaken collective actions in 2016/17 to drive performance in these areas across south west London as detailed in the next section.

In developing the STP for Cancer we have considered the national policy and guidance to ensure our five-year initiatives will deliver against the national priority areas.

Local Context

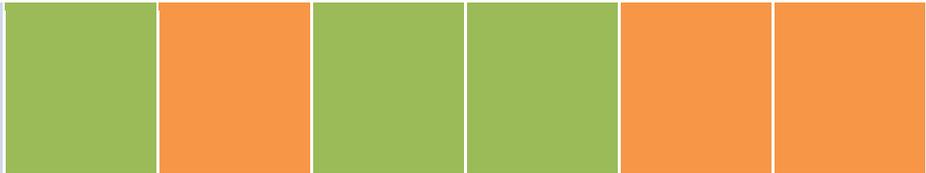
Cancer is one of the top three causes of premature death across all six CCGs in south west London (HLP Commissioning for Prevention: south west London SPG, May 2016).

Whilst there is a predicted increase in prevalence of cancer across all south west London CCGs, uptake for breast, bowel and cervical screening across the sector is generally below national averages (Public health profiles 2014/15 data). Early detection of cancer has a significant impact on survival, and performance across south west London is poor against the percentage of cancers diagnosed at an early stage - all south west London CCGs are in the third quintile or below.

There is significant variation across south west London CCGs, compared with demographically similar CCGs, in the diagnosis and treatment of cancer – which in turn contributes to variation in cancer outcomes and mortality, as outlined in the 'traffic light' table below (Source: Right Care 2015 Atlas of Variation)

Indicator	Performance by south west London CCG compared with demographically similar CCGs (NHS Atlas of Variation, 2015)					
	Croydon	Kingston	Merton	Richmond	Sutton	Wandsworth
Percentage of new cases of colorectal cancer that were diagnosed at stage 1 or stage 2 by CCG, 2013	Red	Red	Orange	Orange	Orange	Red
Percentage of all cancer diagnoses that were made at stage 1 or stage 2 by CCG, 2013	Orange	Red	Green	Green	Orange	Orange
Percentage of people aged 15-99 years who survived one year after being diagnosed with any cancer by CCG, 2012 followed up to 2013	Orange	Orange	Orange	Green	Orange	Orange
Percentage of people aged 15-99 years who survived one year after being diagnosed with breast, lung or colorectal cancer by CCG, 2012 followed up to 2013	Orange	Orange	Orange	Green	Orange	Orange

Rate of mortality from cancer in people aged under 75 years per 100,000 population by CCG, 2013



There is also wide variation across south west London CCGs in the patient experience in cancer services, which on the whole is only marginally better than the London average, with significant opportunity for improvement to reach the best in England⁸.

Costs of cancer services in south west London

It is not possible to accurately determine the local cost of cancer services, due to overlap between disease groups and lack of robust disease-specific financial reporting. The current spend by south west London CCGs on cancer services is estimated at somewhere in the range of £63m⁹ - £140m¹⁰.

Current performance for cancer waiting times in south west London

Current performance for cancer waiting times, specifically the delivery of the 62 day Urgent GP referral to first treatment standard across south west London providers, is being overseen by the System Leadership Forum (SLF). There have been significant improvements in Cancer 62-day performance over the last 12 months, increasing by 2.93 percentage points (March2015 to March2016).

The south west London SLF is well attended by provider and CCG leads and has been instrumental in driving improvement in cancer waiting time performance across south west London, building on local host provider/CCG discussions. It provides leadership across the system, resulting in collaborative working to the benefit of cancer patients. The SLF has focussed on tackling process issues, such as agreeing a common access policy and common approach to performance monitoring within and between providers. In addition, the SLF has developed clinical working groups to address issues within Urology and Head and Neck Pathway.

The ongoing focus for 2016/17 will include:

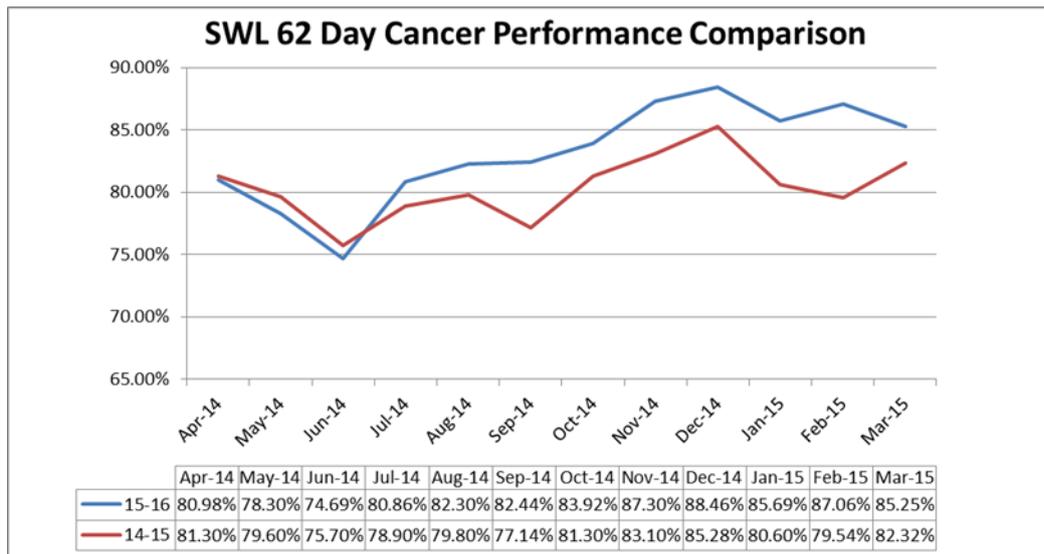
- Delivery of Trust trajectories for Inter Trust Transfers (ITTs)
- Joint breach process
- Minimum requirement to referral to specialist teams
- Head and Neck pathway improvement
- Lung pathway improvement.

Current performance for 62 day waits is detailed in the graph below.

⁸ Cancer Patient Experience Survey 2014

⁹ 2013/14 CCG Programme Budgeting Data. This is known to be an under-estimate, excluding some cancer diagnostic outpatient appointments and A&E attendances.

¹⁰ 2012/13 estimated total cost of cancer to NHS (National Audit Office), scaled to south west London according to 2013 cancer diagnoses (NCIN). Note: Includes NHSE Specialised Commissioning spend.



National Cancer Vanguard

The aims of the National Cancer Vanguard are to develop a new care model to leverage financial and contractual innovation to support the five major clinical deliverables of the Cancer Vanguard:

1. Early diagnosis and detection of cancer to improve 1-year survival.
2. Patient and family leadership to focus all care on improving patient / family experience.
3. Reducing unwanted variation across the patient pathway to all patients including populations who find it difficult to access cancer services.
4. Comprehensive delivery of the Recovery package to improve living with and beyond cancer in partnership with Macmillan Cancer Care.
5. Improved access to high quality palliative and end of life care 24/7.

The Cancer Vanguard already produces excellent cancer informatics at CCG and Trust level and is working with the national cancer team and PHE to ensure ever more comprehensive data is available. By the end of June 2016 all partners in the SPG (CCGs, Community Trusts, Hospices, Hospitals) will be able to access the cloud-based repository of these cancer informatics. The aim of these clinically validated metrics are to aid the leadership of the SPG CCGs and Cancer clinicians across the system in driving improvement in performance. The Vanguard informatics system is designed to be accessible and proactive and is available to all CCGs and Trusts to request bespoke work for their local service.

In December 2015 the Cancer Vanguard commissioned work by Cancer Research UK and 2020 Delivery to establish the demand/capacity gap in imaging and endoscopy to inform the work needed in developing new models for early diagnosis, and to complement the LCA pathways on “straight to test”. This information is available to all SPG partners and can be used in planning and commissioning cancer services. The Cancer Vanguard is also working with the national Radiology Vanguard (EMRAD) to determine new ways of working to mitigate the current equipment and workforce gaps. The Vanguard project managers and secondary care clinicians will work directly with community and primary care clinicians to improve early diagnosis and reduce delays in the pathway.

The Cancer Vanguard workforce group is working with Health Education England (HEE) across all providers to look at new smarter workforce models and new roles. The group is also agreeing a Pan-London Passport for education and training to assist clinical staff who relocate within London to be able to do so without having to undertake site-specific

competencies. The workforce group is also working to reduce the delays and unnecessary bureaucracy in medical honorary contracts between providers. One of the drivers for success is to change behaviours across the system so that everyone is focused on delivery in collaboration across the system. The Vanguard has commissioned work from HEE to work with primary, community and secondary care teams to maximise the 'Every Contact Counts' approach and to use the change academy methodology to assist collaborative behaviours across the place based system.

The Cancer Vanguard ICT group is working on establishing replicable web-based IT solutions to enable clinicians from any part of the SPG to view their patient's pathway and thereby track and improve on the delays currently seen in the 62-day cancer wait. It is the aim of the Cancer Vanguard in late 2017/18 that patients will also be able access their pathway and will be able to view what their ideal pathway is, where they are in real time and any educational / self-help education also in real-time.

The Cancer Vanguard is focused on improving population health knowledge and prevention regarding cancer and is keen to work not only with HEE but also schools and population groups to improve prevention, healthy lifestyles and engagement with early detection. The Patient and Family leadership group is central to this work and includes expertise from The Point of Care Foundation, real time monitoring and PROMs supported by iWantGreatCare and the support of the cancer charities.

Finally, the Vanguard will lead on the following palliative and EoLC initiatives:

1. Transformational change in the model of community palliative and end of life care to enable better integration, coordination, responsiveness and effective use of resources.
2. Support for specialist palliative care services to develop and deliver seven-day face to face visiting
3. Support earlier Advanced Care Planning to reduce hospital deaths of cancer patients.
4. To enable all specialist palliative care services to implement and use a standard set of person-centred outcome measures effectively
5. Educational support for unified ceilings of care documentation.

Key initiatives for south west London

The population of south west London deserves world-class cancer care which delivers the best possible outcomes and patient experience. In order to meet the health and wellbeing challenges, as well as to close the current gaps in care and quality, significant transformation across the Cancer system in south west London is required.

We have identified initiatives against the key themes below which are in alignment with the Taskforce recommendations, London's Transforming Cancer Services Team (TCST), and the National Cancer Vanguard priorities as described above. The key themes are as follows:

1. **Screening and Early Diagnosis** – Improving targeted screening and early diagnosis interventions through reducing variation in primary care to tackle health inequalities, deliver better access to services and outcomes. This includes raising patient awareness and acting on symptoms of Cancer.
2. **Cancer waits and diagnostics** – working across all acute providers to deliver sustainable waiting times to access diagnostics and treatment through delivery of new pathways (including "straight to test"), reviewing PTL processes and improving MDT arrangements.

3. **Reducing variation** – identifying the priority pathways to be commissioned to reduce variation in treatments rates and outcomes – particularly a greater role for primary care to help deliver improved diagnosis rates and improved care for people within and beyond cancer.
4. **Living with and Beyond Cancer** – improving the quality of life for people living with and beyond cancer, defining cancer as a long term condition and ensuring it is managed as such across health and social care.

In addition, we recognise that there are significant opportunities for prevention of primary cancers and recurrence. We will work with local authorities and public health to drive awareness of risk factors and healthy lifestyles amongst patients, communities and staff.

We recognise that there is a need to provide sustainable targeted investment in some areas to deliver the strategy though there are also opportunities to realise significant clinical benefits and some financial savings across all these areas through innovation and integrated commissioning. We will work collaboratively across the six CCGs and acute providers as well as in collaboration with the National Cancer Vanguard as our delivery mechanism for transformation across the system to reduce variation, improve outcomes and align incentives.

The initiatives below will build on the current work being done by the six south west London CCGs in line with the Transforming Cancer Services Team (TCST) plans as well as 2016/17 cancer commissioning intentions.

Implementation and ownership

Planning and delivery of cancer improvements are currently being driven at local CCG level. At south west London level, we have begun taking a more SPG-level view to ensure consistency of approach and delivery of the benefits at scale and pace. STP support to further assisting implementation through the current south west London Cancer Clinical Delivery Group would be beneficial to this. CCGs and providers will also continue to work together through the System Leadership Forum (SLF) to drive in-year operational performance improvement in the delivery of the cancer waiting time targets in 2016/17. The exact governance arrangements for the current Cancer Clinical Delivery Group are to be further shaped as the STP develops. We will also continue to work closely with the London Transforming Cancer Services Team (TCST) as well as the National Screening Programme in delivery of the STP.

The National Cancer Vanguard will be critical to the success of delivery of cancer improvements across south west London, as well as paving the way for major changes in the commissioning and provision of cancer care. This includes a long term vision for an alliance approach for the provision of Cancer to ensure an integrated approach to Cancer care across SWL from April 2017. The Executive Director of the Cancer Vanguard (RM Partners) sits on the south west London STP Clinical Board and south west London Cancer Clinical Delivery Group so a close working relationship already exists in the sector. Specialist and Local Commissioners also sit on the Vanguard Executive Programme Board together with clinicians from across the sector. As the STP initiatives develop in more detail, we will continue to develop the ways in which south west London will work with the Cancer Vanguard.

iii. Care Homes

Care Homes

There are two important strands of work happening in south west London in relation to care homes: the Sutton Vanguard and work being led by the south west London authorities: *From Analysis to Action - collaborative commissioning to improve efficiency, and shape a sustainable supply of bed based care in south west London.*

We want to share and roll out good practice from the Sutton Vanguard, as well as understand from *Analysis to Action* how we can better manage the care home market in south west London for the benefit of care home residents and support sustainability.

Sutton Vanguard

Sutton Homes of Care Vanguard Programme

Sutton Homes of Care – Vanguard Programme
Our vision is to **have a vibrant, high-quality care home market not just in Sutton but across SWL** delivering care that embraces the national nursing values of patient care – Care, Compassion, Competence, Communication, Courage and Commitment. We believe our residents deserve and need high quality care, our care homes are an integral part of our health and social care system and the staff are valued and equal members of the MDT.
To achieve this vision, our three key areas of care home vanguard work focus on:

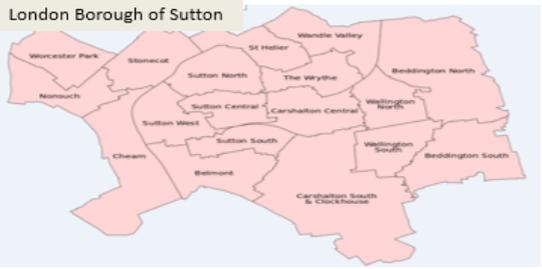
1. Integrated Care - designing a system of care wrapped around the health and well-being of our residents
2. Care Home staff education and development - providing the necessary training and education to upskill our staff, and provide them with the confidence and positive belief to want to deliver provide great care
3. Quality Assurance - increasing safety and improving quality by enabling the collaborative sharing, monitoring and evaluation of information

Impacts on the wider system to date:

- Reduction of 5.80% in LAS call outs and conveyances from 2014/15 to 2015/16
- Reduction of 10% in A&E attendance from 2013/14 to 2015/16
- Reduction of 4 days length of stay since implementation of Hospital Transfer Pathway (preliminary results)
- Increase of 6% in residents achieving PPD from 2014/15 to 2015/16
- Reduction of £50k in medicines costs from Nov15 to Mar16 through resident medication reviews

Working together across Sutton with our partners: NHS Sutton Clinical Commissioning Group, NHS Epsom and St Helier University Hospitals NHS Trust, NHS Sutton Community Health Services, NHS London Ambulance Service, NHS South West London and St George's Mental Health NHS Trust, Alzheimer's Society, Age UK Sutton, St Raphael's Hospice, Sutton Centre for the Voluntary Sector.

London Borough of Sutton



Working smartly across organisational boundaries

- An underlying principle of the Vanguard is a collaborative approach with all partners, including care homes, being involved in co-producing solutions and resources.
- This genuine partnership is working pro-actively and across organisational boundaries to embed the vision for the programme.
- The programme has produced a series of products which can be adapted and adopted by other boroughs across SW London.
- Expand learning to community settings to support people with LTCs and frequent flyers e.g. through adaptation of the hospital transfer pathway (red bag scheme); and sharing learning resources with domiciliary care staff

The care home population is comprised of residents with a high degree of vulnerability and/or frailty. As people are living longer, care home residents are displaying more complex healthcare needs; reflecting multiple long-term conditions, significant disability and advanced frailty. Additionally, other populations living in care homes, such as people with mental health conditions or learning disabilities, are presenting increasingly complex mental and physical health needs.

The standard of care provided to this complex cohort of people is often fragmented, with residents receiving a variable standard of care services due to workforce limitations. Smith et al (2015) noted that emergency admissions are higher for those aged 75 from those areas with higher numbers of care home residents. Evidence has shown that Enhanced Primary and Community Care and upskilling staff can support reductions in acute admissions and improve quality of life indicators such as preferred place of death and resident and family satisfaction as well as increasing staff satisfaction.

Sutton Homes of Care is one of six enhanced health in care home vanguards in England. Each of the vanguards has been working with care homes in their respective areas, adopting different approaches to improve care for residents and implement a new model of care.

The Sutton Vanguard serves a population of around 200,000, with 74 care homes and three more due to open shortly. It includes nursing and residential care as well as a number of mental health and learning disability places. Sutton made use of 2015/16 to identify areas of improvement, and develop ideas to change, enhance and support the local system to support people in care homes, whilst valuing the staff and contribution of this sector to the overall delivery of local and strategic plans.

The Sutton Vanguard has been based on three pillars:

- (1) Integrated Care: to provide integrated proactive care to enhance health and wellbeing;
- (2) Care Staff Education & Development: to have confident, competent and well trained care home staff; and
- (3) Quality Assurance & Safety.

In 2016/17 the Vanguard programme will expand on developments from 2015/16, in order to reach a wider cohort of residents. The programme will also continue to be developed and implemented in phases across south west London over a 4-year period.

Major Activities			
Three pillars of Sutton Vanguard model	<ul style="list-style-type: none"> • Integrated, proactive model of care: collaboration to enhance health and well-being and deliver a more joined up model of care with patient centred care planning 	<ul style="list-style-type: none"> • Skilled, competent and well trained staff: to invest in staff and provide key competency training and support for enhanced roles and empowered decision making 	<ul style="list-style-type: none"> • To deliver high quality care: minimise the risks by compiling a dashboard of agreed data that can accurately and effectively be used in a timely manner to offer support and training to Care Homes and to implement assurance processes
Measureable outcomes	<ul style="list-style-type: none"> • Increased number of health and well-being reviews • Improved advanced care planning rates • Specialist Clinical Lead Roles created in care homes and community services 	<ul style="list-style-type: none"> • Improved advanced care planning rates 	<ul style="list-style-type: none"> • Confident, proactive intervention by better trained and more knowledgeable staff • Joint Intelligence Group – sharing of hard data and soft intelligence to enable the early detection of quality issues and low level concerns and to agree pro-active action plans
Implementation	<ul style="list-style-type: none"> • GP Care Home alignment / allocation • Upskilling of staff and 	<ul style="list-style-type: none"> • Enhanced levels of training and improved access to resources and 	<ul style="list-style-type: none"> • Agree key data required and collate data set • Continuation of best practice & process i.e.

Major Activities			
	development of care co-ordinator role within homes <ul style="list-style-type: none"> • Standardised training to identify key competencies • Proactive Care Plans i.e. End Of Life • Introduction of new roles in the community to enhance care and offer more support to care home staff 	courses <ul style="list-style-type: none"> • Standardised training to identify key competencies 	Community Swoop and Hospital Transfer Pathway (Red Bag scheme)
Benefit and year of impact	<ol style="list-style-type: none"> 1. Improved, personalised, proactive care, delivered in a timely and effective manner (<i>Year of impact 2016/17 – 2020/21</i>) 2. Motivated, and empowered staff with reduced levels of turnover and reduced levels of agency usage (<i>Year of impact 2016/17 – 2020/21</i>) 3. Quality of care and patient experience improves with reduced levels of incidents adversely affecting patients (<i>Year of impact 2016/17 – 2020/21</i>) 		

Analysis to Action - managing the care home market

‘Analysis to Action’ and managing the care home market is another project taking place to improve efficiency, and shape a sustainable supply of bed-based care in south west London. Although this work and the Sutton Vanguard are care home orientated, they are focusing on different aspects of the future of bed-based care in south west London.

It is becoming increasingly difficult for councils and CCGs in south west London to find local, bed-based care at sustainable rates. The problem impacts all client/patient groups, with specific and urgent pressures in finding placements for people with dementia and/or challenging behaviour. Residential and nursing care represents 45-50% of commissioned service costs in adult social care in south west London. As a result, ‘Analysis to Action’ is concerned with forecasting, commissioning and managing the bed-based care that will be required over the next three to five years. Its outputs should help with informing:

1. Better information on supply and demand for bed-based care
2. A greater choice of quality bed-based care being available across south west London with particular emphasis on the choice available for people with dementia and challenging behaviour
3. Stability of prices available to local authorities and CCGs with less spot-purchasing and crisis negotiation of rates
4. An increased number of providers expressing confidence in viability and the five year future of their businesses
5. Improved joint working between local authority commissioners and health commissioners
6. Improved management and delivery on care home budgets

This work is being led by the south west London authorities (LB Croydon; RB Kingston; LB Merton; LB Richmond; LB Sutton; LB Wandsworth) working alongside the CCGs. South west London ADASS agreed the project brief and have supported the early stages of the project getting underway. Key timelines for this phase of the work are:

Timeline: *Analysis to Action*

June'16:	July'16:	August'16:	September'16:
<ul style="list-style-type: none"> • CCG leads nominated • Scoping discussions commenced • Data requirements defined 	<ul style="list-style-type: none"> • Initial joint analysis and commissioners workshop 	<ul style="list-style-type: none"> • Data validation and refinement • Draft recommendations to project board on priorities for co-operative/collaborative commissioning 	<ul style="list-style-type: none"> • Project board review and decision on next steps

iv. Childhood Obesity

Context

National context

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century, with the UK presenting one of the highest levels of childhood obesity. Recent data reveals that one in five 5 year olds and one in three 10 year olds are overweight or obese (Master & Kingdom, 2015)¹¹. Current trends show that half of all children will be obese or overweight by 2020 (Wang, McPherson et al, 2011)¹². There is also a strong correlation between deprivation and prevalence of obesity (NCMP, 2014).

Childhood obesity has significant consequences for the health economy with huge cost to the NHS as well as critical consequences to children's physical and mental health and wellbeing. Obesity in children is related to ill-health such as asthma, skin infections, and some cancers, as well as early onset of puberty (PHE, 2015) and psychological disorders (NOO, 2011). Obese children and young people are more likely to become obese as adults (Simmonds, Burch et al 2015) with increased risk of cardiovascular disease, Type 2 diabetes and other obesity-related diseases (Wijga et al., 2010). High consumption of sugar also results in dental disease and associated tooth extractions which are entirely preventable and a significant cost to the NHS.

The causes of childhood obesity are multifaceted, and include behavioural, environmental and genetic factors (Karnick & Kanekar 2012). A whole-system approach, co-ordinating efforts in a variety of settings is required with robust structures, partnership working and co-production with children, young people and their families. Essential to tackling obesity is the provision of support for young people as they become independent, to embed healthy weight and eating habits. The Child Obesity Framework (DH, 2008 2009) is a vehicle to support local issues as commissioners, local authority, providers and other cross sector partners tackle obesity.

Local context¹³

Within south west London public health data profiles for 2014/15 show that excess weight in 4-5 year olds generally compares favourably to England and London averages. Excess weight levels for year six children at a higher rate than the England average have been identified in Wandsworth, Croydon and Merton. Croydon's prevalence is also higher than the London average. The case for intervening early to prevent obesity is compelling, and within south west London current initiatives exist to manage childhood obesity.

Key initiatives

In order to tackle childhood obesity it has been recognised that population-wide policies that target behavioural change would be most beneficial. These types of initiative would result in long term impacts for the health and care sectors and the majority of the benefits would be realised in decades rather than years. Interventions will need to work at a government, NHS, educational and community level in order to do this.

¹¹ Master, W. and Kingdom, U. (2015) via Royal College of Paediatrics and Child Health (2015) Tackling England's childhood obesity crisis

¹² Wang, Claire, Y., McPherson, K., Marsh, T., Gortmaker, S. L., Brown, M., Wang, C. Y., author Affiliations New and Dip, P. (2011) Health and economic burden of the projected obesity trends in the USA and the UK via Royal College of Paediatrics and Child Health (2015) Tackling England's childhood obesity crisis

¹³ Right Care 2015 Atlas of Variation, via south west London STP Draft Base Case

As part of the STP we have identified several key behaviours that should be targeted in order to reduce childhood obesity. These include:

- Increased prevalence of breastfeeding;
- Increased fruit and vegetable consumption;
- Reduced consumption of beverages high in sugar (e.g. “soft” drinks);
- Reduced consumption of foods high in fat, saturated fat, salt and sugar;
- Decreased television viewing and other screen-based activities;
- Increased competitive and non-competitive sport participation;
- Increased active transport to schools.

To tackle childhood obesity it is necessary that interventions address early years, school age children and supporting a healthy environment.

Early years initiatives

Initiatives that target pregnant women and babies are also effective at reducing and preventing obesity levels in children. These initiatives involve changing attitudes to bringing up children and mobilising communities to support healthy behaviours.

The initiatives would include:

- Working with local authorities and CCGs to develop baby-friendly maternity, health visiting, neonatal and children’s centres services. Baby friendly awards are awarded to those centres who have high standards of supporting and encouraging women to feed their babies in a healthy manner
- Implement the Ready Steady Mums programme which involves community-based walking groups for pregnant and new mums
- Encourage breastfeeding by creating breastfeeding-friendly communities and using digital technology
- Provide breastfeeding support to targeted groups who prefer not to attend children centres e.g. teenage mothers.

Current initiatives in south west London

Children’s centres across south west London currently provide support for breastfeeding and child weaning with support from health visitors. However, only one CCG currently has registered intent to achieve Baby Friendly status. It is proposed that more centres and services aim to achieve Baby Friendly status as part of our future plans.

Some CCGs have specific initiatives which target pregnant women. For example, Kingston have a Maternal Obesity Action Group to support the development of services for pregnant women who are above a healthy weight.

Croydon CCG is implementing a multi-agency approach to health, family support and learning for pre-birth to 5 year-olds and their parents. This integrated approach is designed to improve a range of outcomes for children in their early years, including the prevention of childhood obesity.

Benefits

As a result of focusing on early years, it is expected that there would be:

- Higher rate of breastfeeding
- Lower rate of childhood obesity in young children
- Increased activity levels of new mums
- Mental health benefits.

Required investments

In order to achieve these initiatives investment will be required in several areas:

- Training workforce in best practice standards for breastfeeding and early child feeding
- Joint working with CCGs and local authorities to promote breastfeeding in the community
- Promoting engagement through the use of digital apps (e.g. Breastfeeding app)
- Commitments by CCGs to apply to gain Baby Friendly status.

In order to successfully implement this proposal, it is recommended that CCGs and local authorities work together to develop a timeframe and plan for implementation. HEE will be required to develop the workforce and ensure professional consistency in applying best practice standards for breastfeeding and early years weaning. STP funding would be beneficial in supporting the deliverability of these initiatives more widely across south west London.

School age children and Healthy Environment

Across London, a Healthy Schools London Programme has been initiated in several schools. The intention of this is to create a holistic school-based approach to educate staff, children and parents on healthy eating and also encourage an active environment. Schools which implement these initiatives will achieve awards based on the level of success. Examples of activities that support healthy schools awards include:

- A commitment to healthy catering
- A daily mile scheme where children run a mile as part of their daily timetable
- Stronger communication links with school nurses through an internet-based or apps-based approach
- Obesity issues taught as part of PHSE
- Consistent and effective health messaging
- More involvement of school nurses in driving obesity initiatives in schools
- Adopting active travel to school
- Providing dedicated obesity teams that oversee several schools
- Walking buses to and from school
- Creating safe environments for children to cycle and use scooters
- Scooter and cycle training for children
- Implementing policy to curtail unhealthy fast food outlets near schools
- Providing community garden projects as part of school extra-curricular activities.

Current initiatives in south west London

In south west London some CCGs have started to implement other school-based interventions to tackle childhood obesity, although there appears to be considerable variation within and across CCGs in these services. Croydon, for example, has provided allotments to schools for children to grow fruit and vegetables as part of their Food Flagship programme. Sutton has also worked to develop more green spaces and safe environments in their borough to promote activity. As part of our plans, it is recommended that more south west London schools sign up to the Healthy Schools London Programme and work to achieve the associated awards.

Local authorities are responsible for measuring and recording the weight status of all 4-5 year olds and 10-11 year old state school children. This is an opportunity to engage with parents of children who are of excess weight, have a conversation about what their needs

are, and support them to utilise the healthy eating, physical activity and weight management services that are available to them.

Additionally, the weight management services that offer support to children and families to make behavioural changes to lose or maintain their weight are variable from borough to borough. A stocktake is required to ascertain what support is available to children and families who require weight management interventions, and whether there is equity of offer between each borough that meets the needs of the population, including BME populations.

Benefits

Benefits which school age and healthy environments initiatives are expected to include:

- Reduction in prevalence of childhood obesity
- Higher activity levels
- Lower disease prevalence
- More schools signed up to achieving Healthy Schools London awards.
- Improved school attainment.

Required investments

In order to achieve these initiatives investment will be required in several areas:

- Given the pressures on school staff, dedicated health improvement staff should be provided to schools
- Training of school nursing teams in obesity reduction
- The implementation of apps and communication links with school health teams.

In order to successfully implement a school age and healthy environments proposal including weight management services, it is recommended that, as part of the STP, CCGs and local authorities work together to develop a timeframe and plan for implementation, drawing upon additional funding that may be provided.

v. Dementia

Context

National context

Nationally, there are currently estimated to be 622,000 cases of dementia in those over 65 years of age¹⁴. Prevalence of dementia increases with increasing age. More women than men are diagnosed with dementia each year and it has become the leading cause of death among women in the UK. Action on dementia has been building nationally for the last five years. In 2009 the Department of Health published an ambitious national dementia strategy which detailed 17 objectives that, when implemented locally, would result in significant improvements in the quality of services and the understanding of dementia in the UK. In 2010, the Dementia Action Alliance was set up “to bring about radical changes in the way society responds to dementia” (dementiaaction.org.uk). A National Dementia Declaration was developed, containing “I statements” or “outcomes” that set out what is important to people with dementia. To drive quality improvements in dementia services, the National

¹⁴ NHS England, Letter from Dr Dan Harwood - London Dementia SCN Clinical Director 2015

Institute for Health and Care Excellence (NICE) issued quality standards for dementia (2010) and for living well with dementia (2013), which give statements on best practice for service provision. The NICE guidelines on dementia, first published in 2006, will be updated for publication in September 2017 due to a number of new research findings.

In March 2012 the Prime Minister launched a national challenge to fight dementia, which has led to unprecedented action across the country. More people have now received a diagnosis of dementia than ever before, over 1 million people have been trained to be dementia friends to raise awareness in local communities, over 400,000 NHS staff and over 100,000 social care staff have been trained in better supporting people with dementia, and there has been a significant increase in research spending¹⁵. Building on this, a new Prime Minister's challenge was launched with the aspiration that, by 2020, England will be the best country in the world for dementia care and support, and for people with dementia, their carers and families to live, and the best place in the world to undertake research into dementia and other neurodegenerative diseases.

Local context

The number of people in south West London over 65 years is projected to increase from 189,000 in 2016 to 209,000 in 2021¹⁶. Unhealthy behaviours, combined with an ageing population mean the number of people with long term ill health, including dementia, will continue to grow. The number of people living with dementia is rising and embedding high quality dementia care into services is vital. Whilst prevalence of dementia is lower than the national average, individuals with dementia experience a longer than average length of stay if admitted to hospital. They are more likely to be readmitted, and are more likely to die in hospital than the national average. Preventative interventions play an important role in preventing, reducing and delaying the need for health and social care interventions.

Approach

From a virtual round-up and a workshop with a series of follow-on conversations held with the identified initiative leads in mid-May 2016, a number of further initiatives were identified. The leads felt that these initiatives, when fully implemented, would provide an opportunity to improve quality of care and reduce costs associated with the provision of dementia services in south west London.

Key initiatives

Current initiatives in south west London

It should be noted that a number of key initiatives are already well underway within CCG areas/boroughs across London. In most instances, the CCGs and local authorities have developed local solutions to address issues around dementia in their area, and there is an eagerness to continue to develop local solutions, with some consistency across areas where it is beneficial in terms of quality and finance to do so.

Some of the existing initiatives which are already underway include:

¹⁵ Prime Ministers Challenge on Dementia <https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020/> prime-ministers-challenge-on-dementia-2020

¹⁶ ONS CCG population projections, 2014

- **Wandsworth** – A diagnosis approach that incorporates post-diagnosis support to ensure patients are suitably informed about how to best manage their dementia and navigate the services on offer. This initiative provides an opportunity to start more people on a cost-effective pathway at scale.
- **Richmond** – a Dementia Action Alliance of a consortium of voluntary sector, private, business, arts / culture, health, community, police etc., organisations promotes a dementia friendly community. They provide activities, raise awareness and signpost those at risk. This initiative could reduce the demand for formal dementia services significantly as communities take more responsibility for their own service
- **Kingston** – a psychiatric liaison service has recently been commissioned which has additional emphasis on keeping people with dementia more independent for longer so they do not need to access more costly inpatient or residential care. Where this is not possible, the service ensures that support is in place to get patients back into the community as quickly as possible.

An approach to scaling up the above initiatives across south west London would look to generate additional savings through reduced non-elective admissions, reduced length of stay and improved patient and carer experience.

Additional initiatives being explored in south west London that would improve quality and generate savings for dementia

1. Health and Social Care collaborative commissioning of care homes and domiciliary care across south west London

As part of the wider focus in south west London on collaborative commissioning it is important that local authorities and the health sector work collaboratively to specify and commission care setting-related services from private sector providers and the voluntary sector for people with dementia. Collaboration in this way creates an opportunity to reduce variation in price and quality that currently exists across the region and across health and social care. It also means developing the scale that enables health and social care to negotiate prices that reduce overall spend across its economy.

Benefits

The benefits of these initiatives are expected to be:

- Reduction in the overall commissioned spend on domiciliary care and care homes
- Consistency in specifications and quality of services across the region and health and social care
- Reduced competition between health & social care commissioning organisations for scarce specialist beds
- Reduction in delayed transfers of care for acute hospitals
- Better quality, seamless services for patients and carers.

Post Diagnosis Support

Dementia services are provided by both mental health (including beds) and acute hospital providers. A key focus will be on how existing in-patient services are currently provided (a review) and by whom (Psychiatrists, Neurologists, Care of the Elderly). This could enable a redesign across the system. This represents a significant opportunity for increasing efficiency and enables collaborative working with the Continuing Healthcare team who have responsibility for assessing the needs of those admitted to hospital with a long term condition (dementia).

2. A south west London approach to providing support to carers for people with dementia

As part of a wider focus on carer support and coordination, developing and implementing a south west London-wide approach to dementia carer support is required. The approach should build on existing work by focusing on opportunities that deliver real impact from a cost and quality perspective. This includes:

- Collaborative commissioning of carer services across the region (e.g. respite for carers of people with dementia);
- Education and training for carers of people with early and later stage dementia;
- Developing peer support services for carers e.g., local dementia cafes.

Benefits

The benefits of these initiatives are expected to be:

- Delayed admissions to residential services
- Reduced avoidable admissions into hospital and care homes
- Reduced length of stay in hospitals
- Reduction in the overall commissioned spend on carer support services
- Consistency in specifications and quality of services across the region and health and social care.

vi. Diabetes

National context

A radical upgrade in diabetes prevention and early intervention is needed to improve people's lives and achieve financial sustainability of the health and care system. It is estimated that nationally, diabetes accounts for 10% of all NHS costs¹⁷. Research also suggests that 80% of the costs related to diabetes come from treating complications of the disease, such as cardiovascular disease, foot ulcers and renal disease¹⁸. We also know that of the different forms of diabetes, most of the costs arise from type 2 – which is largely preventable through lifestyle changes.

People living with diabetes (types 1 and 2) also experience disproportionately high rates of mental health problems, with 41% reporting poor psychological wellbeing¹⁹. A number of factors associated with living with a long term condition, specifically diabetes, may affect psychological wellbeing factors include acceptance of the diagnosis, adjustment of lifestyle, living with symptoms and progression of diabetes, and prospect of complications. Mental health problems for people with long-term conditions, including diabetes, are disabling, poorly detected and inadequately treated²⁰.

Local context

In 2015, there were an estimated 82,000 people aged 16+ with diabetes, across the six south west London local authorities²¹. As is the case nationally, most costs are attributed to type 2 diabetes, and complications of all types of the disease. Mental health problems are also common in diabetics and are associated with poor diabetes control, complications and increased mortality. These factors can be addressed through lifestyle changes, patient education and management, and mental health interventions.

By 2020, it is estimated that diabetes incidence will have grown by 12.3%²² from 2015. Healthcare costs of diabetes in south west London are also expected to increase from ~£249m to ~£316m by 2020²³ without mitigating activity. (This figure is the expected underlying growth prior to the impact of our improvement initiatives. It is scaled to south west London based on recorded diagnoses (PHE), and inflated to 2020 based on projected incidence growth²⁴).

¹⁷ Association of glycaemia with macrovascular and microvascular complications of Type 2 diabetes: prospective observational study. *British Medical Journal* 2000; 321: 405-412

¹⁸ N. Hex et al., 'Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs', *Diabetic Medicine* (2012)

¹⁹ Peyrot M, Rubin RR, Lauritzen T, Snoek FJ, Matthews DR, Skovlund SE. Psychosocial problems and barriers to improved diabetes management: results of the Cross-National Diabetes Attitudes, Wishes and Needs (DAWN) Study. *Diabet Med.* 2005 Oct;22(10):1379-85

²⁰ No Health Without Mental Health, Royal College of Psychiatrists, (2010)

²¹ (YHPHO Diabetes Prevalence Model for Local Authorities (2012)

²² % YHPHO Diabetes Prevalence Model for Local Authorities (2012)

²³ 2010/11 national cost estimates (N. Hex et al., 'Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs', *Diabetic Medicine* (2012)

²⁴ YHPHO Diabetes Prevalence Model) and Monitor estimated annual cost inflation rates

	2012	2015	2020
Treatment (£m)	49	52	66
Complications (£m)	183	197	250
Total cost estimate – (£m)	232	249	316
Methodology	<i>Demographic growth applied from 2010 (CCG population growth figures, ONS)</i>	<i>Projected activity growth from 2012 applied</i>	<i>Projected activity growth from 2015 applied, as well as Monitor estimated annual cost inflation rates</i>

Note: these should be treated as high-level estimates only, based on a number of assumptions. This table shows underlying growth in cost pressures, prior to the impact of the improvement initiatives that are planned within SW London (i.e. the “do nothing scenario”)

The south west London approach:

Across south west London healthcare organisations have developed and are implementing a number of different initiatives and schemes which focus on prevention of diabetes and enabling those with the condition to manage their conditions and “live well” with the disease. As part of the STP we want to draw attention to areas where greater emphasis could realise significant benefits. We have set the following four lenses through which to identify opportunities:

- **Preventative:** Tackling the root cause of type 2 diabetes through prevention and identification of those at risk
- **Self-care:** Supporting those with diabetes to “live well”, manage the disease independently, and tackle mental health problems
- **Redesign:** Improving patient experience and outcomes through system level pathway redesign
- **Primary Care:** Improving patient experience and outcomes through improved management of diabetes in primary care

We have also identified two major enablers to tackling prevention of type 2 diabetes and improving care for all forms of the disease, which should be embedded at every level of this approach:

Digital: Targeting vulnerable and at risk groups with innovative techniques designed to tackle those at risk of diabetes and supporting those with the disease to “live well”.

Education: Targeting patients and clinical and other medical staff, with the aim of improving self-care and management, and reducing variation in care for at risk or vulnerable patients.

Across south west London, organisations are already implementing initiatives aligned to these four lenses and enablers, albeit at different levels of pace, scale and scope. This is an opportunity to address variation by implementing schemes at scale across the whole south west London area, and bring all organisations up to similar levels by focusing on best practice in order to help maximise impact across the region.

Prevention

Tackling the root cause of type 2 diabetes and identifying those at risk early is key. South west London is a first wave adopter of the National Diabetes Prevention Programme, a behavioural change programme designed to support patients to lose weight and adopt healthier behaviours in order to slow the progression of diabetes diagnosis.

In addition to this scheme, there is potential to upscale digital risk assessment tools as a first step in identifying patients at risk of developing type 2 diabetes earlier; and providing support (i.e referral to the National Diabetes Prevention Programme if eligible) and improved management to address contributing unhealthy behaviours in a primary care setting:

- Diabetes risk register – piloted in two GP practices in Croydon where all patients that are deemed “high risk” are contacted and recorded on a database. If patients are in the appropriate designation range, they can be referred to the National Diabetes Prevention Programme (Croydon).
- Qdiabetes risk scoring system - GPs can use this tool to work out the potential risk of patients developing type 2 diabetes. This has led to patients being given targeted health advice to change unhealthy behaviours – the biggest root cause of the disease.

Self-care

Patient Education is recognised as imperative to enable patients wherever possible to intelligently self-manage long-term conditions with clinical support, and easily navigate services as required. Education programmes have been recommended by NICE since 2003, and across south west London DAFNE and DESMOND programmes for type 1 and type 2 diabetes are in place. However, programmes and methods need to be maximised to have more of an impact. Furthermore, mental health problems are common in diabetics and are associated with poor diabetes control, complications and increased mortality. These issues are disabling, poorly detected and inadequately treated. Offering psychiatric treatments to diabetics can improve outcomes and help patients better manage their condition.²⁵

Three potential areas of consideration for going further in south west London are:

- the roll out of patient simulation education as currently implemented by Croydon CCG to promote self-management and improve continuity of care through the pathway
- The extension of the digital platform “Just Be Croydon” to target vulnerable and at-risk diabetics with advice to help self-management.
- Referral of type 1 and type 2 diabetics to psychological therapies with a specific focus on newly diagnosed and young people, to promote emotional wellbeing and self-management to increase mental health awareness at diagnosis, resilience, as

²⁵ . No Health Without Mental Health, Royal College of Psychiatrists, 2010.

well as self-management. Richmond is piloting psychological screening in diabetes clinics. All Improving Access to Psychological Therapies services should proactively work with all those with long term conditions including diabetes.

Redesign – System-level pathway

Improving patient experience and outcomes by ensuring services operate in the most effective way for their needs is key to supporting those with all types of diabetes to “live well” with the disease.

Across south west London, CCGs have undertaken work to review diabetes pathways and service models in order to develop a number of different approaches leading to better join-up of services and improved patient care. There are a number of different areas of focus across the south west London footprint. However, two stand-out areas for wider rollout across the region are:

- Improvements to the hypoglycaemia pathway, with the aim of enabling the safe and appropriate management of patients in their homes with support from the community health services and paramedics – reducing repeated hypo episodes and decreasing conveyances to A&E; and
- The integrated service model, as implemented in Kingston, which aims to improve patient care by placing more services in the community to support diabetics to “live well” and out of hospital.

Primary Care

There is a recognised inconsistency in the management of diabetes and related complications across a range of primary care services – from general practice to opticians and pharmacy. There is significant potential for addressing variation in care in order to support consistency in patient management within this setting.

As part of the STP, two initiatives that could be rolled out across the region are:

- Group consultation in general practice – this supports patient education and improves productivity by delivering support and care advice to groups of diabetic patients together.
- Addressing practice level variation to ensure that every practice is offering consistent care and support to tackle those at risk of developing type 2 diabetes, and helping those with the disease to “live well”

vii. End of Life

Context

National context

The NHS has set out a national goal to personalise End of Life care, particularly through increasing the number of people able to die in the place of their choice, and involving the patient and their families in their care decisions. More broadly, and in line with NICE guidance, the 'Five Priorities' have been identified. These priorities are:

- to **recognise** people approaching the end of life in a timely manner
- to **communicate** with them and their families in an accessible and sensitive way and support them with relevant information.
- The person should be **involved** with their care decisions and offered holistic assessments in response to their changing needs.
- Emotional, practical and social **support** should be offered to patients and their families throughout the process.
- A personalised and detailed **plan** should be agreed upon with the person and their families and delivered in a kind, compassionate and consistently competent manner.

Local context

Within south west London it is estimated that the annual spend on end of life care is £93m²⁶ (where 'end of life' is defined as the last 90 days of a person's life). Around £65m of this spend is estimated to be attributable to care in an acute hospital setting (70% of total costs on end of life care). In turn, the percentage of people dying in hospital is higher in south west London than across London, however south west London does have fewer people dying in hospital than some other SPG areas in the capital.

Data from the NHS Atlas of Variation (Right Care) shows that performance across the six CCGs are in the bottom three quintiles for the following measures related to end of life care:

- Percentage of all deaths that occurred in usual place of residence by CCG
- Percentage of all deaths that occurred in hospital by upper-tier local authority.

In addition to this, NHS London's Strategic Clinical Networks have recognised that at a London-wide level, there is a complex care environment with poor sharing of information. There is variation in commissioning and provision of end of life care. This situation needs to be addressed in order to deal with an expected 18% rise in deaths (currently there are around 47,000 deaths per year across London, rising to 55,000 by 2030) and the growing population of older people (there is a 66% rise in the number of people aged 65 or over by 2041). At London level, only 37.8% of people die in their usual place of residence compared to 45.5% nationally.

There is a significant amount of work being undertaken across south west London to increase the number of people who die in their preferred place. For example, in Wandsworth a coordination centre has supported 86% of people to die in their preferred place, and in Sutton 450 people have been added to Coordinate My Care (CMC) in the last year, with 75% dying in their preferred place and only 18% dying in an acute setting. The CCGs across

²⁶ Based on data from Georghiou and Bardsley (2014) for the Nuffield Trust on "Exploring the cost of care at the end of life" and ONS data (2014) on "Deaths registered in England and Wales".

south west London are working collaboratively, sharing learning and best practice regarding End of Life Care, while recognising that not all initiatives will work across all of the boroughs. They are building on experience of systems such as CMC, while also recognising that the CMC system does require further development and infrastructure support.

Data from a national survey of perceptions of bereaved carers shows that London performs worse than the national average in certain areas. Fewer carers in London felt that:

- Overall quality of care was outstanding or excellent (35% in London, 42% nationally)
- The patient was always treated with dignity and respect by hospital nurses (46% in London, 51% nationally)
- The patient was always treated with dignity and respect by hospital doctors (52% in London, 60% nationally)
- Care from district and community nurses was excellent (34% in London, 45% nationally)
- They had been given enough support at the time of their relative's death (53% in London, 59% nationally).

Key initiatives

Current initiatives in south west London

It should be noted that a number of key initiatives are already well underway within CCG areas across London. In most instances, each CCG has developed local solutions to address issues around End of Life Care in their area. There is also an eagerness to continue to develop local solutions, with some consistency across areas where it is beneficial in terms of quality and finance to do so.

Some of the existing initiatives which are already underway include:

- **Croydon** – end of life care services which allow people who need an urgent response to be seen within two hours and be provided with multi-disciplinary community services and the development of a medicines optimisation strategy.
- **Kingston** – a number of practices have piloted the new CMC-[EMIS](#) connectivity, and work is underway to maximise CMC usage by GPs
- **Merton** – expansion of their existing End of Life scheme in 2 specific areas:
(1) delivery of case management approach for non-specialist palliative care cases within the district nursing service; and
(2) increasing the extent of the hospital at home service
- **Richmond** – provision of end of life care via a palliative care nurse and psychological worker (Mental Health) to ensure advanced planning takes place
- **Sutton** – work through the Care Homes Vanguard project (see further details below)
- **Wandsworth** – an end of life care co-ordination centre, including a Marie Curie HCA service to provide care packages to fast track patients.

In addition to this, in the Sutton CCG area there is a Care Homes Vanguard project underway. This builds on work which has already been undertaken with care homes in this area. In 2015/16 the Sutton Vanguard Programme will be focussed on three new interventions:

- An integrated, proactive model of care
- A quality and safety dashboard to allow for monitoring of quality and safety indicators, to support early intervention and prevention of avoidable incidents and illness.
- A robust education and training programme for staff, through an online education and training platform and bespoke courses.

Please refer to Appendix A section iii for more details.

The CCGs across south west London are also working collaboratively to utilise the London Clinical Network's Commissioners' checklist for end of life care to improve the quality of end of life care across south west London.

Additional initiatives to be explored in south west London

From a workshop and a series of follow-on conversations held with representatives from each of the CCGs in south west London in mid May 2016, a number of further initiatives were identified. This group felt that these initiatives, when fully implemented, would provide an opportunity to improve quality of care and reduce costs associated with the provision of end of life care in south west London. In summary, the initiatives (in order of priority as agreed by the group) are listed below.

1. Identification of patients in their last year of life through education and training for all staff
2. Developing a commissioning specification for acute End of Life care
3. Co-ordinated care/ enhanced use of Co-ordinate My Care (CMC)
4. Work with care homes.

We will also engage with the workforce action group and IM&T programme in respect of the staff and investment in Coordinate My Care needed to support these initiatives.

viii. Engaging Patients and Communities

South west London is committed to engaging patients and communities through:

1. A step change in patient activation and self-care
2. Expansion of personal health budgets and choice

Progress in these areas is important because:

- There is a strong moral and ethical case for developing a health and care system which starts with what matters to people, what skills and attributes they have, and recognises the contribution strong communities can make to support health and wellbeing.
- There is growing evidence that suggests person- and community-centred approaches lead to better outcomes.
- People are keen to take a more active role in managing their own care and support, working with professionals to design and deliver care in a personalised way.
- Advances in digital technology offer new opportunities to support and enable self-care.
- There are opportunities to improve outcomes for individuals and their experiences of services, whilst meeting the multiple challenges of: growing demand from an ageing population; increasing prevalence of long term conditions; fragmented and unsustainable models of care and an unprecedented financial challenge.
- More evidence is needed on what interventions work best in different circumstances, how to embed and scale the most effective approaches to achieve best case ROI and the system levers to enable spread.

Patient Activation

Patient activation refers to patients' willingness and ability to take independent actions to manage their health and care. It relates to an individual's knowledge, confidence, beliefs, skills and ability to take on roles to self-manage their own health and healthcare. Evidence suggests that investing in supporting patients to become more activated will be critical in enhancing the potential of self-care and delivering improved outcomes for individuals for example through improved health & wellbeing; increased engagement in healthy behaviours such as exercise and healthy eating and less health-damaging behaviours such as smoking or drug-use; and improved uptake of preventative interventions e.g. screening and check-ups.

Patient activation in south west London

A range of schemes are in place to support activation, such as:

- Increased engagement in healthy behaviours as promoted by Public Health and including activities relating to exercise and healthy eating (highlighted under Prevention and Early Intervention in the main STP document).
- Improved uptake of preventative interventions e.g. screening and check-ups
- Access to self-care information hubs to navigate people towards appropriate community-based services and resources
- CCGs engagement with community groups, third sector organisations and faith groups to co-design community-based initiatives to support delivery of innovative local services
- Peer education and support.
- Use of PAM tool (a tool for methodically assessing how activated a patient is and what to do with that information, to improve outcomes).

Personal Health Budgets (PHBs)

Personal health budgets are a way of enabling people with long-term conditions and disabilities to have greater choice, flexibility and control over the healthcare and support they receive, and to be more involved in discussions and decisions about their care.

A personal health budget can be offered to the following categories of people:

- People receiving NHS Continuing Healthcare or children's continuing care who already have a right to have a personal budget
- People who have high levels of needs but are not NHS Continuing Healthcare, but who have health needs which would be suitable.
- Children with education, health and care plans (EHC) who could benefit from a joint budget from the NHS and social care
- People with learning disability and/or autism and high support needs
- People who make ongoing use of mental health services
- People with long term conditions for whom current services don't provide optimal outcomes, resulting in more acute services usage; and
- People who need high cost, longer term rehabilitation e.g. people with an acquired brain injury and spinal injury.

Across south west London, commissioners and local authorities along with users and carers are working together to assess health and social care needs and support more personalised support packages. This involves using personal budgets (including direct payments), personal health budgets, or integrated budgets to ensure a more personalised approach to care. It involves working together to allow maximum choice and control and individualisation to be taken on board. South west London CCGs are working together to share best practice and co-produce the local offer for personalised health budgets.

CCGs are promoting greater integrated approaches with providers so that work is aligned to clinical need, developed in partnership with healthcare professionals as well as achieving the outcome families hope to achieve with personalised support packages.

South west London is also now scoping work to develop a plan with milestones for improving the uptake of personal health budgets and patient choice by 2020, particularly in maternity and end of life care (which includes plans to ensure more people are able to achieve their preferred place of care and death). It is recognised that CCGs need to increase their rate of implementation of personal health budgets in order to meet the mandate commitment of between 50,000-100,000 PHBs in place by 2020. It is also acknowledged that there is a large support programme in place to help CCGs implement PHBs. Staff across south west London are engaging in this and seeking to roll out best practice across colleagues and teams.

Examples of priorities across south west London

<p><i>Patient Activation:</i></p> <ul style="list-style-type: none">• PAM tool• Coaching & Peer Support	<p><i>Self Care:</i></p> <ul style="list-style-type: none">• Exercise• Counselling services• Relaxation tips
<p><i>Personal Health Budgets (focus LTCs & disabilities):</i></p> <ul style="list-style-type: none">• People with learning disabilities (Target 85% offered)	<p><i>Choice:</i></p> <ul style="list-style-type: none">• Place of birth• Maternity budgets• Place of death• Elective care location

Choice

Service Area:	Example of expansion of choice:
Maternity Services	<ul style="list-style-type: none"> • One of the recommendations of the 'Better Births; Improving outcomes of maternity services in England' was as follows: <i>'Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice informed by unbiased information'</i> • South west London has recently been successful in becoming one of the seven Maternity Personalisation and Choice Pioneers to test out and develop new ways of increasing choice for women as well as trial personal maternity budgets. • Part of this work will involve developing resources to enable women to make informed choices, including place of birth, and to develop a personalised care plan based on their choices. This information could be given to women at their booking-in appointment and throughout their maternity journey, if and when their needs change. • The pioneer scheme will seek to deepen as well as widen the choices available to women across CCG boundaries, by attracting new providers into its areas and by empowering women to take control in decisions about the care they receive to meet their needs and preferences. • As a pioneer region, NHS England and other national partners will support and work with south west London to develop and test new approaches, and promote their national adoption.
End of Life (EOL) Care	<ul style="list-style-type: none"> • South west London's focus for personalisation in EOL care is to support professionals in having conversations with people nearing the end of life and develop a care plan to support their wishes; particularly to increase the proportion of people dying in their preferred place of death. • Local initiatives include promoting uptake of Coordinate My Care (CMC), a web-based record used to share information about a patient, their care and their preferences for treatment in acute and community settings. • Implementing CMC has increased the amount of people dying in their preferred place of death significantly to 75% of patients in Sutton.
Elective Care	<ul style="list-style-type: none"> • For elective care, south west London is currently focusing on providing choice. For example, when being referred for elective care by their GP, patients have the choice of where to book their appointments through the 'Choose and book' service. • In particular, within south west London there are numerous day-case settings from which patients can choose, and beyond this, patients can request to see a consultant if they so choose.

ix. Learning Disabilities

In south west London we are taking a life course approach ensuring that services for learning disabilities are available for all ages. To achieve this we will set out the vision and standards of care needed through childhood, adulthood, to healthy older age; the process of transitioning services will also be key to this approach. This will be delivered through person-centred care. We also have a particular focus upon the national programme of action “Transforming Care Partnerships” (TCPs), which aims to reshape services for people with learning disabilities and autism away from institutional models of care, closing some inpatient provision which is no longer the most appropriate care and strengthening the support available in the community. This vision is set out in ‘Building the Right Support – a national plan to develop community services and close inpatient facilities’.

Furthermore people with learning disabilities have poorer health than the general population, although many of the health problems are avoidable. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The impact of these health inequalities is serious because as well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers. Men with learning disabilities die, on average, 13 years sooner than men in the general population, and women with learning disabilities die 20 years sooner than women in the general population. Overall, 22% of the learning disabled population were under the age of 50 when they died.

Key changes

Areas for focus include the following:

1. Reduction in the use of inpatient treatment, including Length of Stay and following a crisis
2. Increase in the use of Care Treatment Reviews (CTRs) for all those in inpatient care and those ‘at risk’
3. Development of services for those with a behaviour that challenges
4. Improvement in the health of people with learning disabilities , including a reduction in the mortality rates

Key characteristics of our approach are set out below.

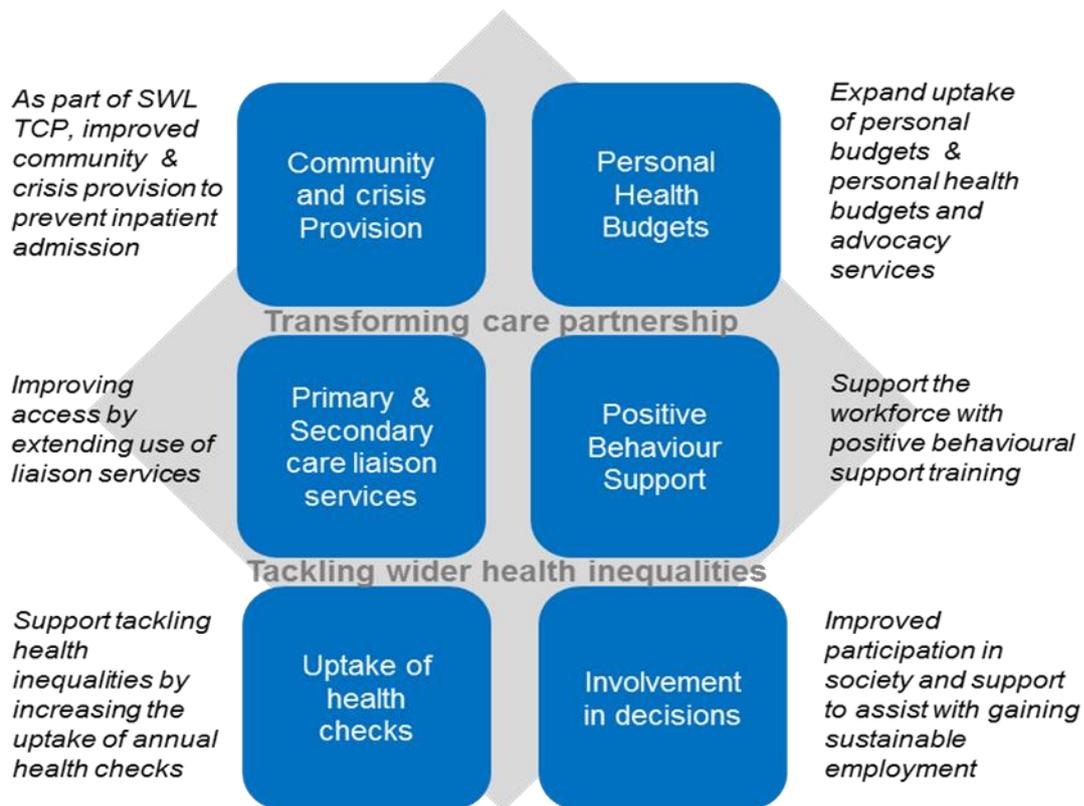
New Model of Care

Given that learning disability is a lifelong condition it is vital that people encounter a seamless transition as they move from children and young people’s services into adult services. The majority of people with a learning disability will be supported in the community and by their GP, with ‘reasonable adjustments’. This will ensure that both their physical and mental health needs are met and will lead to an improvement in the health of people with learning disabilities, together with a reduction in mortality rates. All people with learning disabilities will be offered an annual health check in primary care and a health action plan, if required. For those requiring treatment at hospital due to physical health needs, a Health Passport will also be offered.

By basing most learning disability services in the community this will improve access to community resources that promote social inclusion and positive wellbeing, including access to education, training and employment and appropriate housing. All care packages will be person-centred and the use of personal health budgets will be actively promoted. Increased community services will also impact upon inpatient treatment as the change will lead to a reduction in length of stays and out of area placements; and ensure treatment is undertaken in the least restrictive setting.

For those at risk of needing inpatient treatment (for example because of their challenging behaviour) there is a need to continue to develop community-based crisis services and a workforce trained in Positive Behavioural support in order to help reduce avoidable inpatient admissions. All those in inpatient care or at risk will be subject to a care and treatment review, chaired by a CCG Commissioner, to ensure that individuals get the right care, in the right place that meets their needs, and that they are involved in any decisions about their care.

Learning Disabilities - Key characteristics of our approach



x. Maternity

National Context

In March 2015, as part of the *Five Year Forward View*, NHS England commissioned an independent review of maternity services in England. The review was completed at the end of December 2015 and a report of the findings 'Better Births; Improving outcomes of maternity services in England' was published in February 2016. The report sets out the vision for maternity services in England for the next five years and makes the following recommendations for action:

- Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information
- Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions
- Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation honesty and learning when things go wrong
- Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family
- Multi professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies
- Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed
- A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

Initiatives/priorities for south west London are aligned with these national recommendations.

Local context

In 2014/15, there were ~21,000 births by women living in south west London. Of these, 16,000 gave birth in south west London units and 5,000 in units outside of south west London.²⁷ Over the last 5-10 years there have been small increases in the number of births and the projected increase in births by 2021 in south west London providers is expected to be 0.6% per annum²⁸.

²⁷ Secondary User Services figures 2015/16

²⁸ Derived from Trust activity data as part of south west London financial diagnostic, 2016

South west London is an urban and suburban area with wide ethnic and demographic diversity; some electoral wards house women in the most deprived quintile for the UK and others accommodate some of London's wealthiest families. All four provider trusts serve mixed populations.

There are four maternity services provided across five acute sites. There are five alongside midwife-led units, and no standalone midwife-led units. The table below summarises the current provision across south west London. Deliveries in alongside midwife-led units accounted for ~16% of total births in south west London. However, the proportion of normal births was much higher which would support the shift of deliveries from obstetric to midwife-led care.

CCG areas	Acute provider
Croydon	Croydon Health Services NHS Trust <ul style="list-style-type: none"> • Obstetric unit • Alongside midwifery unit
Kingston	Kingston Hospital NHS Foundation Trust <ul style="list-style-type: none"> • Obstetric unit • Alongside midwifery unit
Merton/ Sutton / Wandsworth	St George's University Hospitals NHS Foundation Trust <ul style="list-style-type: none"> • Obstetric unit • Alongside midwifery unit Epsom & St Helier Hospitals NHS Trust <ul style="list-style-type: none"> • Obstetric units at St Helier and Epsom Hospital • Alongside midwifery units at St Helier and Epsom Hospital • NB. Epsom Hospital mainly serves Surrey population but is included within the south west London planning footprint for the STP as part of Epsom & St Helier NHS Trust.
Richmond	Kingston Hospital NHS Foundation Trust <ul style="list-style-type: none"> • Obstetric unit • Alongside midwifery unit Richmond population also served by West Middlesex Hospital.

Outcomes and intervention rates vary widely between maternity units – see below.

Local challenges

- South west London lies in the worst performing quartile for women's experience of maternity services (2015)²⁹
- South west London neonatal mortality and stillbirth rate per 1000 births in 2013 was 6.51. This was better than the national average. However, there was significant variation in the figures across individual south west London CCGs (5.50 – 7.30)³⁰. In 2014/15 the stillbirth rate per 1000 live births in south west London was 4.9³¹.
- 5.4% of women are still smokers at the time of birth against a national average of 12%.³²
- Rising maternal age is leading to increasing complexity
- Services are organisation-focused rather than woman-centred
- Key clinical staffing standards are not met, or not met consistently. 8 out of the 27 London Quality Standard maternity standards are not currently being met consistently by trusts in south west London³³.
- No units are currently meeting the London Quality Standard of providing 168 hour obstetrician presence on a labour ward.
- In the 2015/16 financial year all trusts made progress towards achieving a minimum of 98 hours obstetrician presence with 98 hours achieved for Epsom and St Helier, Kingston, Croydon and 132 hours for St George's Hospital as at December 2015.
- Continuity of carer could be improved
- Hospital and community postnatal care experience can be poor
- There is variation in quality and quantity of antenatal care provided by GPs
- Screening programmes are not always well integrated with maternity services, and there is variation in uptake and follow up
- The current home birth rate is only 1.8% (2014/15).

Vision

Our vision for maternity care in south west London is to provide consistently high quality healthcare that supports women to have a normal healthy experience as well as caring for higher risk, more complex births. In particular, maternity services in Southwest London will be designed in a way that:

- Prepares women and their partners for pregnancy and parenthood through education and up-to-date, evidence-based information
- Provides care to women as individuals, with a focus on their needs and preferences
- Invests in improving continuity of care and carer, with a strong emphasis on midwifery-led care for normal pregnancy and birth
- Provides care which meets the London quality standards for all women and their babies
- Values and takes on board feedback from the women we look after and their families in order to drive continuous improvement in the quality of care.

A south west London maternity specification has been agreed and contracted to support delivery of the maternity vision in south west London through development of best practice and new models of care.

²⁹ CQC National Maternity Services Survey – 2015, south west London STP Data Pack, April 2016

³⁰ CCG OIS Indicator 1.25, south west London STP Data Pack, April 2016

³¹ south west London Maternity Dashboard, 2014/15

³² south west London Maternity Dashboard, 2014/15, HSCIC

³³ south west London Maternity Services Specification - 2016/17

Implementation and ownership

The South West London Maternity Network, which has been established since 2013, working under the auspices of the six CCGs and four acute providers in south west London will be responsible for delivery of the maternity initiatives in the STP. This group comprises commissioners and clinicians from across the south west London footprint.

We are further refining the list of initiatives, including what could be accelerated through the Maternity Choice and Personalisation Pioneer during 2016/17. Planning is currently being undertaken in partnership with NHSE to scope the programme for the Pioneer.

In line with the recommendations of the National Maternity Review, further work will be undertaken to further evolve and strengthen the governance and structure of the Network to ensure full success of delivery as a local maternity system. STP support would be beneficial in supporting the implementation of these plans to deliver the Better Births National Maternity Review recommendations across south west London.

xi. Mental Health

Our approach

In south west London we are taking a life course approach to ensuring good mental health and well-being for all ages. To achieve this we will set out the vision and standards of care needed from conception (Perinatal), through childhood (CAMHS), working ages to healthy older age. We are focusing on prevention, screening and early intervention and putting in place clear pathways to improve access to services which provide timely, effective, personalised, compassionate care for all mental health conditions across all settings of care. We welcomed the recent publication of the *Five Year Forward View* for Mental Health and will embed the recommendations in our implementation plans.

We have identified three areas of focus:

1. Promoting prevention, emotional wellbeing and early intervention
2. Living well with mental health, with a focus upon recovery
3. The provision of Acute services, including crisis.

Our mental health transformation programme recognises that mental and physical health and wellbeing are interrelated and as such mental health will be referenced throughout the STP, given that mental health is everybody's business. The programme also recognises that there are barriers between mental and physical health systems, even though mental health interventions can contribute to improving a person's overall wellbeing and specifically in the recovery of those with conditions including long term ill health, medically unexplained symptoms, and pain management.

Our Challenge

By 2020 the south west London population is forecast to increase by 4.7% with an increase in the BAME (Black, Asian and Minority Ethnic) population of 1.8%. Based on national prevalence figures, there could be up to an estimated 330,000 people in south west London with mental health illness by 2020³⁴. There were 14,704 people with a severe mental illness known to their GPs in south west London in 2014/15³⁵.

We will be required to meet a growth in demand that is only partly due to an increase in the number of people living in south west London. As the awareness of the importance of good mental health and wellbeing grows, together with an increase in screening and early detection, more people with common mental health problems, such as anxiety and depression, will be accessing services. This is in line with the *Five Year Forward View*.

The majority of people with a mental health illness will be supported in the community and by their GP. This will mean that we will have to put in place the tools to allow GPs and other community professionals to support people across the spectrum of mental health illness. The focus will not only be on services such as IAPT (Improving Access to Psychology Therapies) but also supporting more people with serious mental illness (SMI) in community settings. For these patients the requirement is not only that their health needs are met but also to ensure that they can access community resources that maintain positive mental health in

³⁴ Estimates based on national prevalence figures by age group ('Adult psychiatric morbidity in England', HSCIC 2009), and using CCG Registered populations with ONS CCG growth projections applied.

³⁵ Severe mental illness profiles', Public Health England

order to achieve their goals. These resources include access to education, training and employment; appropriate housing; friendships and employment.

Our aim is to prevent people from experiencing avoidable inpatient admissions, particularly via the current acute crisis pathway. We know that currently there are too many people being admitted into an inpatient mental health bed as there is no other alternative care available for them. Sometimes, due to the pressure on inpatient beds people are placed out of area, which we know often leads to a prolonged length of stay and less positive outcomes. For those who are placed out of area, beds will be made available locally. Furthermore, in accordance with the recommendations of the *Five Year Forward View*, we aim to end out of area treatments by 2017. Overall, the plan is to develop services to reduce the need for inpatient treatment. These may include: crisis cafes; crisis house; psychiatric decision unit; rolling out the challenging behaviour services.

When an inpatient admission is the most appropriate care option for an individual we will ensure that their inpatient care will be close to home, in the least restrictive setting, and be of therapeutic benefit with the length of stay kept to a minimum.

We also recognise that we need to do more to integrate physical and mental health services. We know that we need to improve the physical health of people with severe mental illness to reduce their premature mortality rates. Furthermore, the recovery of patients with long term physical health conditions is often prolonged when their psychological needs are not acknowledged or met.

Our Plans for our Priority Areas

We aim to transform mental health services in south west London to meet these challenges, delivering the three priority areas that we have identified, as well as wider requirements set out in the Five Year Forward View for Mental Health. Among these developments is the implementation of the Crisis Care Concordat and new and enhanced services such as IAPT and Psychiatric Liaison. We are also conscious that mental health has an important place in and across the STP and therefore we will ensure that there is strong evidence of mental health being appropriately addressed in all STP work streams.

We will work collaboratively with partners to commission and deliver mental health services, moving to an outcomes-based approach and away from the 'block' arrangements that have historically been used to fund mental health services. We have established a south west London Mental Health Network to develop these relationships.

We will continue to focus on achieving Parity of Esteem for mental health and physical health. This will lead to the reduction of stigma and the willingness of people to seek early help for their mental health issues. We also want to encourage more people locally to seek a career in mental health to secure a sustainable workforce for the future.

xii. Planned Care

Context

National context

Elective care accounts for around 18% of providers' total annual expenditure in 2013/2014, rising to over 30% if outpatient spend is included. It represents 34% of activity in acute specialist trusts, 23% in acute teaching trusts and 21% in district general hospitals³⁶

Finance:

- Elective care accounted for 14% of south west London acute providers' total annual income in 2015/16
- Elective & OP care together accounted for 30% of south west London acute providers' total annual income in 2015/16

Activity:

- Elective care accounted for 20% of spells and 24% of bed days at St George's in 2014/15
- Elective care accounted for 14% of spells and 13% of bed days at south west London acute providers (including St George's) in 2014/15 (Secondary User Services, SLAM).⁴

Local context

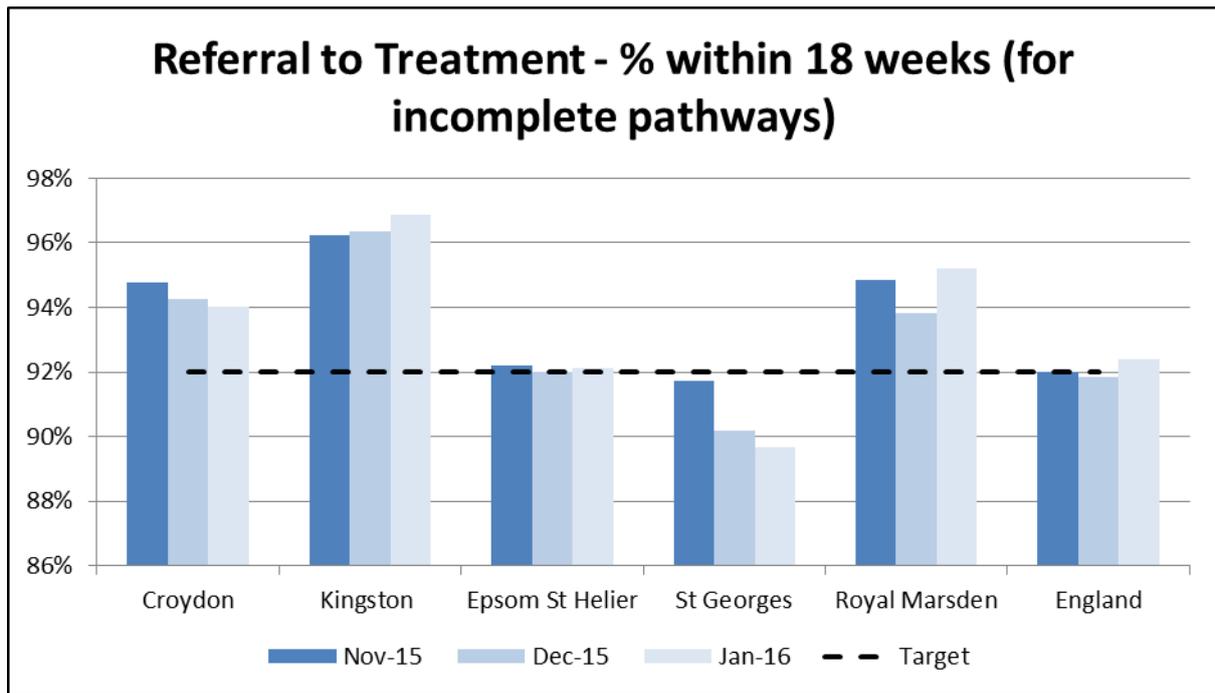
In 2014/15 there were 27,000 elective inpatient spells (SUS) across south west London providers (excluding Specialised Commissioning).

There are currently four providers providing elective care across five sites/settings of care in south west London. They are:

- Croydon Health Services NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- St George's Healthcare NHS Trust.

Most of the providers across south west London achieve 92% of the Referral to Treatment standard within 18 weeks, with St George's being the only provider to miss this target.

³⁶ Helping NHS providers improve productivity in elective care, Monitor 2015



A significant number of patients from South West London are treated outside SW London , for example in the Royal Marsden NHS Foundation Trust. If their bed numbers are included. Between them these five providers have approximately 330 elective beds. In 2014/15 south west London also commissioned circa 8,000 elective care spells for patients from south west London in non-south west London providers. For example, there were 753 elective spells for cancer patients in the Royal Marsden.

Patients rightly expect to receive high quality planned care. We also know that some planned care can be subject to long waiting times, cancellations for non-clinical reasons and unnecessary treatment delays. Planned care is, therefore, an essential area of focus in our STP. We are committed to improving local planned care services so we better meet patient needs and ensure patients receive high quality, personalised care safely and efficiently.

Key initiatives

Current initiatives in south west London

Improving planned care services is directly aligned to one of the six characteristics of high quality and sustainable health and care systems; ‘a step-change in the productivity of elective care³⁷’. This characteristic refers to the need for planned care services across the health system to be ‘designed and managed from start to finish to remove error, maximise quality, and achieve a major step-change in productivity’. There is an expectation that centres across south west London will be able to deliver high quality treatment, develop expertise, and use the most modern equipment available.

There are three groups working across south west London supporting the development of more effective and efficient elective care:

³⁷ *Everyone counts: Planning for patients 2014/15 to 2018/19, NHS England, 2013. Retrieved from: <http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf>*

1. Planned Care Task and Finish Group – this group has been tasked with defining the different elements that will make up the future acute model of care to enable a (non-site-specific) list of all possible whole-system models. The outputs of this group is incorporated within Appendix C of this document.
2. The Demand Management and Provision Group – this group is focusing on moving Outpatient activity into the community.
3. The south west London Elective Care Commissioning Network. This group is made up of the Elective Care Lead Commissioners from the six Clinical Commissioning Groups across south west London and they are taking forward a number of initiatives including:
 - Introduction of standardised pathways and protocols
 - Introduction of effective performance management systems¹ across south west London
 - Reduction in “Did Not Attend” through better use of technology and the introduction of virtual clinics
 - Ring-fencing of elective care beds
 - Improved access to diagnostics (08:00 to 20:00hrs)
 - Expansion of one stop diagnostics
 - Improved networking and referral management
 - Theatre productivity review and sharing best practice
 - Consistent application of “Procedures of limited clinical effectiveness” policy
 - Improve access to Psychological Therapies (Mental Health) for patients with long term conditions or those who are being treated conservatively (e.g. chronic pain).

Many of these initiatives have workforce, IM&T and estates implications, for example, altered shift times for diagnostic staff, the need for improved radiology interoperability and networking and sharing of services.

xiii. Public Health

Introduction

The *Five Year Forward View* sets out that a 'radical upgrade in prevention' is needed to improve people's lives and achieve financial sustainability of the health and care system. Sustainability and Transformation Plans (STPs) provide the NHS with an opportunity to work closely with local government and other local partners to build on existing local efforts and strengthen and implement preventative physical and mental health interventions.

Context

Public health is a key area of focus for the STP - preventative interventions have an important part to play in stemming the tide of long-term physical and mental health conditions, and increasing health and care costs.

The NHS spends more than £15.5 billion per annum³⁸ treating illness which directly results from alcohol and tobacco consumption, obesity, hypertension, falls, and unhealthy levels of physical activity. Most of this treatment is avoidable.

Mental illness is the largest single source of burden of disease in the UK: no other health condition matches it in the combined extent of prevalence, persistence and breadth of impact. It is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour, with wider costs in England amounting to £105 billion a year. Healthcare costs attributed to alcohol consumption in south west London are estimated at approximately £72m³⁹ and healthcare costs related to smoking in south west London are estimated at approximately £39m.⁴⁰

Mental health is inextricably linked with physical health and wellbeing. Most mental illness begins before adulthood and often continues through life. Improving mental health early in life will reduce inequalities, improve physical health, reduce health-risk behaviour and increase life expectancy, economic productivity, social functioning and quality of life.

Poor physical health also increases the risk of mental illness and is associated with key public health conditions such as obesity, alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease, chronic lung disease and diabetes. Despite this, prevention of mental health problems and promotion of positive mental wellbeing often receives limited attention in health improvement work, and is not well integrated with action on other priority public health issues such as tobacco, alcohol or obesity.

Creating conditions in which people can live healthy lives for as long as possible, changing people's unhealthy behaviours, and thus improving the physical and mental health and wellbeing of our population, are integral to reducing the risk of illness, premature deaths, disability, and health inequalities. Improving the physical and mental health and wellbeing of our population also has an impact on the demand for health and care services, leading to savings in the longer term – ultimately contributing to the sustainability of the health system.

³⁸ <https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-aide-memoire-prevention.pdf>

³⁹ Alcohol Concern, 'Alcohol Harm Map'

⁴⁰ Action on Smoking and Health, 'Local Cost of Tobacco: Ready Reckoner' (2015)

There is overwhelming evidence that changing unhealthy behaviours can have a major impact on some of the greatest causes of mortality and morbidity such as cancer, diabetes, and some forms of dementia. Mental wellbeing is also a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health.

The Wanless Report (Wanless 2004) outlined a ‘fully engaged’ scenario – where levels of public engagement with health are high, and the use of preventive and primary care services are optimised, helping people stay healthy – as the best option for future delivery of NHS services. This scenario requires changes in unhealthy behaviours to be at the heart of all disease prevention strategies.

Tackling the main unhealthy behaviours and improving mental and physical health are fundamental to closing our health and wellbeing gap and preventing ill health.

Approach

In order to achieve maximum benefit, it is essential to work with local authorities and other partners across the health and care system and adopt a multifaceted approach to tackling unhealthy behaviours – deploying a range of interventions and techniques (policy, education, technologies, and resources) which are targeted and delivered at different population levels:

1. Whole population/place-based
2. Community
3. Individual
4. Digital

The following sections provide examples of successful interventions that are taking place across south west London and potential good practice interventions to be rolled out across the CCGs under the STP.

In order to drive this approach forward, it is essential to engage the workforce across the system so as to co-produce plans from the outset which will achieve the change and shift necessary for a radical upgrade in prevention.

Whole population/place-based approach

Interventions aimed at the population as a whole are key to targeting societal influence on behaviours, reducing the exposure to risk factors which might prompt unhealthy behaviours, and creating an environment where healthy choice is the easy choice.

Population-based approaches are tailored to change specific behaviours and deployed to target the public at the source e.g. in shops or in their homes. Planning, licensing and pricing mechanisms (e.g., sugar tax, alcohol pricing, etc.) are all cost-effective means to change the environmental factors which impact on an individual’s behaviour. There is growing evidence that, compared with individual interventions, population level interventions cost around five times less and are more cost-effective in reducing health inequalities.

Examples of actions include:

- Fiscal and legislative interventions e.g. increasing the cost of cigarettes; banning promotions on alcohol; banning smoking in cars with children; mandating plain packaging for cigarettes; and licencing restrictions

- Point of sale promotions and interventions – working in partnership with retail outlets and food companies to offer nutritional information on food packaging and units on alcohol; and healthy food promotions
- Promoting health messaging through national and local advertising and media campaigns

Current initiatives in south west London

A number of boroughs have identified specific planning, licencing and pricing measures. Croydon, for example, has introduced an alcohol licencing zone scheme where off-licences have committed to stop selling cheap beer and cider products above a certain alcohol content or alcohol by volume (ABV). It has also introduced restrictions on the sale of alcohol in four cumulative impact zones across the borough. Richmond has also undertaken joint work with the Met Police on local licensing decisions and restrictions have been imposed on premises due to alcohol related incidents.

Benefits

The benefits of these initiatives will be realised in the longer term as they impact on culture and behaviour and are expected to include:

- Reduction in disease prevalence (alcohol related admissions, smoking prevalence, number of adults overweight);
- Reduction in crime and disorder;
- Financial savings due to reductions in unhealthy behaviours.

Required investments

A number of population-wide initiatives have been identified within south west London and the costs of these are expected to be negligible as they are based on implementing legislation. However, substantial time and support will be required to work with local authorities to influence changes in legislation.

Key considerations

Population level interventions have the greatest benefit if they are supported by local government. This will require local authorities to seek support for the approach through the democratic process and achieving a pan-south west London approach will be challenging to achieve. However, giving politicians a mandate from the public through 'public debates/conversation' is one way forward and should be incorporated into a south west London approach.

In order to successfully take this proposal forward, it will be essential for Directors of Public Health to work together with key individuals within the NHS and wider local authority in order to give traction, gain momentum and identify implementation plans across the whole of south west London.

Whilst population-based initiatives have centred on alcohol within this section, the principles could be applied to other unhealthy behaviours e.g. sales promotions for food/high sugar or fat content items.

Community-based approach

Community-based interventions are applied to social/family groups, geographical locations, or subgroups of the population such as cultural groups; with the aim of identifying and building on the strengths and relationships to create healthier environments.

Example of specific actions include:

- Supporting local organisations and businesses to promote health messages and healthy work place initiatives;
- Facilitating the creation of healthy places – better air quality, transport, and housing.
- Supporting organisations or voluntary groups that promote participation in leisure activities;
- Promoting healthy catering in workplaces and in public vending machines.

Current initiatives in south west London

There are a number of community-based interventions currently being implemented in south west London boroughs. These interventions focus on creating healthy environments around places of work or education through promotion of physical activity, addressing emotional and mental wellbeing and physical health issues, and reduced accessibility of unhealthy foods.

For example, Croydon has also introduced a number of education-based and school partnership programmes, including the food flagship programme. The programme is focussed on transforming the local food environment by raising awareness about the importance of eating nutritious meals to tackle obesity and reduce health inequalities.

According to Healthy London Partnership data on cost savings and return on investment, initiatives of this kind offer benefits over the long-term through generally improving the health and physical, emotional and mental wellbeing of targeted groups.

Community-based services are variable between each borough and address many of the following topics: weight management, unsafe alcohol and drug use, tobacco, smoking, weight management, physical activity, falls prevention and mental and emotional wellbeing.

South west boroughs are now pulling together these services under an online single point of access which links to the community health hubs that provide integrated lifestyle services. These integrated services offer online, face-to-face or group behaviour change advice and support. They are also linked to community assets such as the leisure providers, pharmacies and charities such as MIND. CCGs will support and work collaboratively with local authorities to support the development of these hubs to maximise best use of existing resources, ensuring the offer is of a high standard throughout south west London.

A community hub with a single point of access offers the benefit of increased and improved communication between agencies and professionals delivering services. This will enable more appropriate, targeted support, and allocation of resources. It will also enable a higher visibility of services. The better accessibility of staff will facilitate improved relationships with clients, and facilitate an increase in opportunities to share positive and consistent health messages.

Across south west London, councils are signed up to delivering the London Healthy Workplace Charter, which recognises and rewards workplaces for investing in workplace health and wellbeing. It provides a series of standards for workplaces to meet in order to guide them to creating a health-enhancing workplace. A commitment to this initiative should be included in future service specifications and contracts.

The Charter aims to support staff to model healthy behaviours and this should increase their confidence in championing healthy behaviours among their client groups, as part of our approach to Making Every Contact Count (MECC). MECC extends across frontline professionals in health and social care, including staff who go into people's homes. MECC does not only address health-related behaviours; it can also be applied to health and social care challenges such as loneliness and isolation, winter warmth, access to new technologies

and active travel. Service specifications, contracts and job descriptions should reference MECC as it is a key commitment in south west London.

Benefits

Community-based approach interventions could yield a number of benefits including:

- Reduction in disease prevalence (alcohol related admissions, smoking prevalence, number of adults overweight)
- Reduced burden on Primary Care
- Reduction in crime and disorder
- Increase in active participation of local non-NHS community services

Required investments

In order to achieve these initiatives investment will be required in several areas:

- Identifying workforce or community volunteers to drive forward community initiatives
- Training workforce to support community-based activities
- Prioritisation of joint working with organisations and businesses in the community to work together
- Identifying resources throughout southwest London for residents and how best to utilise these resources

Key considerations

Developing community approaches on a south west London basis should be led by local authorities. Directors of Public Health should work together with key individuals from across the health sector, wider local authorities and London Assembly (planning, housing, transport etc) to develop plans for implementation, identifying how to upscale many of the positive initiatives that are currently implemented across south west London.

Individual

Individual or 1:1 based approaches are focused on interventions which help and support people to understand and manage their unhealthy behaviours through:

- Promoting the benefits of behaviour change;
- Planning a manageable way to change and adapt;
- Developing coping strategies to prevent relapse; and
- Supporting ways to commit to changing behaviours by setting goals.

South west London will be putting together a system-wide strategy to provide preventative support for specific groups. This will include building a Making Every Contact Count (MECC) and Social Prescribing strategy.

MECC is a method of providing opportunistic brief advice on health behaviours so that local residents or patients are encouraged to make positive lifestyle changes for better health. This will be focused in areas of high return on investment within hospital services and by the Fire Service as part of the 'Safe and Well' visits to the vulnerable population and those with complex conditions. Some approaches already adopted include working with health champions from the workforce, communities and groups and local leaders, e.g., local councillors (Merton and Richmond).

Social prescribing links patients in primary care and other community settings to sources of support within the community that are available to them. It provides a non-medical referral option that can operate alongside existing treatments to improve health and well-being or

prevent ill-health. The social prescribers can utilise the resources that are already existing: for example, the single point of access community health hubs.

Social prescribing should focus on promoting community assets and building social capital within communities. This is very much a partnership between primary and community care, local authorities and the voluntary and community sector, operating at borough level and with a bespoke approach in each hub.

Benefits

As a result of these individual interventions a number of benefits are expected including:

- High rate of effectiveness (for the smoking interventions)
- Reduction in alcohol related admissions
- Reduction in smoking prevalence
- Reduction in severely obese people.

Key considerations

To be most effective, service-based individual approaches need support from the NHS in order to be scaled up and rolled out in a systematic way. Public health allocations are decreasing and cannot support the investment that is required to reach all those who would benefit from these interventions.

The key challenge here is that investment is required upfront, with returns and benefits several years later. Current incentives within the health system do not support this longer lead-in and capitated budgets and longer-term contracts need to be considered.

Digital

Digital approaches offer an alternative to individual or 1:1 service level interventions and present an opportunity to reach a wider group at a lower cost.

Whilst digital approaches are still largely experimental, many areas are developing them to complement their traditional service level approaches, i.e. drug, alcohol and smoking cessation services. There are also many regional and national digital campaigns that we can better utilise. The development of more digital based approaches may mean that service-based individual interventions can be refocused to support more vulnerable and at risk groups – for example, supporting mental health and wellbeing – leading to more targeted interventions. Interventions should be included in service specifications and contracts if they are to have a population-wide effect.

Current digital initiatives

There are a number of London and national digital campaigns that encourage healthy behaviour changes for targeted groups and whole populations. These include: Change 4 Life, One You and Start4life.

There are also a number of digital campaigns in development that we should support and adopt such as the London Sexual Health Transformation Project and the universal digital option to support smoking cessation.

Based on HLP data, digital approaches to smoking cessation have been identified as achieving one of the highest net savings. Wandsworth is leading a project with Tower Hamlets, on behalf of the London borough Directors of Public Health, to develop a universal

digital option to encourage and promote smoking cessation. It is anticipated that this will be in place by 2017. This involves an evidence-driven programme through various channels:

- An app
- E-mail
- Web-interface
- A smoker's helpline (web-based support tool)
- An online community
- Text2Stop.

The London Sexual Health Transformation Project will offer online information about sexual health, online triage, signposting and the option of ordering self-testing kits. This will be complemented locally by GUM clinics opening longer hours and integrated care, linked more closely with primary care.

South west London is a first wave adopter of the National Diabetes Prevention Programme, a behavioural change programme designed to support patients to lose weight and adopt healthier behaviours in order to slow the progression of diabetes diagnosis. In addition to this scheme, there is potential to upscale digital risk assessment tools as a first step in identifying patients at risk of developing type 2 diabetes earlier, and providing support (i.e referral to the National Diabetes Prevention Programme if eligible) and improved management to address contributing unhealthy behaviours in a primary care setting

These avenues could be used to help provide online support, online exercises, tracking of progress, tracking of monetary savings and other supporting information.

Benefits

As a result of using digital mechanisms a number of benefits could be realised including:

- Healthier behaviour
- Higher engagement and access
- Low cost and high returns.

Key considerations

In order to provide digital solutions in the most cost effective way, a pan-London approach, rather than a regional approach, may be preferable.

In order to successfully implement this proposal, it is recommended that CCGs, local authorities and Public Health work together to develop a timeframe and plan for implementation and consider the application of this technology to wider unhealthy behaviours.

xiv. Transforming Primary Care

South West London's Vision for Primary Care

Primary care is pivotal to the delivery of effective healthcare across south west London. It is important in tackling the needs of the population and the changes we know our local populations want to see. Our vision is informed by the publication from NHS England London region: Strategic Commissioning Framework (SCF) for Primary Care. Our vision is underpinned by supporting quality, and aims to deliver:

- **Accessible care:** which is timely and responsive to individual needs for routine and urgent advice and care and is not limited to consultations in the surgery.
- **Coordinated care:** which is holistic, provides continuity and reassurance for patients whose condition and complexity of care, require it.
- **Proactive care:** which focuses on prevention, encourages self-management and supports the overall health and wellbeing of the population.

This will be enabled by:

- Financial investment
- Increased skill mix and new roles
- Utilising technology to improve access and create capacity
- Estates that are fit for purpose
- Increased efficiency through working at scale
- Delegation of commissioning to CCGs to optimise local transformation

Priorities for primary care in South West London (*reflected in the General Practice Forward View*)



As a result we will support primary care and help ensure that:

- General practice is enabled to take collective responsibility for the health of their population.

- There is an increase in the use of technology to create additional capacity and access.
- GPs and practices are enabled to be the key co-ordinator of care in communities, working proactively with community services, mental health, and social care and specialist services.

Key to delivering this vision and supporting the wider integrated health and social care agenda will be the delivery of the 17 specifications that form the Strategic Commissioning Framework, in relation to accessible, proactive and coordinated care. The vision also aligns with the aims of the General Practice Forward View (GPFV - published April 2016), which recognises the need to invest and introduce new models of care within general practice as well as supporting the workforce.

Implementation of the 'Ten High Impact Actions' (HIAs) referred to in the General Practice Forward View, will be supported by the work underway around the accessible, proactive and coordinated care specifications together with the role of south west London federations as well as collaboration across the Community Education Provider Networks (CEPNs) in south west London in supporting sustainability. For example, action around productive work flows and personal productivity should help support improved efficiency and will involve training and support arrangements for staff.

10 High Impact Actions	Supported by delivery of 17 specifications:			The role of SWL federations & SWL CEPN
	Access	Co-ordinated	Proactive	
1. Active signposting	✓			✓
2. New consultation types	✓			
3. Reduce DNAs	✓			
4. Develop the team				✓
5. Productive work flows				✓
6. Personal productivity				✓
7. Partnership working		✓		✓
8. Social prescribing			✓	✓
9. Support self-care		✓	✓	✓
10. Develop QI expertise				✓

Across south west London, work is underway to progress the vision and there are common approaches amongst the CCGs around federation development, arrangements for enhanced primary care access, patient online promotion, MDTs and risk stratification. There is also a range of work underway to share learning and support local implementation, such as:

- E-consult pilots
- Telephone triage systems
- Live well champions and care navigator role and function
- Primary care role in care homes
- Designing approaches to support improved integration, outcomes and patient experience

South west London will continue to build on this work and is committed to fully delivering the 17 specifications and aligning this to the General Practice Forward View.

In 2016/17 priority is being given to the access specifications, which recognise the impact that timely access can have on the wider system. For example, primary care has many more interactions with patients than any other part of the NHS:

- Early diagnosis and treatment in primary care reduces harm and distress for patients.
- Effective and timely responses can help minimise adults and children being treated in emergency departments and so ease the pressure on A&E.

Figures 1-3 set out the timeline for south west London implementation of the access, coordinated care and proactive care specifications respectively, followed by tables detailing how actual implementation of each specification will be supported. Scoping and phasing of these is underway, alongside financial modelling to better determine the ongoing resource implications and scale of provision.

Implementation of all the access specifications is planned by quarter 4 (Q4) of 2018/19, with 100% implementation across proactive and coordinated care planned by (Q4) 2019/20.

Figure 1: South west London SPG Primary Care SCF delivery timescale – Access



Table 1: How the implementation of the Accessible Care specifications will be supported across south west London

A1 - Choice	<ul style="list-style-type: none"> • Provision of access hubs to provide greater flexibility to patients • Increase in patient online and availability of online appointments and apps to support patient education messages • Infrastructure availability and review for accessibility (e.g. hearing loops) • PMS contract review should assist - <i>although finalisation of this review is still being worked through</i>
A2 - Contacting the practice	<ul style="list-style-type: none"> • Website development at practices to provide email consultations • Patient online promotion for online booking • Telephone booking systems enabled • PMS contract review - <i>although finalisation of this review is still being worked through</i>
A3 - Routine hours	<ul style="list-style-type: none"> • Federation development
A4 - Extended hours	<ul style="list-style-type: none"> • Mix of hub arrangements to support extended opening • Shared medical record implementation • PMS contract review - <i>although finalisation of this review is still being worked through</i>
A5 (Same day access)	<ul style="list-style-type: none"> • Triage schemes such as Doctor First or AskmyGP being piloted in parts of south west London • Telephone triage systems being tested in a number of practices
A6 (Urgent & emergency care)	<ul style="list-style-type: none"> • Training of practice staff to identify emergencies • Engagement at CEPN level to determine any additional training to support staff to

	identify and respond appropriately <ul style="list-style-type: none"> • Exploration of GP Triage and plans for 111 to be able to book appointments via 'Hubs'.
<i>A7 (Continuity of care):</i>	<ul style="list-style-type: none"> • Provision of flexible appointment lengths at practice level • Risk stratification tools • Provision of named GP with responsibility for ongoing care coordination and continuity • Introduction of roles such as care navigator will support signposting as well as supporting continuity

A PMS contract review has been underway across south west London (PMS contracts cover around 66% of south west London GP practices), in order to help ensure that PMS contract agreements deliver quality standards, meet the needs of the local population and are aligned to strategic objectives. As a result, part of the PMS offer currently under negotiation includes areas of the SCF, in particular additional weekend capacity (A3 & A4), technology use to support the availability of online appointments, online repeat prescriptions and the offer of electronic consultations (A1 & A2). The outcome of the PMS review has been delayed due to a 'pause' during which London-wide LMCs and NHS England (London Region) have sought to agree a way forward. This has affected timelines for the planned achievement of some access elements of the SCF.

South west London SPG has made a commitment to working towards achieving a seven day working service model. South west London had one Prime Minister's Challenge Fund site (PMCF) which provided additional access to same day primary care for patients in Richmond, through the creation of four extended access hubs, open 8am-8pm, seven days a week.

Example of 7 day working service model via PMCF - Richmond

Extended GP access is available from four hubs in Barnes, Hampton Wick, Twickenham and East Twickenham. Patients contact their GP in the usual way and are offered a daytime, evening or weekend appointment in the nearest location to their home. New technology has enabled electronic access to patients' notes, so the GP or nurse in either of the locations can access the patient's record and better understand their medical background quickly. This scheme, offering extra GP capacity over seven days a week supports the CCG's out of hospital strategy which aims to commission services that are local and link up around the patient.

In addition, London has successfully bid for funds to accelerate extended access. £4.9 million will come to South west London in 2016/2017 and £4.59 million in 2017/2018, to speed up the achievement of the extended access specification, which will be fully delivered across south west London by the end of 2017/2018.

Another key factor around access is urgent and emergency care, ensuring that patients will be able to access high quality urgent and emergency care seven days a week, which will be complemented by seven-day services in primary care.

The south west London urgent and emergency care network is working closely with primary care to deliver four of the seven access specifications which could have a more direct impact on attendance at A&E, namely:

- A2 *Contacting the practice*
- A4 *Extended hours*

- A5 Same day access
- A6 Urgent and emergency care

111/Out of Hours will be used as the front door to an integrated hub, which provides access to advice/treatment from primary, community, and acute professionals.

Ultimately implementation of the access specification across south west London will support a consistent offer by Q4 2018 which means



Accessible Care

- Confidence that general practice can offer the level of continuity which enables the local population to receive high quality routine care and the provision of urgent advice and care when needed.
- A primary care service delivered with improved continuity, access, discharge planning, and effective local out-of-hours care arrangements.
- A range of access options are available and there is choice of services that best meet local needs.

Figure 2: south west London SPG Primary Care SCF delivery timescale – Coordinated Care



Table 2: How the implementation of the Coordinated Care specifications will be supported across south west London

C1 – Case finding and review	<ul style="list-style-type: none"> Risk stratification tools in place Coordinated care register in place Focusing on 2% caseload of patients under case management with personalised care plans
C2 – Named professional	<ul style="list-style-type: none"> Coordinated care register in place Named professional assigned to each individual on care register Training for healthcare professionals
C3 – Care planning	<ul style="list-style-type: none"> Coordinated care register in place
C4 – Patients supported to manage their health and wellbeing	<ul style="list-style-type: none"> Named professional assigned to each individual on care register Patients and carers invited to develop holistic care plan Developing the evidence base on MDTs and care planning - supported by a Darzi fellow in one borough sharing and disseminating good practice MDTs working to support patients to manage their health via care plans
C5 – Multidisciplinary Working	<ul style="list-style-type: none"> Baseline of the extent of multidisciplinary working within practices to be recorded and actions developed to address shortfalls Networks of practices to develop and review obstacles preventing MDT working

South west London is committed to implementing the coordinated care specifications. Risk stratification and multidisciplinary working will accelerate joined up working between professionals providing intensive support to identified individuals. This will enhance relationships and communication between primary care, social care, community and care home professionals and community-based specialists, as well as with service users and their carers. The implementation of the coordinated care specifications in south west London will help achieve the following outcomes for our patients by Q4 2019.



Coordinated Care

The right amount of time, attention and skill allocated to all patients including those who are most vulnerable in society, including those with a Learning Disability or at risk of losing their independence, and to those who have significant health and/or mental health conditions.

- Responsibility amongst providers for jointly co-ordinating holistic care of people suffering with multiple LTCs, and includes helping people to identify and seek further help for associated mental health conditions , such as anxiety and depression or accessing services which will increase their social welfare.
- Integration with urgent and emergency care, including effective signposting, patient flow analysis and appropriate adjustment to changes in demand.
- Care co-ordination, case management, risk stratification, shared care records and multidisciplinary working - joining community teams, social care professionals and specialists - to deliver joined up care for people with long term conditions and complex needs, as well as those identified to be at the end of life.
- Frontline care in premises which are safe, suitable and facilitate multidisciplinary working between health and social care professionals where possible - a physical space in the community associated with health and wellbeing. For those with a mental health issue that these settings are also free from stigma.
- Support for patients with medication management through regular reviews, use of IT and decision-support tools, pharmacist- and nurse-led interventions and the involvement of pharmacy

Figure 3: south west London SPG Primary Care SCF delivery timescale – Proactive



Table 3: How the implementation of the Proactive Care specifications will be supported across south west London

<i>P1 - Co-design</i>	<ul style="list-style-type: none"> • Patient participation group representatives sitting on CCG Boards and committees, inputting into commissioning decisions • Proactive GP practice pilot in one borough • Roles such as care navigator, community involvement coordinator and care co-ordinator in place or rolled out
<i>P2 – Developing assets & resources for improving health & well being</i>	<ul style="list-style-type: none"> • Asset maps developed for each CCG to help patients and the public find organisations and services to support their health and well-being needs • Wellbeing hubs and care/community navigator roles being explored and tested
<i>P3 – Personal conversations focused on an individual’s health goals</i>	<ul style="list-style-type: none"> • Risk stratification tools in place • Roles such as /care navigator, community involvement coordinator and care co-ordinator in place • Exploration of training to better support staff to have these conversations
<i>P4 – Health and well-being liaison and information</i>	<ul style="list-style-type: none"> • Introduction of expert patient programmes and self-management programmes • Planned applications to the Primary Care Estates and Technology Transformation Fund (ETTF) to provide TV screens and Wi-Fi to support proactive care/health and well-being messaging
<i>P5 - Patients not currently accessing primary care services</i>	<ul style="list-style-type: none"> • Engagement and work with Public Health to align approaches and identify further actions • Range of local initiatives at borough level such as: Help yourself to health programme for transitory or new patients to support learning about NHS services and how to appropriately access services. Work with mental health organisations to support registration at local practices

Our future model of proactive care will achieve the following for our patients:

Proactive Care



- Signposts and provides opportunities for people to learn and be empowered to manage their condition, where appropriate, from self-limiting or minor illness to chronic conditions impacting on long long-term quality of life
- Promotes self-management by using a portfolio of techniques and tools to encourage patients to choose healthy behaviours and/or transforming the patient-caregiver relationship into a collaborative partnership by offering patients the opportunity to be involved in the development of a personalised self-management plan.
- Reduces incidences of health problems and diseases through primary prevention through measures to reduce lifestyle risks and their causes or by targeting patients at high risk, supporting a change in behaviour and engaging the community through systematic community interventions in schools and regulatory actions.
- Systematically detects diseases at the early stages through secondary prevention with appropriate availability of interventions and processes by collaborating with local authorities, the community and voluntary sector groups.
- Prevents acute exacerbations and avoidable hospital admissions of chronic conditions through active disease management, telephone health coaching, behavioural change programmes, and early identification by using risk stratification tools and clinical decision support technology.
- Provides increased uptake and equity of access to immunisation and health screening.
- Provides holistic care for those with a serious mental illness who have reduced mortality by undertaking physical health checks.

Governance

In terms of governance, the south west London Transforming Primary Care Delivery Group consists of CCG primary care leads, LMC, Healthy London Partnership, south west London Federation Collaborative and is led by a CCG Chief Officer as SRO and a CCG Chair as Clinical Lead. It meets approximately every four weeks to coordinate and oversee the work of transforming primary care across south west London. The following chart summarises the range of governance arrangements in place.



South west London will continue to use a collaborative and strategic approach to achieve the SCF and aims of the national GP Forward View, and will continue to work together with providers to ensure that we have the infrastructure in place to effectively transform primary care and achieve the desired outcomes. The Transforming Primary Care Delivery Group has been discussing the Planning Guidance and the requirement for CCGs to complete their GPFV plan by 23 December 2016. In addition to local nuance there is strong commitment across all CCGs to collaborate on a south west London-level approach across a number of areas including workforce, social prescribing, continued work with federations and taking forward the ten High Impact Actions.

Another key mechanism to take forward south west London's vision is the delegated commissioning of primary care. Since April 2016, five of the south west London CCGs have operated as delegated commissioners and Croydon CCG has operated in 'shadow' delegation mode. The recognition that general practice can no longer be commissioned in isolation from other parts of the health economy has led to a strong commitment across south west London to work with local providers, patients and the public to develop solutions that will deliver safe, high quality care for everyone. Part of our vision is to ensure that patients and service users not only experience better single episodes of care, but a high quality experience of overlapping parts of their care.

Delegated commissioning will be an integral part of our strategy for delivering 'Right Care in the Best Setting', helping us to manage demand on acute services and shifting more appropriate care in to community settings. This will also enable people to live well and manage their conditions before escalation or crises arise.

This governance structure recognises delegated commissioning i.e. the local south west London CCG Primary Care committees and the south west London Advisory Panel for Primary Care, which has been set up to support colleagues in individual CCGs who may be dealing with challenging or contentious local primary care commissioning issues.

Quality & Sustainability

Quality

Across primary care there are a number of measures available to us to understand local performance and quality. Clinical achievement and patient satisfaction are generally used to benchmark quality and the data from these areas show a variation between providers in the quality of care received.

Variation in health and quality of care is one of a number of key drivers for practices to work in a federated way and increase opportunities to achieve healthier outcomes.

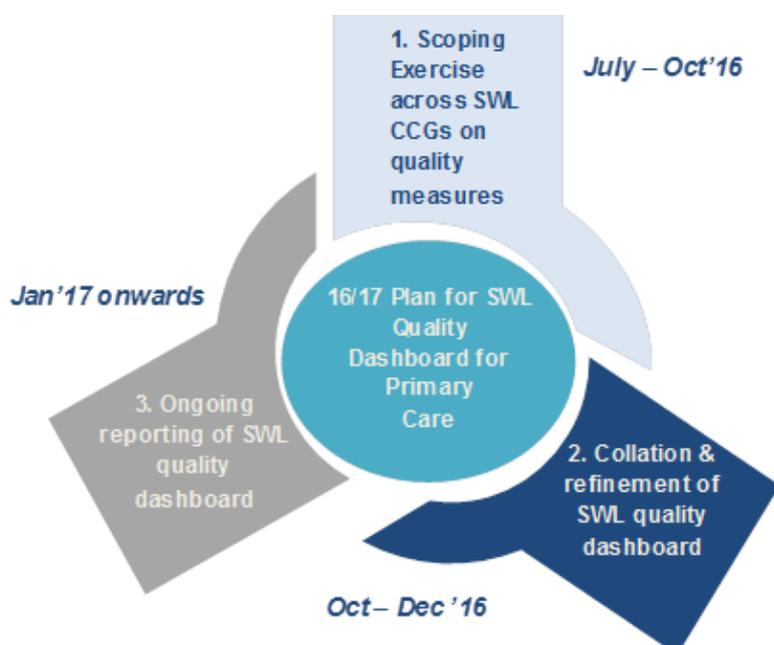
It is south west London's aim to 'raise the bar' in primary care to reduce unwarranted variation in all aspects of quality and to bring measurable standards up to those of the best of local and national general practice.

For patients and the public this will mean:

- High quality primary care services
- Safe services
- A positive experience of general practice
- Patient and public views being seen as a key part of supporting successful general practice

The figure below provides a summary of the process in south west London to agree and develop a quality dashboard in 2016/17 to report upon and help promote a reduction in variation. The dashboard will provide a consistent overview of key agreed quality measures and help ensure high quality services for our patients. Commissioning primary care leads and south west London federations will be involved in the process of development, to help determine how working at scale can support quality and reduce variation at practice level.

Approach to developing a south west London quality dashboard in 2016/17



The CQC have provided a comprehensive assessment of the quality of care provided by practices based on their inspections to date. By April 2016 they had inspected 35% of practices nationally, and found that the vast majority (87%) are providing care that is good or outstanding. CQC inspections across south west London are underway and have highlighted variation in performance and areas for improvement locally.

CQC rating as a proportion of inspected practices in south west London – May 2016

	Total No of Practices	Total no of visits	Total no of visits outstanding	CQC Rating			
				Outstanding	Good	Requires Improvement	Inadequate
Croydon CCG	59	12	47	0	8	4	0
Kingston CCG	25	7	18	0	7	0	0
Merton CCG	24	12	12	0	9	3	0
Richmond CCG	28	7	21	0	6	1	0
Sutton CCG	26	12	14	0	8	4	0
Wandsworth CCG	42	9	33	0	7	1	1
Total	204	59	145	0	45	13	1

A programme to support practices rated as ‘inadequate’ or ‘requiring improvement’ by the CQC or those assessed by local commissioners in south west London as ‘in need of support’ has been launched by NHS England.

The GPFV also highlights the importance of a practice resilience programme to support struggling practices, changes to streamline the CQC inspection regime, support for GPs suffering stress, cuts to red tape, legal limits on administrative burdens at hospital/GP interface and action to cut demand on general practice. All south west London CCGs created provider development plans in October 2016 to take forward key activities to support practice resilience.

Sustainability and working differently

The sustainability of general practice is at risk due to the pressures of increasing and changing health needs and patient need. Across south west London, CCGs are working to mitigate these risks and make general practice more sustainable. The achievement of seven day working will extend access for patients to be seen in a primary care setting out of hours and will divert a level of attendances from A&E.

New models of care brought about through the proactive and coordinated care specifications will improve integrated care and make more services available to patients outside of hospital. For example, the needs of people with medically unexplained symptoms vary enormously. GPs have an important role to play in this, identifying people affected, exploring relevant psychosocial factors, and doing so in a way that acknowledges physical symptoms as real. However, where symptoms are mild, sensitive handling and watchful waiting by the GP may be sufficient, or signposting them to the voluntary sector or other specialist support as required. Voluntary and community sector organisations can play an important role in supporting lifestyle changes. Working to involve families and carers (especially for those with symptoms of severe mental illness) as well as implementation of the coordinated and proactive care specifications and community hub working arrangements, could mean a very different

service for individuals with mental health, as well as GPs being better supported in dealing with them.

This shift of care and focus on integrated care should enable savings across the health economy. Across south west London, work is underway to scope the impact of these changes and the service and financial benefits that could be achieved.

In order to support general practice sustainability, south west London is aiming to:

- Support working 'at scale' via the six south west London federations.
- Increase the use of technology to create more capacity and access.
- Support GP practices in coordinating care and working jointly with community services, mental health, social care and specialist services.
- Review primary care estates so that they are fit for purpose. Condition and utilisation surveys have since been completed along with a high level analysis indicating the financial capital needed to address improvements.
- Support new roles such as care navigators and make better use of existing roles such as community pharmacists. South west London CCGs have agreed to take forward a collaborative approach to utilising funding they have received, for example on training for receptionists.

In common with the rest of London, a key factor influencing sustainability is workforce, and there are significant workforce challenges in south west London. South west London will work with its relevant CEPNs to disseminate and accelerate training and this is discussed further under the 'Enablers' section below.

Working at Scale

South west London sees 'at scale' working via the six south west London federations as key to supporting the transformation of primary care.

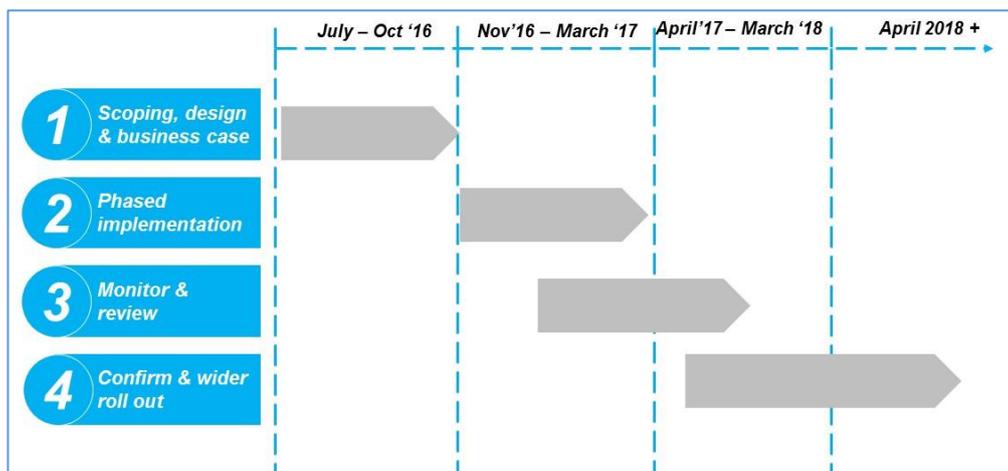


South West London GP Federation Collaborative

- Six federations are established which map across to the six south west London CCG populations (two federations established over five or more years and four established within the last two years.)
- The six federations have formed a collaborative (south west London GP Federation Collaborative).
- Federations in Kingston and Wandsworth have contracts in place (for example community diabetes and ophthalmology services and dermatology and MSK out-patients' activity). Wandsworth also have a contract in place with their federation which focuses on care planning for patients with LTCs (PACT – Planning All Care Together). Croydon are key partners in both the Accountable Provider Alliance for over 65's and the Croydon Urgent Care Alliance, which has been awarded the contract to deliver Croydon's Urgent Care services from April 2017.
- The federation in Richmond is delivering four GP hubs, providing 8am-8pm access seven days a week for pre-bookable appointments (via the practice or NHS 111) with an interoperable medical record.
- The south west London federations recognise that individually they are at different stages of maturity but are committed to supporting each other and sharing resource and experience as appropriate.
- There is a strong desire to continue to develop constructive working relationships with commissioners and support delivery of a quality-driven, sustainable service in south west London. As a result the south west London GP Federation Collaborative have held several key sessions to input to the STP process. In supporting the south west London STP vision, they have committed to work with commissioners during 2016 and onwards to start delivery on the following and develop a timeline for when this may be achieved.
 - ✓ *Development of primary care access hubs (to support 8 to 8 working, 7 days a week) and effective integration of hubs with UEC system*
 - ✓ *A shared operations and strategy team for the south west London federations to support the HR, finance and operational delivery skills needed as*

- ✓ *they develop into provider organisations ready for rapid delivery*
- ✓ *Training and education for the primary care workforce via a south west London Collaborative CEPN*
- ✓ *How the 10 HIAs are applied to benefit local practices and support the release of capacity*
- ✓ *Dermatology and MSK outpatient activity being undertaken locally in primary care as agreed appropriate*
- ✓ *Planning and progressing towards greater primary and community care provision via MCP type models or locally defined models (for example building on Wandsworth's Enhanced Care Pathway work - integrated proactive delivery of care for frail older adults or the role of the Croydon GP Federation being part of the OBC Accountable Provider Alliance)*

Timeline for scoping collaborative working and implementation across south west London federations



From November 2016, an additional series of workshops will take place, again bringing together the six south west London federations, to achieve the following objectives by the end of 2016/2017:

- The formal creation of a GP Federations Collaborative in south west London, operating to an agreed service model that provides a secure platform from which general practice in south west London can deliver enhanced primary care services at scale in accordance with the STP delivery programme;
- Exploring and agreeing a future operating model that determines the scope for shared back office functions, costs and governance at south west London level, together with appropriate alignment with local operating arrangements at individual federation level;

- Ensure the delivery of 2016/17 transformation plans for general practice, notably the roll-out of extended access initiatives (8-8, seven days per week access in each borough) across south west London in accordance with the Strategic Commissioning Framework specifications in London and CCG level delivery plans;
- Sharing of best practice across the Federations to prepare for the future delivery of a broader range of out of hospital services (e.g. referral management services, outpatients/alternatives in primary care settings; Multispecialty Community Provider models of service) consistently across south west London.

The Enablers

Primary Care Funding & Investment

The baseline 'do nothing' case shows by 2020/21 under a 'do-nothing scenario the aggregated projected surplus for south west London primary care is £14.4m.

The baseline includes the new primary care allocations (part of the national investment of £2.4b as set out in the General Practice Forward View). With these additional allocations included, in aggregate, a small surplus starts to be achieved from 2018/19 onwards on a south west London basis but not necessarily at each of the six CCG levels, per the following table.

The surplus is likely to be directed towards the following enabling areas to support service transformation:

- Organisational models (GP federations, optimum clinical networks)
- Workforce development
- Workforce growth
- Premises development (revenue implications)
- IT infrastructure
- Incentivising changes in provider behaviour e.g. outcomes-based commissioning

South west London aggregate position (without primary care investment)

Do something scenario (0.5% QIPP assumed)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£'000	£'000	£'000	£'000	£'000	£'000
Allocation	186,717	195,848	202,206	208,134	215,792	226,245
Expenditure (after QIPP adjustment)	188,326	196,888	200,638	204,426	208,137	212,807
Surplus/ (Deficit)	(1,609)	(1,040)	1,568	3,708	7,655	14,438

It is expected that further expenditure will be incurred to support the costs of extended primary care access hub arrangements, as well as workforce requirements and full implementation of the 17 specifications within the SCF. The financial gap for south west London includes a further £32m at 2020/21 under 'do something', which, together with the £14.4m surplus (per the table above), allows £45m recurrent funding for primary care.

The development of primary care services will also require capital investment to support increased future service configurations. Whilst there are some identified and specific investments in new infrastructure, the expansion and development of GP and multi-specialty community services is largely expected to be achieved through better utilisation of existing premises, use of technology and/or virtual hubs. It is anticipated that Estates and Technology Transformation Fund funding will provide a significant incentive and contribution to support primary care developments. A numbers of south west London bids have been successfully prioritised and taken forward to the next assessment stage. The outcome of bids is currently awaited as part of the London-wide evaluation process.

In terms of the current PMS review, CCGs have been reviewing the services currently being provided by its PMS practices. The outcome of the PMS review has been delayed due to a 'pause' during which London-wide LMCs and NHS England (London Region) have sought to agree a way forward. Where those services fit with the CCGs' strategic direction and with the London Strategic Commissioning Framework, CCGs will largely plan to recommission these services. In such circumstances, the service specifications and prices will be reviewed to ensure that they are still 'fit for purpose' and plans are being made to offer those services to any GMS Contractors in each CCG area.

Workforce

South west London like the rest of the country, faces a range of population demand and workforce issues that have implications for the delivery of primary care services. For example:

- A growing and ageing population that results in more complex cases presenting in higher numbers than ever to general practice.
- A national and local shortage of GPs and other primary care staff coming into the profession, while the Royal College of GPs estimates that more than 1,000 GPs will leave the profession on an annual basis by 2022. This is exacerbated by high projected retirement rates amongst GPs, with estimates suggesting 22% could step back from front line patient care within five years.
- Multi-disciplinary team working in primary care is recognised as a benefit to patients and staff. However, factors such as the proportion of single handed practices and poor quality estate across primary care can make effective MDT working more difficult to achieve.
- The majority of patients with mental health needs are supported and treated in primary care and make up a significant amount of a GP's surgery time, yet GPs do not always feel adequately skilled or supported to meet their needs.

In terms of the primary care workforce across south west London, HLP has applied its workforce model⁴¹ and some points to note about the current context for this workforce are:

- 21.8% of GPs and 39% of nurses in south west London are aged over 55, suggesting that retirement numbers over the next decade will be significant, but not above the London average.
- Particular pockets of strain seem to exist: for example, 50% of nurses in Merton, and 42% of nurses in Sutton are over 55, representing a potential continuity issue.

⁴¹ This model builds on work previously undertaken for Transforming Services Together in East London. The model uses a system dynamics tool called Stella and focused initially on qualitative interactions, secondly on data and assumptions to build an interactive model of primary care demands, activity and workforce.

- Croydon has over 27% of its GP workforce over 55, whilst it also has the highest number of patients per GP (1,708) vs 1,551 south west London average.
- South west London has a lower percentage of single handed GP practices versus the rest of England. However, Croydon and Kingston CCGs index more highly (10.6 and 8.3 respectively compared to a London average of 11.9).

The baseline modelling has surfaced a number of strategic issues for south west London's future primary care workforce including the following:



SWL Future Workforce Projections

- As the population of SWL increases (by 5%) there will be rising demand for GP services and FTE, while deteriorating health and clinical models predicated on more work happening in Primary and Community care will exacerbate the increase in demand (by a further 10% per patient). It will be difficult to meet this demand with current projections for NQ trainee numbers flat at 80 into SWL each year.
- Given projections around retirement rates and turnover rates, recruitment of 10 GPs (in addition to the 80 ST1s) per year is likely needed from wider London pool or internationally to keep the present level of staffing flat. To achieve the projected demand of GP FTEs for SWL (1081), an additional 200 GPs will be required (40 per year).
- South west London will require recruitment of 45 Nurses into Primary Care for each of the coming 5 years to sustain current levels given high likely retirement and general turnover rates.
- South west London has a fairly strong Direct Patient Care workforce which helps mask some of the pockets of strain from the GP workforce shortage. The modelling predicts recruitment of 15-20 roles per year will be required to keep up with projected demand – assuming no further shift towards adopting enhanced use of new roles.
- Current reliance on GP and nursing staff (totalling 88% of 2015 Primary Care workforce) is costly, and funding challenge set to increase in coming years.

A priority for organisations across south west London is to work collectively with Health Education South London and the collaboration of CEPNs on the following core priorities which assist with developing and supporting the workforce:

1. Supporting improved value, quality and productivity
2. New roles
3. New multidisciplinary models of care
4. Improving staff health and reducing sickness absence
5. Recruitment, retention, training and development

The south west London Workforce Board has been set up and a focus in 2016 will be to work with its representatives on the outputs of the HLP primary care workforce model and to develop an associated action plan, as well as working with the south west London CEPNs on how the 10 HIAs can support the workforce.

A primary care workforce group has been formed (a sub-group of the Transforming Primary Care Delivery Group, also feeding in to the south west London Workforce Board) with wide-ranging clinical input from across south west London. Its initial focus has been to identify a range of future scenarios to model, and assess the impact on the workforce challenge. The agreed scenarios are:

- Use of pharmacists in practice
- Care navigators
- Development for receptionists/practice managers
- Remote working for GPs (including telephone and email consultations)
- Physicians Associates
- Rollout of the Sutton Care Homes Vanguard
- Review of the areas already modelled by HLP (skype consultations, group consultations, clinical assistants and locum banks)

Following the completion of the modelling by HLP, an action plan will be created to take forward a programme of work at a south west London-level.

Delivering Technology and Digital Roadmaps

Digital maturity assessments for south west London in 2016 have indicated that there is a way to go to make the best use of technology, particularly in terms of how clinical information is shared within and across the NHS and with social care.

There are, however, examples of progress and a commitment in south west London to embrace the opportunity that better information sharing affords, and also the use of technology to monitor patient symptoms remotely. One example of this is the investment and work completed in relation to the Patient Online programme across south west London in 2015/16 to support improved choice and access options for patients.

Patent Online in SWL

For six months in 2015/16, the SWL CCGs supported a business case around investment in the roll out of patient online, as follows:



Support clinical and practice teams – local GPs and practice teams supported with more information on patient online and opportunities to have a key contact individual to work with them to progress roll out ('Patient Online Facilitators')



Employ 'Patient Online Facilitators' to project manage and deliver a range of services across the six CCGs – in particular the facilitators will help with practices having a clear understanding of demand and capacity and ensuring that systems are configured so that there are sufficient appointments made available online locally (work to date has identified this as being an obstacle in roll out of patient online)



Support patient activation – improve patient awareness of online services through a multi-channel communications campaign

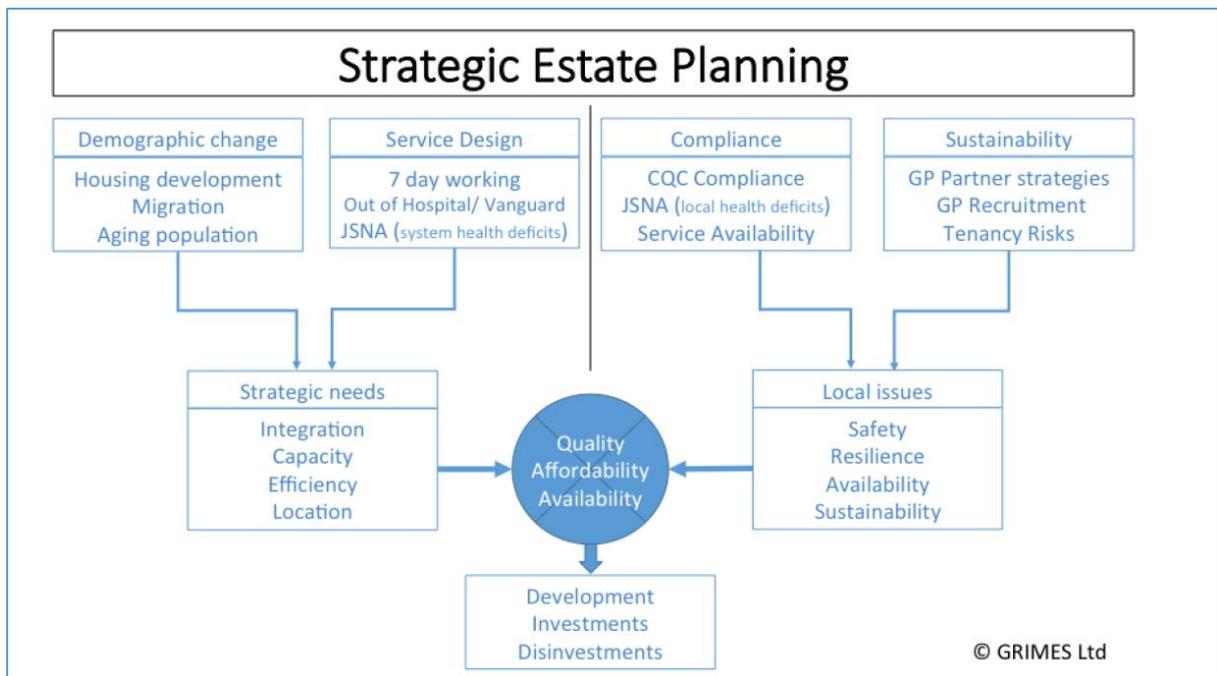
In 2016/17 a bid has been put forward on a pan London basis by HLP, (building on the patient online work undertaken by south west London) to the Estates and Technology Transformation Fund. This will support continued work on the roll out and uptake of patient online but in addition focus on the percentage of patients with explicit consent code for Summary Care Record additional information.

In 2016/17, priorities centre around delivering the local digital roadmap, with three phases to deliver a marked increase in digital maturity across CCGs, health and care providers over the next five years, and in turn support primary care:

Phase
1 - Developing a Collaborative Future - a south west London collaborative capability that supports the delivery and provides ongoing support for the tactical and strategic solutions (1 to 5 year horizon)
2 - Building on the Current Position - a tactical foundation that achieves short term Objectives (1 to 2 year horizon)
3 - Delivering a Strategic Platform - a strategic solution that achieves the long term Objective (2 to 5 year horizon)

Estates

The six CCGs in south west London each produced an Estates Strategic Framework document in December 2015, in line with Department of Health and NHS England requirements. These documents provided high level reviews of the current primary care, community and acute estates in each borough, as well as detailing the principles to apply when determining the future estate.



Ongoing estates work is required and the principles to be applied will include making the best use of what we have and making a longer term case for new investment.

Overall the existing primary care estate in south west London is unlikely to be 'fit for purpose' to deliver the scale of provision required and new models of care. There is little void space although there is known under-utilisation across the estate and some community assets that could be optimised in order to offset future space requirements and enable greater co-location of services.

Priorities in 2016/17 therefore include:

- Completing a programme of utilisation studies for primary care and community assets to determine existing capacity and ability for existing estate to absorb growth in out of hospital settings. These have been completed along with a high level analysis indicating the financial capital needed to address improvements
- Completing feasibility studies for key community/primary care schemes
- CCGs revising Strategic Estates Plans and confirming future community hub locations (existing assets and new investment) and the clinical model. The work with local CCGs has identified key centres across south west London.

It is recognised that, as the clinical strategy is developed, our estates will need to reflect the requirements for south west London and our local CCGs' estates plans will be further developed to reflect the local priorities. The One Public Estate initiative, and on-going joint working with our providers, will help us get better use of the public estate across the health economy in south west London. These will be priorities that will be worked on over the next 12 months.

A number of bids were also made against the Estates and Technology Transformation Fund (ETTF), to support a mix of improved physical access, relocation to improved 'fit for purpose' premises, and to support compliance with measures such as health & safety requirements and infection control. Some of these bids include further feasibility to seek out the most suitable estates solutions. This work will be subject to approval of the ETTF bids. So far, feedback for south west London has indicated that 13 schemes have been prioritised and ranked in the top two quartiles. Therefore, there is the potential of a pipeline of schemes that will be implemented over the next three years across south west London to support trans-

formation. The next stage of the STP process will be to work through business case development once the schemes have been approved nationally.

Engagement

In south west London we are engaging with key stakeholders to ensure their views are at the heart of everything we do. The table below provides examples of engagement underway to support understanding and involvement around transformation in primary care.

Stakeholders	Examples of engagement activities
The public	<ul style="list-style-type: none"> <li data-bbox="469 577 1458 674">❑ A series of deliberative events at CCG level occurred in September 2015 which picked up on transformation across services in south west London and the implications for primary care <li data-bbox="469 696 1458 763">❑ A list of emerging priorities for the STP were sent out to a wide range of local community and voluntary sector stakeholders asking for early feedback <li data-bbox="469 786 1458 853">❑ A Patient and Public Engagement Steering Group (PPES) in place at the south west London level, discussing a range of issues including primary care
Patients	<ul style="list-style-type: none"> <li data-bbox="469 889 1331 911">❑ A range of patient involvement takes place locally through CCG PPG groups <li data-bbox="469 934 1442 1030">❑ A new Patient Representative steering group has been created for patients, public and carers to contribute to the work of the transforming primary care delivery group in south west London, which commenced operation in July 2016
Practices	<ul style="list-style-type: none"> <li data-bbox="469 1093 1458 1189">❑ Practice PPG groups are actively involved in the work of the practices they serve. They have also contributed to south west London-wide strategic transformation projects, such as Patient Online <li data-bbox="469 1211 1434 1279">❑ All south west London practices were involved in a baseline audit around planning for, and implementation of, the 17 primary care specifications
At scale providers	<ul style="list-style-type: none"> <li data-bbox="469 1317 1406 1384">❑ The six GP Federations in south west London meet routinely as a collaborative and share and update on latest progress and areas to work through <li data-bbox="469 1406 1458 1473">❑ As part of the STP development for primary care, sessions involving the federations and senior CCG representatives have taken place to help discuss and confirm priorities
Local authorities	<ul style="list-style-type: none"> <li data-bbox="469 1507 1466 1574">❑ A local authority representative is invited to the south west London Transforming Primary Care delivery group meetings <li data-bbox="469 1597 1466 1664">❑ Local authority representatives attended the Joint Committee of PC Co-commissioning in 2015/16 <li data-bbox="469 1686 1326 1709">❑ Presentations and discussions take place with Health and Wellbeing Boards
CEPNs	<ul style="list-style-type: none"> <li data-bbox="469 1753 1442 1821">❑ CEPNs have been involved in the workshops held to apply the HLP workforce model to the south west London primary care workforce and discuss the outputs

xv. Urgent & Emergency Care

Vision

In accordance with the direction of the pan London team, the south west London network is working towards transforming the Urgent and Emergency (UEC) system service model.

The six CCGs across the network are in agreement that the targeted changes to services should be **co-ordinated**, **consistent**, and **clear** throughout the model. This will ensure that people are:

- Provided with improved access to a well-connected and clearly defined, functionally integrated urgent care system (111 & GP Out of hours service) including Urgent Care Centres (UCCs), primary care, social care, ambulance services, and other health professionals such as pharmacists and dentists. Services will comply with national guidance on the naming of UEC services.
- People with urgent care needs, including mental health crisis, receive a highly responsive service that delivers care close to home, minimising disruption and inconvenience for patients and their families.
- Those with more serious or life-threatening emergency care needs receive treatment in centres with the best expertise and facilities, to maximise the chances of survival and good recovery.

People who are admitted to hospital in an emergency should receive the same high quality care seven days a week. Currently, lower staffing levels over the weekend contributes to increases in waiting times and disrupted patient flow.

Local Priorities

To help south west London realise their vision for 2019/20 the UEC network have identified **three priority areas**:

Ambulance Pathways

- Improving the skill mix of paramedic staff to facilitate 'see and treat' and 'hear and treat'
- Identification of frequent callers and development of care plans and escalation plans to reduce avoidable call outs
- Streamlining of the ambulance pathway.

Mental Health

- **Places of Safety:** Review of places of safety and psychiatric liaison capacity and access in south west London
- **London MH Crisis Group:** Develop a plan for joint working with London MH Crisis Group to improve access
- **Crisis Care Concordat:** Review of Crisis Care Concordat and implementation

Self-Care/Management

- Increasing information, advice and support online and over the phone
- People using technology to understand their own health and wellbeing at home
- People who need to monitor their conditions will be able to do so through convenient methods to ensure a minimal impact on lifestyles.

The UEC network has developed working groups in each priority area with a collaborated vision agreed.

Priority	National	Local
Acute Hospital Services (7DS)	All patients admitted via the UEC pathway will have access to acute hospital services that comply with priority clinical standards on every day of the week	The south west London Task & Finish group have hosted a series of workshops to ensure providers meet the London Quality Standards in order to provide a seven day service
Transforming Primary Care	To enhance primary care services; providing patients with increased access 12 hours a day, 7 days a week	South west London are committed to delivering accessible care in its locality; focusing on four of the seven specifications to reduce pressure on UEC: <ol style="list-style-type: none"> 1. Contacting the Practice 2. Extended Opening Hours 3. Same Day Access 4. Urgent & Emergency Care
Integrated Urgent Care	24/7 Integrated Urgent Care access, treatment and clinical advice service working together with 'all hours' GP services	<p>South west London will use 111 as the front door to its finalised Integrated Urgent Care (IUC) Clinical Hub, which will provide access to advice, treatment and onward referral, including direct booking, into Primary, Community, and Acute professionals.</p> <p>The IUC service went live in September 2016, and is provided by Vocare and SELDOC. South west London are one of the first areas in the country to procure and mobilise new IUC services, and are currently working with the LAS and south west London Primary Care to integrate all appropriate care pathways and GP hubs with the service</p>
Ambulatory Emergency Care	Ambulatory emergency care is a streamlined way of managing patients presenting to hospital who would normally be admitted	All six CCGs in south west London have agreed to a new AEC specification which will see all patients presenting at A&E considered for AEC unless clinically inappropriate

Appendix B. Right Care Best Setting

1. Overview of progress

The south west London Right Care Best Setting (RCBS) workstream is being led at south west London level to ensure consistency of approach to the transformation of community-based care. We recognise the importance of developing and implementing our plans at a local level, within each locality or borough, to reflect the differing needs of our population as well as local services and delivery models. Where it makes sense to do so our plans will initially be developed at scale, either around the acute providers or across the whole of south west London. Progress is overseen and monitored through the RCBS Steering Group, which has CCG, acute provider, community provider, local authority, mental health and clinical lead representation.

The RCBS workstream has now clearly defined the three initiatives that will deliver our ambitious strategy to shift care from acute hospitals to the community, and deliver less care in hospital. While the three initiatives address people's needs in different contexts, all three have an emphasis on supporting people to self-manage and maintain independence, delivering care using a 'home first' principle, and preventing, delaying, and minimising the need for acute care.

The transformation will be delivered through three key developments:

- **Locality teams** will proactively manage the care of populations of at least 50,000 people, with a focus on frailty and people with long-term conditions. There will be 24 locality teams across south west London. At-risk individuals will be identified through risk stratification and will have their care coordinated and managed by an integrated team from social care, mental health and physical health, working in partnership with primary care and acute hospital specialists to manage needs holistically. While working collaboratively, teams will operate using a single point of contact and named care co-ordinator model, carrying out care planning and review in partnership with patients. The locality teams' focus is proactive management and care coordination; they will be able to step patients up to the community crisis and intermediate care team if a more intensive level of support is required to maintain someone in the community.
- **Community crisis and intermediate care** will deliver an enhanced system response to manage people who are in crisis, or are ready to be discharged from hospital, in a community setting. The response will work on a 'home first' principle, but bedded facilities will be available for those who cannot safely be managed at home. We will look at bedded capacity on a south west London basis. There will be clear pathways and hand-off points with the locality teams to step patients up and down following a crisis event. There will also be clear pathways to and from acute hospital care as patients are escalated to a more specialist service or discharged for reablement and recovery.
- There will be a radical upgrade in **prevention and self-care**, incorporating population, community and individual level interventions. Self-care will underpin the work of both the locality teams and community crisis and intermediate care response, whilst prevention activities will support the wider population to maintain good health and independence. Prevention and self-care activities will integrate physical and mental health to ensure we support people holistically and address the interdependencies between physical and mental health. Activity will draw on voluntary and community sector skills, expertise and services, and use technology to support people in new ways. The direction of travel is towards promoting healthy lifestyles, promoting self-care for minor ailments, ensuring appropriate use of health and social care services, facilitating effective self-management by people diagnosed with long-term conditions,

building a strong culture of Shared Decision Making and partnership among patients and clinicians, and embedding of Making Every Contact Count (MECC) culture across services to improve health of the public and service users.

A clear principle has been agreed that there will be consistent processes and ways of working for these teams and services across south west London, unless justified based on population need. All new contracts for these services will be awarded from 1st April 2018 at the latest.

2. Current focus of sub-regional work

The sub-regions are currently producing a number of outputs to progress local implementation of these transformation initiatives:

- **Gap analysis** of current sub-regional provision against the south west London model
- **Implementation plan** detailing how these gaps will be filled and how the south west London model will be delivered, ready for contracting for this model from 1st April 2018
- **Demand and capacity modelling** to evidence how the implementation plan will deliver the agreed level of ambition to shift activity into the community

The work carried out by Kingston/Richmond and Croydon sub-regions is shown below as an example of how local work is progressing.

3a. Kingston and Richmond summary

Prior to the STP process, Kingston and Richmond were already working towards a new way of working for out of hospital care. Outcome-based commissioning (OBC) in Richmond, and Kingston Coordinated Care (KCC) in Kingston, are working with providers to develop new models of care; building on existing infrastructure, working relationships and collaboration to develop a single view of how services will be delivered.

OBC and KCC mean that Kingston and Richmond are well placed to build capacity and capability within the community to ensure that people's needs can be met outside of an acute setting.

Since the June STP submission, Kingston and Richmond have carried out the gap analysis and high level plan described in Section 2 above, and have begun work to complete the demand and capacity modelling to evidence how the implementation plan will deliver the agreed level of ambition to shift activity into the community. The key findings are summarised below:

Gap analysis highlights:

- Risk stratification tools are being rolled out across the sub-region by 31 March 2017 to identify patients with long term conditions that need support
- Some multidisciplinary teams are under development and currently meet on an informal basis. An MDT pilot is underway in Richmond and it is expected that locality teams will be fully rolled out across the sub-region during 2017/18. This will be supported through the rollout of Kinesis and DXS to support patient management
- The sub-region is working on a consistent approach to developing locality teams across Kingston and Richmond
- The model for Kingston and Richmond will be delivered via KCC and through Richmond's Physical and Mental Health OBC Programme
- Plans for prevention and self-care are currently in line with the south west London model

Delivery plan highlights:

- Kinesis/DXS/Sollis and Kingston Care Passport to be rolled out by end of the 2016/17 financial year
- Locality and multi-disciplinary teams to be rolled out by end of 2017/18 financial year
- Richmond Primary Care Strategy and Primary Care Home rollout to take place between 2017-2019
- Kingston Coordinated Care to have a phased rollout from 1 April 2017, with rollout complete by 31 March 2018. Richmond Physical and Mental Health OBC also to have a phased rollout from 1 April 2017, with rollout complete by 31 March 2019. These programmes will enable common principles and ways of working including:

- | | |
|---|--|
| <ul style="list-style-type: none"> ○ Locality teams ○ MDT working; integrated working and care pathways ○ Community outreach | <ul style="list-style-type: none"> ○ Improved access to crisis and intermediate response services ○ Patient education programmes |
|---|--|

Demand and capacity modelling:

- High level work has been undertaken to identify the number of patients that are using c. 65 beds in Kingston Hospital
- Using the ratios of admission avoidance and early supportive discharge opportunity, established a high level understanding of the services which patients will require to meet their needs in a community setting
- Using existing contract values to calculate an indicative cost of reprovision

Next steps for the sub-region

- Complete further analysis and engagement to test the high level additional patient numbers and indicative costs of reprovision. A particular area of focus will be quantifying the number of additional patients that will be identified through risk stratification, who will require service provision
- Further understand how patient flows will affect future service provision in both a community and hospital setting, particularly in relation to early supportive discharge and ongoing patient care
- Carry out a baseline of existing service capacity
- Ensure that services planned through Richmond Outcomes Based Commissioning and Kingston Coordinated Care meet the level of need identified through risk stratification, and admissions avoidance and early supportive discharge opportunities

3b. Croydon summary**Gap analysis highlights:**

- Croydon has defined an operating model for locality teams and is partially delivering some aspects, including MDT working, extended GP appointments for LTCs and access to social prescribing. Full delivery will be achieved by implementing the Croydon model of care by November 2017
- For intermediate care, Croydon are reviewing pathways across the Rapid Assessment Medical Unit, Edgecombe Unit Services and LIFE services by November 2017 which will lead to implementation of revised pathways. This will complement existing delivery of an 8-8, 365 day intermediate care service
- Initiatives like Together for Health and Asset Based Community Development support prevention and self-care in Croydon. Review and evaluation of initial pilots in late 2016/17 to early 2017/18 will inform scaling and roll-out of initiatives

Delivery plan highlights:

- Significant progress towards the implementation of locality teams will be made by Q1 2017/18 including:

- Care homes “integrated MDT care planning standards”
- Phase 1 Complex Care Locality MDT Hubs
- Phase 1 Integrated Community Networks
- Integrated health, SC, MH & voluntary sector community network based teams
- Single point of access & information streamlining to health and social care information
- ‘My Life Plan’ supporting person-led preventative care planning
- Following the review of intermediate care provision and pathways, and the completion of work to align local and STP models, updated pathways and models will be implemented by Q3 2017/18
- By early 2017/18 an expanded risk stratification tool will be implemented and a review of LTC pathways, telehealth and telecare provision will have been completed
- Croydon will soon launch the Health Help Now app to support the population to make lifestyles healthier and use services proportionately. By Q1 2018/19 the Together for Health programme and Asset Based Community Development initiatives will be embedded across Croydon

Next steps for the sub-region

- Complete bottom-up demand and capacity analysis and engagement to test the high level additional patient numbers and indicative costs of reprovision for Croydon
- Drive detailed planning and implementation across locality teams, intermediate care, and prevention and self-care

4. Next steps

The diagram below shows the main activities we will be completing over the next three months. We will be working closely with the Contract & Delivery Group to ensure timescales are aligned to requirements of the two year contracting round.



Appendix C. Acute Configuration

Summary of non-financial assessment of three, four and five sites providing acute services

We have tested the analysis of three, four and five sites that we have done to date against the non-financial considerations identified in Chapter 4.

	3 acute sites	4 acute sites	5 acute sites
Clinical outcomes	Green	Amber-Green	Amber-Red
Access	Amber	Amber-Green	Green
Robustness against range of scenarios	Amber-Red	Amber	Amber-Green
Level of risk during transition	Amber-Red	Amber Green	Amber-Green
Support from commissioners	Red	Amber-Green	Red
Support from clinical leaders	Amber-Red	Amber-Green	Red

Converting these ratings into scores Green = ++ Amber Green = + Amber = 0 Amber red= - Red = --			
	3 acute sites	4 acute sites	5 acute sites
Clinical outcomes	++	+	-
Access	0	+	++
Robustness against range of scenarios	-	0	+
Level of risk during transition	-	+	+
Support from commissioners	--	+	--
Support from clinical leaders	-	+	--
Total	-3	5	-1

Appendix D. Specialised Commissioning

1. Context

Specialised services are those provided in relatively few hospitals/providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

Four factors determine whether NHS England commissions a service as a prescribed specialised service. These are:

- The number of individuals who require the service;
- The cost of providing the service or facility;
- The number of people able to provide the service or facility; and
- The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

The specialised tertiary services that our population requires are delivered by a number of different providers. Within south west London the main providers of specialised acute services are St George's Hospital (£231m p.a.), the Royal Marsden (£107m focused on cancer) and Epsom and St. Helier, which provides renal services (£51m p.a.). Specialised mental health services are provided by South West London and St. George's. South west London provides specialised services to a population that goes well beyond London. One third of all activity at St George's is from the south of England (mainly Surrey). In addition to St George's, there are two other major providers of acute specialised services within a 7-mile radius in South London (Guy's and St Thomas' (GSTT), and King's College Hospital (KCH)) both of which are included in the south east London Sustainability and Transformation Plan. The population of south west London currently receives some specialised services at GSTT and KCH, as well as at South London and Maudsley for mental health services.

In September 2016, NHS England published commissioning intentions 2017/18 and 2018/19 for prescribed specialised services. These are primarily based on the new strategic framework for Specialised Care as set out in May 2016. The framework sets out three priority areas for implementation:

- **Delivering place and population based care:** Local level collaboration to agree patient and service priorities, identify sustainable provider configuration and develop options for commissioning.
- **Providing national level support:** National support to enable local flexibility, including reform of clinical advice, improving data and information, support for innovation and improving the prioritisation of new drugs and treatments.
- **Ensuring financial sustainability and value for money:** Putting in place financial controls in ways that provide clear incentives to transform provision and integrate specialised elements with the whole care pathway. The constrained expenditure growth over the next two years provides a shared requirement for greater efficiency and productivity across the NHS for both commissioners and providers.

2. South West London's Case for Change

We are facing a number of challenges around specialised services, which we are spending more time understanding through discussions with a range of stakeholders. These include national, regional and local issues, such as:

- The rising demand for specialised services, driven by advances in science and an ageing population with long-term conditions, which have prompted an increased demand for specialist care;
- Increasing financial pressures on specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue;
- Rising public expectation and choice for specialised treatment;
- Pathway fragmentation (duplication of activity, gaps in provision, disconnects between specialised, non-specialised and local services, and treatment not being provided in the most appropriate place);
- Overlaps in provision – an initial scoping of provision across the acute specialised services providers in south London has identified a high level of service overlap, the majority of which aligns to areas of high spend. The close proximity of similar services in south London offers opportunities to increase efficiency, but attempts to change specialised services to create larger and more effective units have often been contested;
- Increased patient flows from the South East, which are driving the majority of the growth at SGH;
- Sometimes London mental health patients are referred to beds/services outside of London.
- Children and young people cannot always access age-appropriate inpatient mental health services when they need them.
- London's neuro-rehabilitation service has experienced continued pressure across the range of its services. The patient pathway is fragmented with bottlenecks and blockages both for accessing and discharging of patients;
- Paediatric services operate independently and there are opportunities to standardise and improve the areas of optimising retrieval times, consistency and costs/resourcing. The Royal Marsden hospital and St George's already operate a joint Principle Treatment Centre with 16 Paediatric Oncology Shared Care Units, which covers south west London and South East England;
- Significant performance challenges and lack of consistent delivery of targets across the acute providers, including:
 - St George's has suspended reporting referral to treatment times nationally due to data accuracy issues. A RTT Executive has been appointed to lead the Trust recovery programme and agreements are in place to secure the delivery of constitutional standards;
 - St Georges is currently non-compliant with RTT in Cardiac surgery, due to onsite operating access, a high level of ITU cancellations and a complex case mix. Regular meetings with the Trust have resulted in agreed actions to reduce the backlog and the Trust is expected to be compliant by April 2017;
 - An external review of vascular surgery and interventional radiology services found that patients could come to harm due to a breakdown in relationships between teams. As a result a team from GSTT is now based in St Georges helping to deliver vascular services. The vascular consultant rota position has improved and work has started to develop a formal network across South London. Kings College Hospital is offering support around Interventional Radiology and St George's is looking to work with Epsom and Kingston in this respect;
 - Difficulties in achievement of 62 day waits at the Royal Marsden, which is directly attributable to late referrals from other Trusts. Work is underway to address this and the Trust is on trajectory for improvement.
 - A CQC inspection of St George's in June 2016 identified estates issues requiring immediate assurance. This is addressed elsewhere in this STP.

3. 'Do nothing' financial challenge

In June 2016, the 'do nothing' specialised commissioning financial challenge for south west London was estimated at £99m. This figure was a high level provisional estimate and was presented as a cumulative figure over five years.

During September 2016 there has been an intensive effort to review and refresh the ‘do nothing’ gap, through the development of a finance and activity model that will estimate, at a greater level of detail, the financial challenge associated with pan-London specialised commissioning.

The importance of reconciling growth assumptions between providers and commissioners and having system-wide agreement to the scale of the challenge is recognised. NHS England will engage with the largest providers of specialised services with contract values over £150m and single speciality providers. The STP’s Finance and Activity Committee will be updated throughout this process of engagement. We will also work with our neighbours and surrounding regions to plan and design schemes to address the gap.

4. Delivering sustainable change

As a consequence of these challenges we, together with NHS England, are considering alternative ways to deliver and plan specialised services.

4.1 Opportunity analysis

In addition to the quality and performance issues highlighted in the case for change above, which are being discussed with NHS England's London Clinical Advisory Group, the 2015/16 performance data have been analysed to identify opportunities. By identifying incidences of variance for particular service lines between CCGs and between providers, it may be possible to improve quality and reduce cost by bringing them in line with peers. We include below some indicative analysis that we will use to engage with stakeholders and support and guide discussions to identify opportunities for improvement.

Total specialised commissioning spend in south west London

The data on specialised services commissioned for patients from south west London CCGs show:

- The highest spend in south west London is on patients from Croydon CCG with £104.5m in 2015/16
- The total spend in London is £368.9m, which is 15% of the total spend on specialised commissioning in London, and the lowest of the London STP footprints
- The average spend per unit weighted population for south west London is £230, which is 13.0% lower than the London STP average (£264)
- Croydon CCG has the highest average spend per unit weighted population at £261

Total specialised commissioning spend in south west London – total spend on 2015/16 activity at 2016/17 prices

CCG	15/16 spend at 16/17 prices	Spend/unweighted population	Spend/weighted population
NHS CROYDON CCG	£104.5m	£270	£261
NHS WANDSWORTH CCG	£90.4m	£280	£236
NHS MERTON CCG	£47.7m	£215	£216
NHS SUTTON CCG	£47.6m	£234	£250
NHS RICHMOND CCG	£40.8m	£213	£194
NHS KINGSTON CCG	£38.0m	£202	£187
South west London total	£368.9m	£244	£230

The unweighted and weighted population figures are taken from NHSE CCG Allocations 'Calculation of specialised services weighted populations spreadsheet' (columns L and J respectively). Weighting normalises for population size, age, health, unmet need and location factors between populations and is normalised so that the total for England is the same as October 2015 unweighted registrations.

These figures exclude spend on non-London providers, London Probation Trust and Ministry of Justice and SEAP - but include spend on non-south east London providers.

Total specialised commissioning spend on patients from south west London CCGs at all London providers

The data on total spend on patients from south west London CCGs at London providers suggest the following:

- Around 61% of spend on patients from south west London CCGs is at providers in the south west London footprint, and 39% at providers from the rest of London
- Spend on patients from south west London CCGs is greatest at St George's (£127.2m), followed by The Royal Marsden (£42.1m) and then Guy's and St Thomas' in south east London (£24.0m)
- £104.5m is spent on patients from Croydon CCG, and £90.4m on patients from Wandsworth CCG, whereas between £38m and £48m is spent on patients from the other south west London CCGs across London

Total specialised commissioning spend on patients from south west London CCGs at London providers – total spend on 2015/16 activity at 2016/17 prices

Cost of 15/16 activity at 16/17 prices £0K £41,335K		SWL						Total
	NHS CROYDON CCG	NHS WANDSWORTH CCG	NHS MERTON CCG	NHS SUTTON CCG	NHS RICHMOND CCG	NHS KINGSTON CCG		
SWL	ST GEORGE'S	£21,414K	£41,335K	£26,605K	£16,020K	£8,009K	£13,858K	£127,240K
	THE ROYAL MARSDEN	£13,341K	£5,283K	£4,461K	£8,886K	£4,335K	£5,751K	£42,057K
	EPSOM AND ST HELIER UNIVERSITY HOSPI...	£7,808K	£241K	£3,051K	£9,335K	£183K	£1,056K	£21,674K
	SOUTH WEST LONDON AND ST GEORGE'S ...	£988K	£9,226K	£2,108K	£1,263K	£2,256K	£1,082K	£16,923K
	CROYDON HEALTH SERVICES	£13,566K	£32K	£11K	£67K		£9K	£13,685K
	KINGSTON HOSPITAL	£30K	£890K	£549K	£89K	£2,681K	£4,099K	£8,337K
	THE ROYAL HOSPITAL FOR NEURO-DISABI...	£615K	£174K	£242K	£163K	£190K		£1,384K
	OAK VIEW			£0K	£0K		£0K	£0K
	Total	£57,762K	£57,180K	£37,027K	£35,824K	£17,653K	£25,854K	£231,300K
NWL	ROYAL BROMPTON & HAREFIELD	£3,326K	£4,000K	£1,852K	£3,268K	£2,698K	£2,882K	£18,026K
	IMPERIAL COLLEGE HEALTHCARE	£1,067K	£3,687K	£835K	£402K	£7,966K	£1,122K	£15,080K
	CHELSEA AND WESTMINSTER HOSPITAL	£1,407K	£7,649K	£923K	£559K	£3,432K	£977K	£14,948K
	WEST LONDON MENTAL HEALTH	£1,117K	£649K	£161K	£120K	£28K	£383K	£2,458K
	CENTRAL AND NORTH WEST LONDON	£541K	£442K	£35K	£92K	£191K	£5K	£1,307K
	LONDON NORTH WEST HEALTHCARE	£133K	£104K	£95K	£235K	£364K	£194K	£1,126K
	TAVISTOCK AND PORTMAN	£32K	£54K	£9K	£32K	£54K	£19K	£201K
	ST PETER'S ANDROLOGY CENTRE	£31K	£19K	£4K		£22K		£75K
	THE HILLINGDON HOSPITALS	£2K	£60K			£0K		£62K
	Total	£7,658K	£16,663K	£3,915K	£4,709K	£14,755K	£5,582K	£53,282K
SEL	GUY'S AND ST THOMAS'	£9,091K	£6,013K	£2,366K	£2,354K	£1,762K	£2,441K	£24,027K
	KING'S COLLEGE HOSPITAL	£12,062K	£1,706K	£1,539K	£834K	£553K	£566K	£17,260K
	SOUTH LONDON AND MAUDSLEY	£5,919K	£342K	£37K	£567K	£141K	£86K	£7,092K
	IN MIND	£383K	£1,020K			£401K		£1,804K
	LEWISHAM & GREENWICH	£474K	£72K	£9K	£1K			£556K
	THE HUNTERCOMBE GROUP	£272K					£141K	£412K
	LONDON AMBULANCE SERVICE	£19K	£19K	£19K	£19K	£18K	£19K	£112K
	OXLEAS	£78K						£78K
	Total	£28,296K	£9,172K	£3,970K	£3,774K	£2,876K	£3,253K	£51,341K
NCL	GREAT ORMOND STREET HOSPITAL FOR C...	£5,023K	£1,569K	£598K	£850K	£1,542K	£879K	£10,461K
	UNIVERSITY COLLEGE LONDON HOSPITALS	£1,530K	£2,219K	£874K	£584K	£1,584K	£916K	£7,707K
	ROYAL FREE LONDON	£497K	£956K	£50K	£505K	£1,222K	£486K	£3,717K
	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	£898K	£505K	£336K	£688K	£636K	£71K	£3,134K
	MOORFIELDS EYE HOSPITAL	£1,305K	£774K	£439K	£91K	£115K	£87K	£2,811K
	LONDON WOUND HEALING CENTRES LTD	£65K	£65K	£65K	£65K	£65K	£65K	£391K
	HOSPITAL OF ST JOHN AND ST ELIZABETH	£39K	£39K	£39K	£39K	£39K	£39K	£237K
	THE WHITTINGTON HOSPITAL	£42K	£62K	£33K	£7K	£30K	£20K	£193K
	BARNET, ENFIELD AND HARINGEY MENTAL...	£3K	£1K	£173K	£10K			£187K
	INSTITUTE OF OPHTHALMOLOGY	£17K	£17K	£17K	£17K	£17K	£17K	£104K
	NORTH MIDDLESEX UNIVERSITY HOSPITAL	£30K	£32K		£3K			£65K
	CENTRE FOR REPRODUCTIVE AND GENETI...	£12K	£12K	£35K				£58K
	BUPA GROUP	£8K	£8K			£8K		£23K
	ELLERN MEDE CENTRE FOR EATING DISO...		£22K					£22K
	Total	£9,469K	£6,281K	£2,659K	£2,860K	£5,260K	£2,581K	£29,109K
NEL	BARTS HEALTH	£781K	£793K	£141K	£208K	£208K	£238K	£2,549K
	EAST LONDON	£492K	£306K		£44K	£12K	£454K	£1,307K
	HOMERTON UNIVERSITY HOSPITAL	£17K	£0K	£1K	£0K		£4K	£23K
	BARKING, HAVERING AND REDBRIDGE UNI...	£3K	£2K	£12K	£3K	£0K		£20K
	NORTH EAST LONDON	£1K						£1K
	Total	£1,293K	£1,101K	£155K	£435K	£220K	£697K	£3,901K
Grand Total		£104,477K	£90,399K	£47,726K	£47,602K	£40,764K	£37,967K	£368,933K

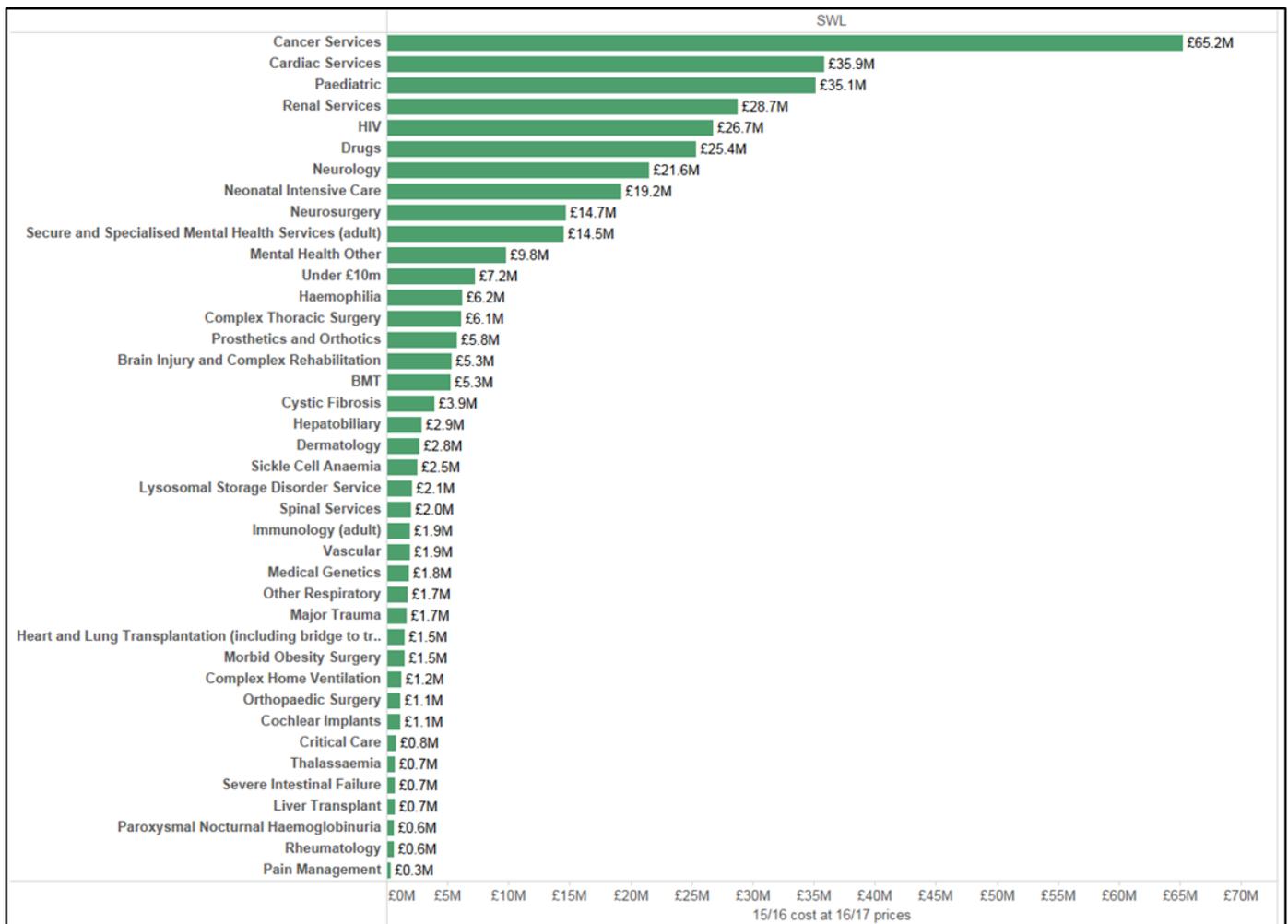
These figures exclude spend on London Probation Trust and Ministry of Justice and SEAP.

Service line spend in south west London

The data on service line spend on patients from south west London CCGs suggests the following:

- The highest spend group of service lines in south west London is Cancer Services with a spend of £65.2m, much higher than the next highest service line, Cardiac Services, with £35.9m
- The top five spend service line groups in south west London are, in descending order (in brackets: % of total south west London spend on all service lines, % of total London spend on the service line):
 - Cancer Services £65.2m (18% of south west London, 19% of London)
 - Cardiac Services £35.9m (10% of south west London, 18% of London)
 - Paediatrics £35.1 (10% of south west London, 15% of London)
 - Renal Services £28.7m (8% of south west London, 13% of London)
 - HIV £26.7m (7% of south west London, 11% of London)
- South west London spends a higher proportion on Cancer Services compared to other STPs – the average spend by STPs on Cancer Services is 14% of their total spend
- South west London spends a lower proportion on Secure and Specialised Mental Health Services (adult) compared to other STPs – the average spend by STPs is 8% of their total spend

Total spend on patients from south west London CCGs on service lines – total spend on 2015/16 activity at 2016/17 prices



These figures exclude spend on London Probation Trust and Ministry of Justice and SEAP.

4.2 South west London priorities

Through initial discussions and review of opportunities set out above, we are suggesting three areas of focus that the system should explore: Transformation Pathways; Drugs and Devices; and Improving Value. These ideas will be the subject of on-going discussions with stakeholders, in order to shape more detailed plans.

4.2.1 Transformation pathways

In order to improve the quality and outcomes of specialised services across London, south west London will engage in a regional approach to pathway transformation, focusing on:

- The development of a whole system, pathway-led approach to provision and commissioning of services, particularly where transformational change is required, maximising primary and secondary prevention to manage demand;
- Understanding the variation that currently exists across the region and identifying opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients. This will include working with other commissioners to ensure that care pathways work in a consistent way to support this in all areas;
- Building upon our knowledge of patient flows and the functional relationship between services to work with commissioners and providers to determine new and innovative ways of commissioning and providing services, in order to improve quality, safety and cost effectiveness.

Our initial transformation priorities are as follows. Development of these areas will be clinically led with a clear scope of work defined.

i. Aligning services across south London

Specialised services account for £1.3bn expenditure across South London and as such the disposition of these services is highly significant in ensuring the successful delivery of our STP. There are eight acute specialised providers in south London, 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. Between them these providers not only deliver a high number of acute specialised commissioned services, but there is also considerable overlap in provision.

Across south London a programme of work has been initiated focused on the scenarios for the future optimal configuration for clinically and financially sustainable acute specialised services that deliver the best patient journey. This work will also consider the patient flows into London from the South East.

T In taking forward this work, we will need to understand the impact of these scenarios on access for patients, particularly for any patients whose nearest service would, under one or more of the scenarios, be outside south London. We would also need to consider the financial implications of any movement of services, and the impact on the overall financial balance of the health economy. The modelling would also need to feed into the assessment of other acute configuration scenarios being considered through this STP. The scenarios and their implications would need to be fully understood and discussed with the public before being taken forward.

ii. Service specific pathway transformation

We are also closely engaged with the work underway at a London level to improve the quality and effectiveness of services for patients and ensure resilient provision, by concentrating on five key themes:

- Pathway inefficiencies;
- Ineffective prevention;

- Operational inefficiencies;
- Fragmented service provision;
- Inefficiencies due to patient flows.

A programme of pathway reviews has been established by NHS England focusing on services where there are significant patient flows across London and beyond. The initial priorities for work are paediatrics, cardiovascular, specialist cancer, and renal. Work is also underway to address some of our local challenges. Further detail of each of these is set out below. This work could lead to some changes in service delivery so we will take the views of patients and a wide range of other stakeholders in determining how to deliver the most effective and high performing services.

London Region Priority: Paediatrics	
Context	The development of paediatric services across London incrementally and over time has resulted in fragmentation. This is exacerbated in some services where there are multiple commissioners across a single pathways. Paediatric critical care is a good example of this.
Areas of focus	<p>A review of critical service interdependencies needs to be revisited; the aim is to ensure that children and young people can access safe, high quality and holistic specialist care in an environment which is appropriate to their care needs and, whenever possible, is close to home.</p> <p>The paediatric workforce is changing and there is a significant challenge in maintaining training, optimal workforce standards and a critical mass of patients to maintain skills and expertise. Work to date suggests that these issues might be best addressed through formally established networked models of care.</p> <p>Further work is required, in collaboration with maternity services, to support prevention right from the prenatal stage, through the early years and into transition where non-compliance can lead to significant deterioration in chronic health.</p> <p>There are two national service reviews which are underway in paediatric intensive care and in specialist surgery in children. These, together with a transformational review of the neonatal service and implementation of the congenital heart disease standards, are likely to lay the foundation for change.</p>

London Region Priority: Cardiovascular	
Context	<ul style="list-style-type: none"> • Value – there are some more cost-effective and improved patient outcomes treatment alternatives • Variation – there is a significant variation in length of stay, even for the same procedure • Referrals – inadequate referrals for some procedures sometimes result in sub-optimal care for patients • There is no organised pan-London plan for the procurement and rollout of new technology
Areas of focus	<ul style="list-style-type: none"> • Networking and transport arrangements need to be improved to reduce waiting time and improve outcomes • Set up for formal comprehensive networks, with five central units linked with several local units (for vascular) • Set out specific standards that need to be adhered to and propose im-

	<p>proved pathways</p> <ul style="list-style-type: none"> • Integrated pathways, with better prevention, identification, early intervention and access to new treatments • Formalising South London vascular network arrangements
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London Region Priority: Specialist Cancer

Context	<ul style="list-style-type: none"> • We support the alignment of our STP plan with specialised cancer commissioning plans, so that the wider health system spending supports improved outcomes and value along the whole care pathway. • Earlier diagnosis – there is a need to diagnose cancer earlier in order to improve survival outcomes • Differences in clinical and organisational practice cause variation in the quality of service offered to cancer patients across London • In London there are unnecessary follow-up attendances and these can be in non-optimal settings
Areas of focus	<ul style="list-style-type: none"> • Deliver priorities of the national cancer strategy, including: <ul style="list-style-type: none"> ○ Delivery of 62 day standard and 2 week wait ○ Reduction in variation ○ Earlier identification through enhanced diagnosis, and better access to services through implementing stratified pathways in outpatient services ○ Enhanced access to smoking cessation services to reduce incidence. • Right-sizing - The centralisation of specialist services has benefits both for patients and the services. Some of London's cancer services should be consolidated to ensure minimum numbers/populations are met (Urology/Liver/Pancreatic/Head & Neck/OG/Lung) • Active participation and then implementation from the national service review programme which will include radiotherapy; chemotherapy; cancer surgery; children's and young people's cancer services and a second phase of PET CT • Development of plans for implementing panel and genome testing • Active participation in best practice work to improve value, such as chemotherapy doses, radiotherapy, and levels of intervention for end of life care • Strengthened provider networks across the specialised commissioning pathway portfolio. In south west London we will work with the Royal Marsden Cancer Vanguard and the cancer alliance in south east London to ensure the delivery of commitments for improved quality and cost effectiveness in relation to specialised services. • We will continue to address non-compliant cancer pathways which do not meet agreed activity thresholds. We will work within the framework of the national strategy to address paediatric cancer services in London

London Region Priority: Renal

Context	<p>End-stage renal disease affects 0.1% of the population. Treatment for this life-threatening condition is through renal replacement therapy (RRT), this is either by dialysis at home, in a unit or through a kidney transplant. Within London there are over 6000 people receiving dialysis at one of seven renal providers at a cost of c.£212m (2014-15). Whilst the national numbers of new patients starting dialysis appears to have stabilised, the London dialysis population has grown by an average of 4.4% a year since 2007.</p>
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	<p>The key risk factors for developing kidney disease are diabetes, high blood pressure, heart disease and a familial history of kidney disease. Of these, diabetes remains the most common primary diagnosis in new patients presenting for renal replacement therapy (38%). Across the STP 38.8% of diabetes patients had achieved all three of the NICE recommended treatment targets (2014/15). Secondary prevention in primary care, better cooperation and data sharing between primary and secondary care to support early detection of renal disease to improve recognition and treatment of chronic disease are all needed. Innovative ways of managing renal demand are being explored.</p> <ul style="list-style-type: none"> • Financial – spend on renal cannot continue to increase without impacting other areas of medicine, and London has lagged behind England in increasing best practice tariffs • Fragmented – commissioning tends to reward activity, rather than support value and patient experience – providers assume responsibility for patients very late along the patient pathway and care often seems fragmented • Prevention – early diagnosis and prevention is key. In 2011/12 there were just under 183,000 people aged 18+ on the London CKD QOF registers, and it is estimated that there could be a further 150,000 with CKD in the SCN who are currently undiagnosed <p>In south west London, St George's is primary renal provider to Wandsworth and Richmond boroughs. Epsom & St Helier is the primary tertiary nephrology provider to south west London boroughs of Sutton and Croydon. The boroughs of Merton and Kingston are shared between the two providers. Epsom & St Helier is also the primary provider for the whole of Surrey and parts of Hampshire and Berkshire. Epsom & St Helier has a network of 9 dialysis units covering this geography and inpatient base at St Helier. St George's is the centre of the south west London, Surrey and Sussex transplant network with over 100 transplants undertaken each year.</p> <p>There are over 1,000 patients on dialysis programmes. Outcomes are consistently excellent. In the London peer review that is about to be published the service has more commendations and fewer areas for improvement than any other service and was specifically rated as 'Good' by the CQC. Our service is at the forefront of developing new models of care and is currently working with Frimley Health around setting up an inpatient nephrology service at Frimley Park hospital with the tertiary links remaining to Epsom & St Helier and St George's.</p>
<p>Areas of focus</p>	<p>Both Epsom & St Helier and St George's are committed to resolving the historical anomaly of there being two tertiary renal services being located in south west London but being managed separately. The Trusts are currently undertaking a high level clinical strategy review which includes renal. The aim of including renal is to create a single renal leadership model for south west London and Surrey and if possible during 2017/18 begin the process of co-locating some of the tertiary services. To achieve this we will have to demonstrate that patient quality and outcomes are enhanced and revenue savings can be made. The outcome of the final disposition and locations of renal services in south west London will need to be part of both the south west London acute service configuration work and the south London specialist commissioning review. In common with the rest of London we will also:</p> <ul style="list-style-type: none"> • Understand and reduce variation – stabilise prevalent dialysis population in London by 2019, reduce incident patients by 20% per annum, reduce late presentation to under 10% • Improve delivery and experience of care in Acute Kidney Injury (AKI) (de-

	<p>liver London's AKI through LAKIN)</p> <ul style="list-style-type: none"> • Optimise the patient experience of renal care through <ul style="list-style-type: none"> ○ Establishing and sharing pan London best practice ○ Supporting shared decision making and patient autonomy in care ○ Access to end of life care • Evolve commissioning through provider collaboratives, or Networks of Care (incentivise provider collaboration and openly report any variation on outcome, experience and value to promote best practice) • Upskill the whole health economy workforce to shift the emphasis on care to one of patient empowerment • We will also focus on: <ul style="list-style-type: none"> ○ Improved early diagnosis and intervention of renal risk factors in primary care to reduce incidence and delay onset of end stage renal failure, hence improving outcomes for patients and reducing demand on costly interventions ○ Increasing the number of patients receiving home dialysis ○ Improving the use of technology in follow-ups and support for patients in virtual clinics
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Local Priority: Neuro-rehabilitation	
Context	<ul style="list-style-type: none"> • In London there are eight providers of neuro-rehabilitation. Flows into neuro-rehabilitation Tier 1 and 1a is poorly understood, as is the interface with other elements of CCG funded neuro-rehabilitation. Inconsistencies in the patient pathway create bottlenecks and blockages for patients accessing and being discharged from the service. • St George's is a major trauma centre and so will experience high demand and a more complex case mix. They provide specialised neuro-rehabilitation but we know there are gaps within the pathway to supporting patients stepping into mainstream neuro-rehabilitation.
Areas of focus	<ul style="list-style-type: none"> • There has been a London wide review of neuro-rehabilitation which focused on opportunities to reduce waits, duplicate referrals and deliver longer term cost benefits through a better understanding of patient pathways. The review recommended: <ul style="list-style-type: none"> ○ Developing a data system to collect referrals, which will be used for bed management and waiting list initiatives. ○ Referring centres which will be linked with CCG and NHS provision. ○ Neuro-navigators to support people moving into CCG and NHSE funded beds. • There are further opportunities to build on St George's work in neurosciences and work on cognitive rehabilitation

Local Priority: Adult Secure Mental Health	
Context	<ul style="list-style-type: none"> • There are three mental health providers across south London (South London and Maudsley, Oxleas and South West London and St George's) • The services covered include all medium secure, low secure, step down and community forensic services covered by the contracts agreed between NHS England and these three Trusts, as well as patients from south west and south east London who are cared for in secure services outside London
Areas of focus	<ul style="list-style-type: none"> • Developing a programme across south London to improve access to and

	<p>experience of care for patients, wherever they are from, in south London – and whether they receive treatment in south London or out of area.</p> <ul style="list-style-type: none"> • Our ambition is to improve overall service quality, improve the patient and carer experience, and increase the efficiency and productivity of our services. This will be achieved through: <ul style="list-style-type: none"> ○ Setting up a new commissioning and case management directorate, with a new team, new patient register and tracker function, and oversight of all transactional and clinical pathway activity required to maximise efficiency and productivity ○ A single point of access for south London for referral, assessment and triage, with a new clinical case management offer across the whole pathway with linked budgetary responsibility ○ Developing specialisation through agreeing what the right distribution of services is, both for clinical efficiency and patient pathway optimisation. For example we will consider a single women's pathway. We will use this option to take a fresh look at our estate development, and, if appropriate, prepare and share recommendations for redevelopment and rationalisation across the partnership; ○ We will invest in reablement, shifting care to a strong step down, rehab and community forensic offer, integrated with housing and welfare providers to ensure safe recovery on transition from inpatient provision ○ We will standardise pathways, advancing quality by building on existing approaches to quality improvement. We will improve throughput (flow) and patient outcomes, actively monitoring protocol compliance. We will also look at commissioning pathway services (particularly substance misuse and personality disorder services) that have been shown to reduce lengths of stay within low secure settings – all evidence suggests that through better pathway management, treatment is timely and more effective, and importantly recovery is quicker. • All four Boards have agreed to the initial proposal. Full go-live is planned from April 2017.
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Local Priority: CAMHS	
Context	<p>CAMHS services are provided across the spectrum of care settings with some of the most complex and/or high risk cases requiring admission to specialised (Tier 4) inpatient care. Local Transformation Plans are expected to result in a significant reduction in demand for Specialised CAMHS services within the next five years. Community crisis care pathways that can provide robust and sustainable alternatives to inpatient care are under-developed, particularly for children and young people with complex needs and behaviours related to learning disability (LD) and/or Autism and emerging personality disorders. The overall distribution of CAMHS inpatient capacity does not match regional population needs and young people are being admitted far from their home, or to paediatric or adult beds; the NHS England National CAMHS Service Review aims to redress service deficits by redistributing/realigning beds to meet local needs. The clear expectation is that by 2020 there will be no inappropriate admissions to adult or paediatric beds and patients will be treated in local care pathways.</p>
Areas of focus	<ul style="list-style-type: none"> • Local plans for CAMHS transformation are a key part of the south west London STP, and strengthening crisis response is one of our priorities. We are working within specialised commissioning to improve access to inpatient CAMHS and couple with local transformation initiatives to improve

	<p>prevention and early intervention. These should help to reduce the burden on the wider acute hospital system</p> <ul style="list-style-type: none"> ● We will promote commissioning of consistent out of hours services for young people particularly to manage crisis and prevent escalation with the clear ambition to manage demand effectively at community level and reduce inpatient admissions to be reflected in local CAMHS transformation plan (LTP) refresh, and Transforming Care Partnership (TCP) plans. ● TCPs - with the engagement and support of NHS England to oversee consistent delivery of multi-agency pre-admission Care and Treatment Reviews for children and young people with learning disabilities, and/or autism to reduce inpatient admissions; with the ambition reflected in LTP to refresh and TCP plans ● NHS England Specialised Commissioning Team to work collaboratively with CCG and local authority commissioners to design and commission effective community pathways with robust links to local acute inpatient services with the ambition to reduce lengths of stay and inappropriate placements reflected in LTP and TCP ● NHS England Specialised Commissioning Team to continue to work with local commissioners to reflect the ambition in LTP/TCP and STP plans to <ul style="list-style-type: none"> ○ ensure regional inpatient capacity meets requirements so out-of-region admissions become the exception ○ reduce variation by introducing standardised access and waiting times ○ adopt consistent models of care based on best practice that reduce the reliance on inpatient care
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Local Priority: Transforming Care Partnerships	
Context	<p>NHS England Specialised Commissioning is responsible for commissioning high secure, medium secure and low secure inpatient services for adults with learning disabilities and/or autism and for commissioning specialised inpatient care for children and young people with learning disabilities and/or autism.</p> <p>There is currently an over-reliance on inpatient-based care for both adults as well as children and young people, and a significant number of patients could be managed out of hospital with the right support. Where a period of inpatient care is required there can be lengthy waits for an appropriate service particularly for children and young people. Lengths of stay for all patients are often extended because of a lack of appropriate community-based alternatives to enable timely discharge particularly where needs are complex.</p> <p>London does not have sufficient inpatient capacity to enable all patients to receive care close to home and a significant proportion of patients are placed out of area primarily in the private sector.</p>

Areas of focus	<p>Working closely with local commissioners within the Transforming Care Partnerships to</p> <ul style="list-style-type: none"> • deliver a robust approach to implementing the pre- and post-admission Care and Treatment Reviews to reduce the numbers of people, particularly children and young people, being admitted to inpatient care unnecessarily • support the design of appropriate community packages enabling timely discharges and reduced lengths of stay • deliver care closer to home by commissioning appropriate inpatient capacity for <ul style="list-style-type: none"> ○ medium and low secure services for adults ○ specialised inpatient care for CAMHS <p>In south west London we are exploring the pooling of budgets to support pathway improvement and expect to pilot this in shadow form in 2016/17.</p>
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4.2.2 Drugs and devices

High cost drugs and devices (HCDD) are "passed through" directly from providers to commissioners and represent a substantial (almost 25%) and growing proportion of south west London attributed spend. The major components of this spend are:

- Cancer drugs
- HIV drugs
- All other drugs
- Devices

Within London, south west London stands out as having by far the lowest incurred spend (both on an absolute and on a weighted population basis). This is driven in particular by a relatively low incidence of HIV patient treatment which means it has less than half the per capita HIV drug costs compared to the other STP territories in the Capital.

We intend to 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 through:

- Aligning priorities and improving efficiencies relating to medicines optimisation and the "Hospital Pharmacy Transformation Programme"
- Working with NICE and the CRGs to ensure that treatment algorithms for medicines reflect optimal use of the most cost effective treatments and enable a reduction in unwarranted variation
- Implementing digital developments such as e-prescribing, electronic prior approvals and standardised contract reporting
- Completing the centralisation of the high cost device supply chain and reducing the variation of specifications for devices
- Incentivising Trusts with a medicines optimisation and devices CQUIN for 2017-19 to support implementation
- Major savings opportunities within HCDD which have been identified and are part of an active QIPP programme include:
 - Two high cost biotech cancer drugs (Rituximab and Trastuzumab) which come out of patent in the next two years. The maximisation of savings will require an aggressive conversion programme from the branded medicine to the "bio-similar" alternative

- A focus on maximising the national procurement leverage when applied to the purchase of devices
- A programme targeted at maximising the savings from HIV generic drug availability through substitution and reconfiguration of tablet combinations

We intend to engage with patients and carer representatives on the CRGs on the medicines optimisation programme to improve the value and outcomes for patients.

4.2.3 Improving value

In line with the national commissioning intentions⁴² we will engage with these important areas of work to drive improved value:

- Fragile services – reduction in occasional practice, non-contracted activity, and address non-compliant services which do not meet agreed activity thresholds
- Improved clinical and operational efficiency, and reducing variation, including the use of the clinical utilisation reviews, Rightcare and Getting It Right First Time,
- Implementation of national reviews
- Clinical Reference Group initiatives which will set out opportunities to deliver improvements, whilst achieving a reduction in overall cost.
- London QIPP programme for 2017-2019, and use of national CQUINs

5. Enablers

5.1 Collaboration

We will take a more collaborative approach to commissioning services on an 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. This will be taken forward in south west London in 2016/17 through a collaborative commissioning approach to adult secure mental health services as described in section 4 above.

We will also explore the allocation of budgets across other pathways such as back pain management, neurosurgery and neuro rehabilitation pathways We will also be pursuing other opportunities such as Cancer Vanguard and transforming care and other programmes.

As part of New Models of Care work will put Lead Provider/Alliance arrangements in place to develop proposals to secure future sustainability and improve the quality of service.

5.2 Engagement with the National Strategic Service Review Programme

We will engage with a rolling Strategic Service Review Programme approach that is being developed by NHS England to address local service issues. We will work with the national team and Clinical Reference Groups.

5.3 Improving quality

We will commit to:

- Better information – quality dashboards and a quality surveillance system for providers and commissioners accessed via secure portals, which will continue to be developed to deliver better information on patient outcomes, cost/value and quality to enable and inform change
- Quality profiles – quality profile will be generated for each specialised service delivered by any given provider, summarising information from quality surveillance and identifying national outliers.

⁴² <https://www.nao.org.uk/wp-content/uploads/2016/04/The-commissioning-of-specialised-services-in-the-NHS.pdf> \ "page=16

5.4 Reforming the payment system

We will support:

- Tariff redesign to support outcomes
- Shared contract models – risk/gain share arrangements; longer two year contracts and contract innovation, such as the recovery oriented payment approach in secure mental health services

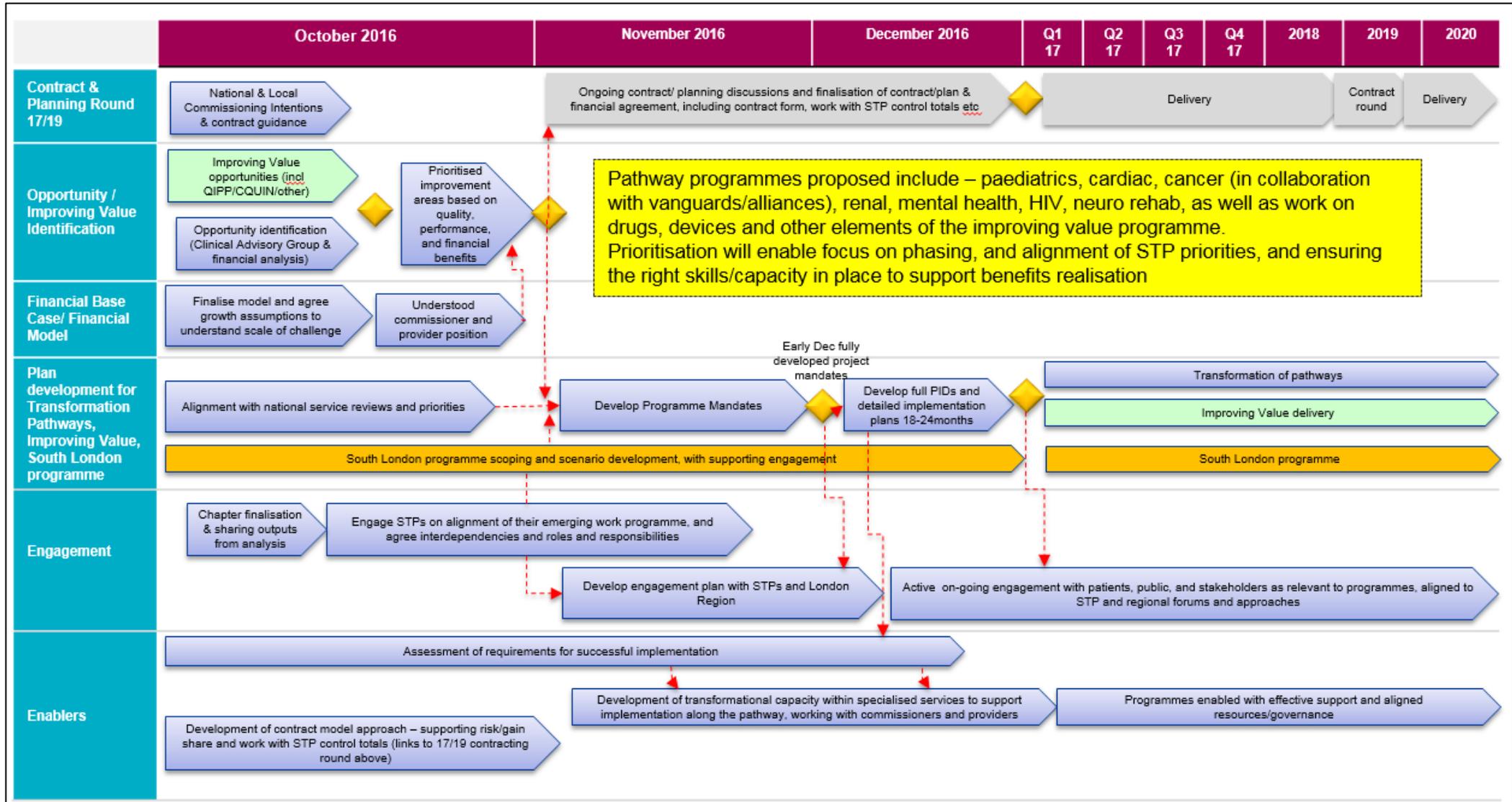
6. Governance and delivery plan

6.1 Governance

Since our June submission, governance arrangements for Specialised Commissioning planning in London have been agreed. The south west London STP has its governance arrangement and delivery agreements primarily through STP Heads of Delivery, with a Specialised Commissioning Planning Board to assist on development.

A Specialised Commissioning Planning Board and Specialised Commissioning Executive Board, and localised working groups (including for south London and with the south and midlands and east regions to discuss flows and planning across regional boundaries) have been established. South west London providers and the STP are fully engaged in these structures.

6.2 High level plan for Specialised Services



Appendix E - Collaborative productivity

The Acute Provider Collaborative (APC) estimates that the south west London acute Trusts could potentially save £55m in productivity savings, through four key collaborative initiatives.

Productivity savings through joint working are not new to south west London and successful examples within the health economy exist such as South West London Pathology and south west London Elective Orthopaedic Centre (SWLEOC). In addition to the focus on individual acute provider productivity, it is recognised that additional benefits could be delivered through joint and collaborative working.

To investigate such areas, the Acute Provider Collaborative (APC) was established in 2014/15 with the aim of identifying key areas of joint productivity opportunities as well as focusing on non-elective admissions and length of stay, to help narrow the deficit within the south west London health economy.

At present the proposals have largely been developed between the four acute trusts since there is the greatest degree of overlap between them. The proposals around optimising the workforce include South West London and St George's Mental Health Trust, and going forward we will explore productivity opportunities across the providers more widely, including with the Royal Marsden Hospital.

Approach taken in south west London

In order to identify the opportunities in south west London the APC used the recommendations from Lord Carter's final report that identified approximately £5.0bn in savings across the English health system. Each recommendation was mapped as either being Trust-specific or directed towards the national regulatory bodies and other agencies.

The APC further focused on the Trust specific recommendations across five key categories (Clinical Workforce, Estate Management, Pharmaceutical and Medicines Optimisation, Procurement and Others) and identified the key initiatives within each category. Additionally, the APC identified initiatives based on local, regional, national and international good practices that were not covered in Lord Carter's report.

The list of initiatives was thoroughly discussed through a series of interviews and workshops with the south west London acute provider leadership and key internal and external stakeholders. Following the engagement with stakeholders, the APC and acute providers agreed on four key areas that could potentially be delivered collaboratively. These areas of collaborative productivity are in line with national directives and Lord Carter's recommendations for acute care Trusts and have been selected on the basis of productivity impact and implementation timeframe. They are informed by the ongoing individual Trust CIPs.

Based on this analysis, south west London has moved to develop a series of collaborative projects across the four trusts.

- **Already underway:** a shared approach to procurement, and a shared approach to staff banks are already well developed, with implementation from November 2016.
- **Being developed:** trusts are already working together to address fragile services such as vascular services which have recently been heavily dependent on locums. South West London Pathology and Epsom and St Helier are also taking forward a collaboration on pathology. These are at an early stage of development.

- **Being scoped:** Finally, the APC is undertaking development of a business case on how savings in the remaining Carter areas can be realised.

Summary table of areas of collaboration

Project	Key Areas (Carter)	Initiative(s)	2020/21 Est. Benefits (£m)
Shared procurement project	Collaborative Procurement and Supply Chain	Joint procurement and supply chain cluster	12
Shared staff banks project	Workforce Optimisation	Pan south west London staff bank across all staff groups including nursing, medical, AHP's and administrative staff	4
Other backoffice opportunities – business case*	Corporate and Administration Costs	Efficiencies in transactional services in - HR, Finance, IT and Payroll	19
	Estates Management Efficiencies	Efficient use of south west London estates	14
	Waste reduction	Reducing waste	2
	Pharmacy	Reducing pharmacy costs	1
	Pathology	Radiology and pathology	2
Fragile services	Fragile services	Optimisation of fragile services	1
	Total		55

* The savings identified against the backoffice business case are provisional top-down estimates. These are in the process of being worked up in more detail for the business case so these numbers are likely to change as the work progresses.

Implementing the collaborative programmes

Procurement, staff banks, back-office

Procurement: implementation is already underway for alignment of some procurement contracts, and the first savings are expected during 2015-16. In the longer term we are developing a business case around a shared, strengthened procurement function for south west London.

Staff banks: Implementation is underway, with rosters being aligned across at least three trusts during 2015-16. We will procure software that enables staff from across all south west London trusts

to have access to shifts at other sites, thus increasing our ability to fill vacant shifts with NHS bank staff rather than agency staff, and reducing the additional costs associated with agency staff.

Backoffice: we are in the process of reviewing other back-office functions across south west London trusts, to identify where there would be the scope to share services, either within the health economy with other NHS trusts, or to outsource specific services.

Pathology

South west London already has a shared pathology service (South West London Pathology), which covers Kingston, Croydon and St George's. Through investment in technology and facilities South West London Pathology has achieved annual cost benefits of £5.9m as well as improved service turnaround design since the service began in April 2014. Epsom and St Helier have services of their own, which scored well against the Carter efficiency benchmarking.

The two services are exploring options around working more closely together and are developing an MoU which agrees to progress four key lines of collaboration:

- Comprehensive review of laboratory and clinical provision to identify efficiency and cost reduction opportunities.
- Review of Clinical Immunology services.
- Joint work to develop improved IT links to provide full access to patients' results to avoid test duplication.
- Review of Cellular Pathology provision to identify further opportunities for collaboration

The APC has reviewed data on both of these services to identify the scope for further collaboration. The data suggests that the current service model is sustainable (low spend on non-permanent staff and stable income flows). There are apparent variations in performance that may be underpinned by the type and complexity of work and different approaches to defining activity/tests and attributing costs. More detailed work is required to define an accurate baseline of activity and cost.

Fragile services

In June NHSI asked providers to identify whether there were any 'fragile services' which were heavily dependent on locums.

South west London identified four such areas: vascular, ENT and dental, maxillofacial and spinal surgery. Work has been taken forward in these areas between the trusts, and with commissioners, to stabilise the service and reduce reliance on locums.

The level of savings identified associated with these services is small since most of the services are themselves relatively small.

Other providers

The other providers in south west London (the Royal Marsden and South West London and St George's) are also reviewing options around collaborative working over the time period of the STP and have identified a possible £2m of savings (£1.7m for SWL&SG, £0.4m for RMH which has a much higher proportion of backoffice functions already shared, and thus a lower opportunity). These are not currently included in the table above since the implementation opportunities have not yet been identified but could further alleviate financial pressures.

Appendix F – Workforce Strategy

1. Introduction and Context

1.1 Summary of what the STP is trying to achieve

The ways in which health and care are provided have improved dramatically over the past 15 years. But in common with other industrialised countries, our health and care services face new challenges in the 21st century.

Across the whole system, quality of care can be variable, preventable illness is common and growing demands on our services mean that local health and care organisations face financial pressure.

Last year, in response to these challenges, NHS England published the NHS *Five Year Forward View*, setting out the challenges and a national plan for the NHS to respond to them. This report outlined a new approach to help ensure that health and care services are planned by place rather than around individual institutions, in order to break the artificial boundaries between organisations and deliver care that is coordinated around what people need and want.

Following publication of the *Five Year Forward View*, local health and care systems have been working together to produce a multi-year Sustainability and Transformation Plan (STP) showing how services will evolve and become sustainable over the next five years.

In south west London NHS organisations have come together to work with local authorities and local people to discuss what this might mean for health and care services across the area. While the challenges are significant, the opportunities are also huge. By using our money and staff differently to build services around the needs of patients, services that are proactive and focused on keeping people well, we know that we can improve care and get better results for our local population.

The STP is an ambitious plan, but it reflects a growing national and local consensus on the way forward. It introduces a new approach to delivering proactive and preventative health and care services in south west London, which will tackle the challenges we face and ensure high quality, sustainable services that meet the needs of local people for years to come.

1.2 STP requirements

To support this plan we need a radical change in our workforce. As part of our STP submission NHS England have asked us to set out how we will address a number of specific points to underpin how we will do this:

- Reducing agency spend and develop, retrain and retain a workforce with the right skills and values
- Developing integrated multidisciplinary teams to underpin new care models
- New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice
- Improving the health and wellbeing of NHS employees and reduce sickness rates

1.3 Workforce background and context

Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of health care. However, there is a growing gap between patient needs and the skills and knowledge of the workforce that cares for them. The current workforce was

trained to provide a model of acute, episodic, disease-based care. This is now falling short of meeting the needs of the growing cohort of patients with increasingly complex needs and multi-morbidities, many of whom are old and frail.

The NHS in south west London needs to evolve from an illness-based, provider-led system and a radical change in workforce is key to this. Reshaping the health and care workforce to deliver this offers many opportunities. It can deliver benefits for patients through more patient-centred care and improved outcomes; benefits for staff through more rewarding roles and enhanced career pathways; it can also deliver benefits for organisations through greater efficiencies, helping to address potential workforce gaps and reducing reliance on agency and temporary staff.

We recognise that we are working within a complex landscape, where nationally there are a number of programmes that impact on workforce and its transformation:

- *Five Year Forward View* New Care Models Vanguard; including south west London's own Sutton Care Home Vanguard, as well as the Royal Marsden's Cancer Vanguard.
- The Primary Care Home Model, of which Richmond is one of the 15 pilots.
- The implementation of 7 Day Services.
- Other priorities such the *Five Year Forward View* Mental Health Task Force, the operational productivity requirements for NHS providers, leadership development, and a new model for social care based on a new relationship with citizens.

There are also a number of transformation programmes underway at a London level through the Capital Nurse Programme, as well as the Healthy London Partnership, including a workforce 'enabler' programme. The programme has recently published a Workforce Strategic Framework as well as a number of tools, materials and case studies.

The concept of new roles and extended roles, the use of apprenticeships to attract and retain staff, the application of clinical networks and the use of the voluntary sector are all avenues promoted nationally to support local development of solutions to address workforce challenges.

1.4 Local context:

As a precursor to support the development of a workforce strategy for the STP a workforce development project was undertaken, involving clinicians, patients, representatives from the CCGs, and service providers from acute, community and mental health organisations across south west London. This work highlighted that:

- More care should take place in the community, including care homes.
- Training placements in primary and community care should be increased to support the direction of travel towards out-of-hospital care.
- Multi-disciplinary teams are important to delivering integrated patient care, but the structure of these differs between organisations.
- Care coordination roles could be useful to support patients to navigate the complex health and care system.
- Obstacles such as funding, contracting and IT intra-operability need to be resolved to facilitate joint working between care settings.

We will seek to build on workforce redesign activity nationally and locally in order to develop a full workforce strategy for south west London.

1.5 Workforce Action Board

In order to address the key workforce requirements set out for the STP, and support our radical plans for transforming services across south west London, we have established a Workforce Action Board to lead the development and implementation of a workforce strategy.

South west London Workforce Action Board: role and responsibilities

The Board is responsible for leading the development of workforce strategy and overseeing its implementation in support of the south west London Sustainability and Transformation plan.

Membership for the Board is drawn from the breadth of health and care organisations within the south west London STP footprint. All organisations in south west London are committed to providing strong leadership, support, and active participation to developing a workforce that supports our STP.

Whilst the Board will be STP-wide, it will seek to work at a number of different levels depending on the size and complexity of local labour markets.

In developing the workforce strategy, the Board will need to ensure that it:

- Reflects national and London initiatives
- Is aligned with the south west London STP and reflects new models of care being developed through the strategy
- Works jointly with the Social Care sector to identify opportunities to align and synergise teams to maximise integrated working
- Reflects the advice of the Finance and Activity Committee in respect of the affordability of workforce proposals

The Board reports to and is accountable to the south west London Transformation Group, Clinical Board and Finance and Activity Committee.

The group is considering how its membership might need to change going forward as the strategy is developed further, including the involvement of staff side/union representative; patients; broader representation from the boroughs; education providers.

1.6 Our approach: mobilising a south west London workforce programme

In order to develop new models and ways of working for south west London we need an understanding of current developments across all levels, from national to individual organisations:

At a National level: Understanding workforce policy direction, new care model development and other pilot programmes supporting innovation

At a London level:

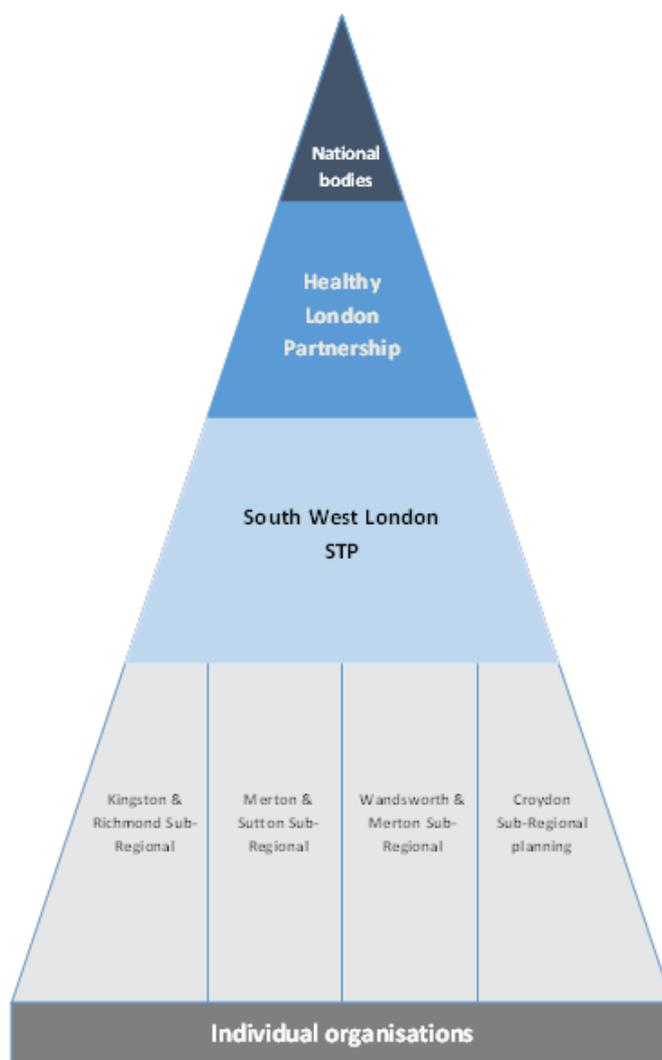
Understanding the similar challenges faced across the other four London Strategic Planning Groups and the outputs, methods and tools produced by the Healthy London Partnership

At a south west London STP level:

Being able to harness the innovation from the national and London levels, share and replicate innovative work that has been undertaken at the STP sub-regional and individual levels but also seek new opportunities to work collaboratively, maximising resources and economies of scale to ensure there is a sustainable fit for purpose workforce across the footprint.

At a STP sub-regional level: Having a workforce framework for commonality so that learning can happen across sub-regional planning groups and encouraging innovation at a local level as addressing truly local challenges and piloting at scale to the benefit of south west London. Working collaboratively between neighbours rather than against.

At an individual organisation level: On-going specific initiatives to provide training and support for a healthy workforce.



2. The local picture – our workforce baseline

2.1 Workforce profile – highlights from our baseline

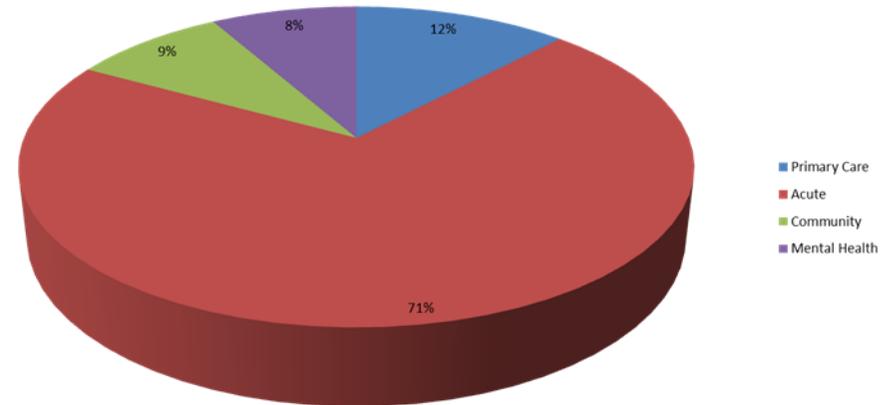
- We have over 25,000 WTE staff working in health in south west London across mental health, primary care, community, acute settings with an additional 32,000 jobs in the social care sector – this includes managers, administration and estates staff.
- Of our NHS settings, the majority of staff are located within the acute sector, with only around 9% of our staff based in community settings (over 2,000 staff).
- Within General Practice, excluding managers and administration staff, GPs account for the majority of the workforce (65%), whilst nurses make up 25% and other qualified clinicians only 2.5%. Of the 10% of other staff involved in direct patient care, 75% are health care assistants. Of our 876 FTE GPs, 21.8% are over 55 and of our 339 FTE nurses, 39% are over 55.
- According to work the Healthy London Partnership have undertaken in south west London to understand our primary care workforce:

- If care continues to be delivered in the same way in the next five years, demand for GPs will rise and the supply will not meet that demand (shortfall of 195)
- Even if it is were possible to recruit enough GPs (which is unlikely), this will pose a significant funding challenge
- Within our trusts over 56% of the workforce are qualified clinicians with the majority of those being nurses, 17% of the workforce are Doctors, and 27% are unqualified. Bands 5 to 7 make up the majority of our workforce at 49%.
- We also know that within our acute hospitals some are running a high vacancy rate as they are unable to recruit for many substantive posts and are relying on expensive agency staff to deliver services and rotas at a cost of c£31m.
- Based on current five year trends for supply and demand for acute settings, we know that without concerted efforts to improve the recruitment and retention of staff, demand is likely to outstrip supply. If the supply of staff were available to meet the projected demand, in the current funding climate it will become unaffordable to continue to deliver this model of care.
- The rapid increase in property prices over the past few years prevents many staff from owning their own homes in south west London. Over the last five years there has been a significant increase in the travel to work distance of all London-based NHS staff, compared to a decrease in travel distance of private sector staff.

2.2 Baseline - total south west London workforce:

Total NHS workforce:

Setting	Whole Time Equivalent
Acute	18,809
Community	2426
Mental Health	2166
Primary Care	2896
Total	26,297



Entire WTE NHS workforce, including managers, administration and estates staff

Social Care Workforce:

The table shows the total number of jobs identified by the HSCIC in Social Care in south west London

	Independent sector			Local authorities		
	Estimated ASC jobs	NMDS-SC workers	Coverage	Estimated ASC jobs	NMDS-SC workers	Coverage
England total	1,190,000	648,392	54%	120,000	120,000	100%
London total	155,000	67,566	43%	14,000	14,000	100%
South West London STP area total	29,000	12,410	42%	2,500	2,500	100%
NHS Croydon	10,000	3,411	34%	500	500	100%
NHS Kingston	3,000	1,271	40%	500	500	100%
NHS Merton	5,000	2,240	45%	500	500	100%
NHS Richmond	2,500	1,393	60%	<250	<250	100%
NHS Sutton	4,500	1,947	42%	500	500	100%
NHS Wandsworth	4,500	2,148	50%	500	500	100%

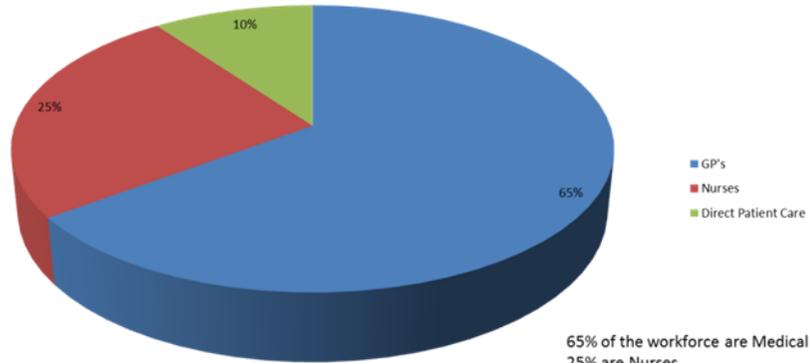
Care Home workforce:

The table below shows the number of CQC regulated professions within London, by care service provided.

	All CQC regulated services	Care home services without nursing	Care home services with nursing	Domiciliary care services	All other services
England total	24,127	11,770	4,588	7,615	154
London total	2,725	1,194	390	1,124	17
South West London STP area total	588	273	115	198	2
NHS Croydon	215	102	36	76	1
NHS Kingston	63	28	16	18	1
NHS Merton	73	24	14	35	0
NHS Richmond	59	35	8	16	0
NHS Sutton	119	59	27	33	0
NHS Wandsworth	59	25	14	20	0

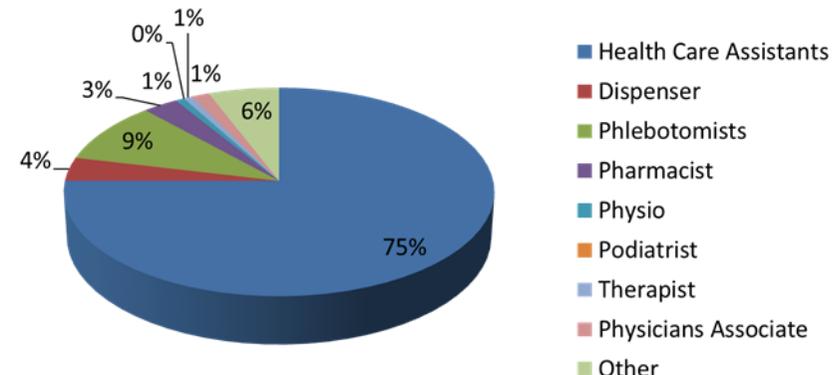
2.3 Skill mix:

Primary care:



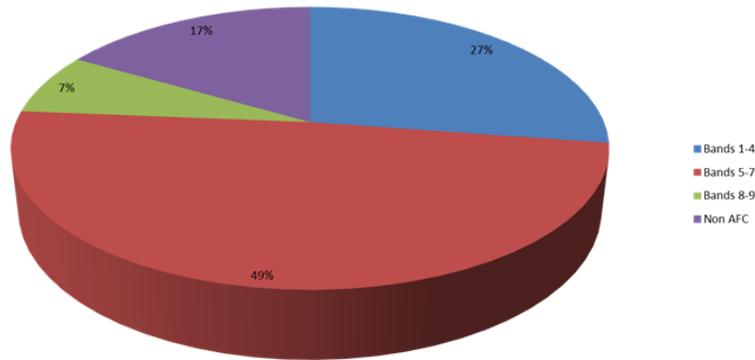
65% of the workforce are Medical
25% are Nurses
7.5% are unqualified
2.5% are other qualified staff

These figures exclude managers and administration staff



A breakdown of the 10% of staff identified on the previous slide as involved in direct patient

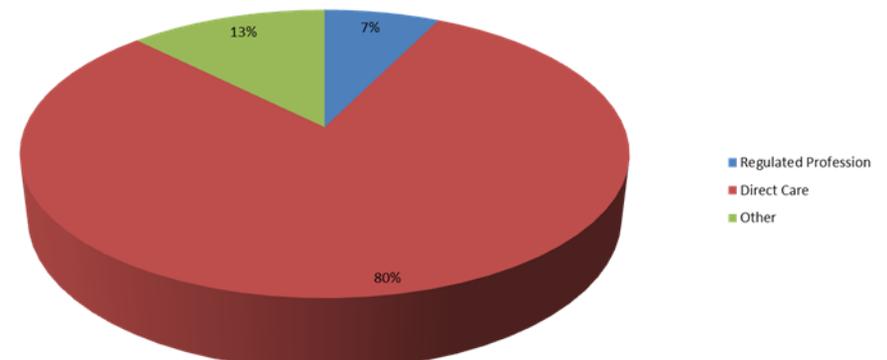
Trust:



17% of the workforce are Medical
56% are qualified clinicians
27% are unqualified

These figures exclude managers administration and estates staff

Social care:



These figures exclude managers and administration staff

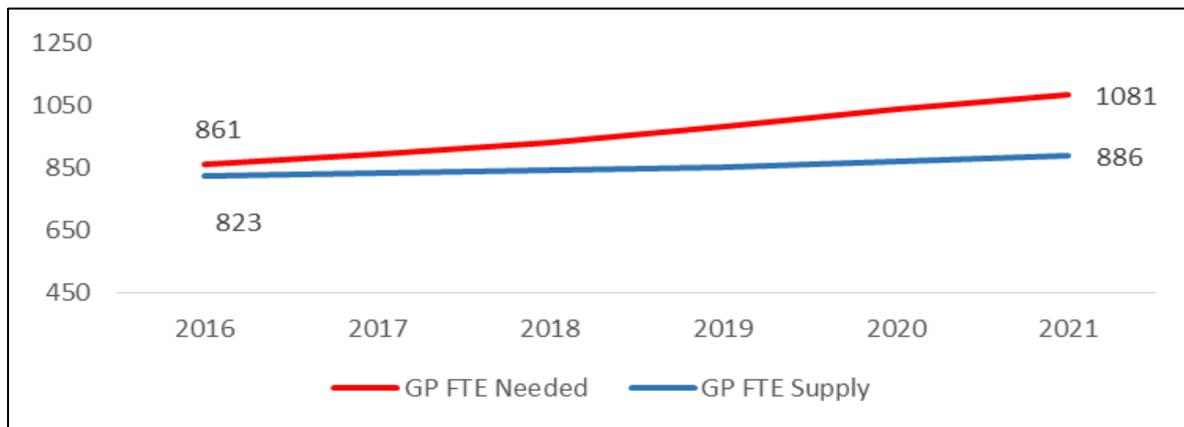
2.4 GP workforce:

There are not enough GPs to meet the baseline demand for activity in south west London over the STP period. According to work the Healthy London Partnership have undertaken in south west London to understand our primary care workforce:

- Demand for GPs will rise over the coming 5 years but supply of GPs will struggle to meet demand (shortfall of 195).
- Even if it is possible to recruit enough GPs (which is unlikely), this will pose a significant funding challenge.

GP FTE Demand (red) and Supply (blue) Projections:

- Existing workforce gap currently 38 GP FTE. HSCIC Patients per GP in SEL at 1,551 vs London average 1,660. Croydon worst performer with 1,708 patients per GP
- Available GP workforce unlikely to increase at required rate to meet shifting demand. Flat trainee volumes (c80 year to south west London), and fairly high retirement impede workforce viability.



South west London GP workforce cost projections:

- South west London has 823 GP FTE currently, with total headcount 1,040, at 0.79 FTE per GP headcount, slightly below London average (0.81).

2.5 The cost of low retention – south west London wide data:

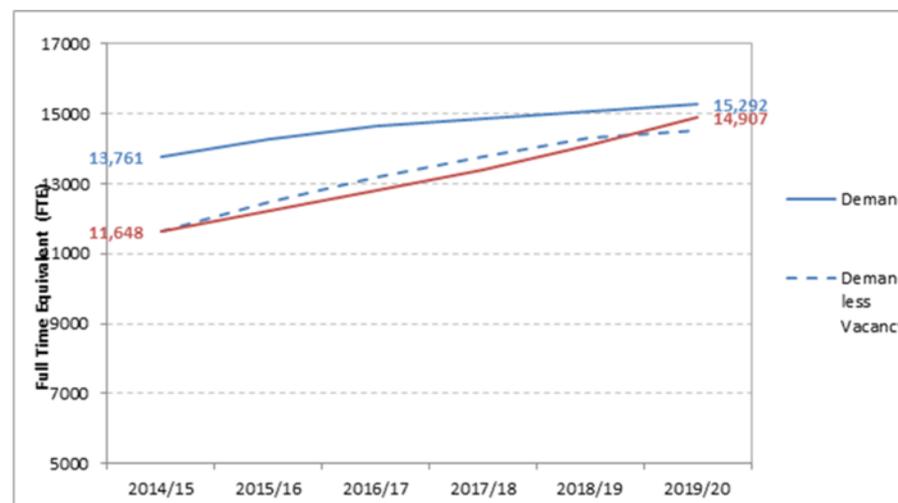
Scenario	Total
Baseline	£6,728.1m
1. Reduce the turnover rate by one percentage point	-£92.4m
2. Replace half Agency staff with Bank staff	-£63.6m
3. Retain newly qualified staff for one extra year	-£36.0m
4. Reduce the in-course attrition rate on 3-year courses (15% to 11%)	+£1.4m
5. Increase the number of education commissions by 25 in each year	+£3.7m

Taken from work done by HEE and London Economics (LE) 'Assessing the cost of low retention in the nursing profession'. This data is for South London.

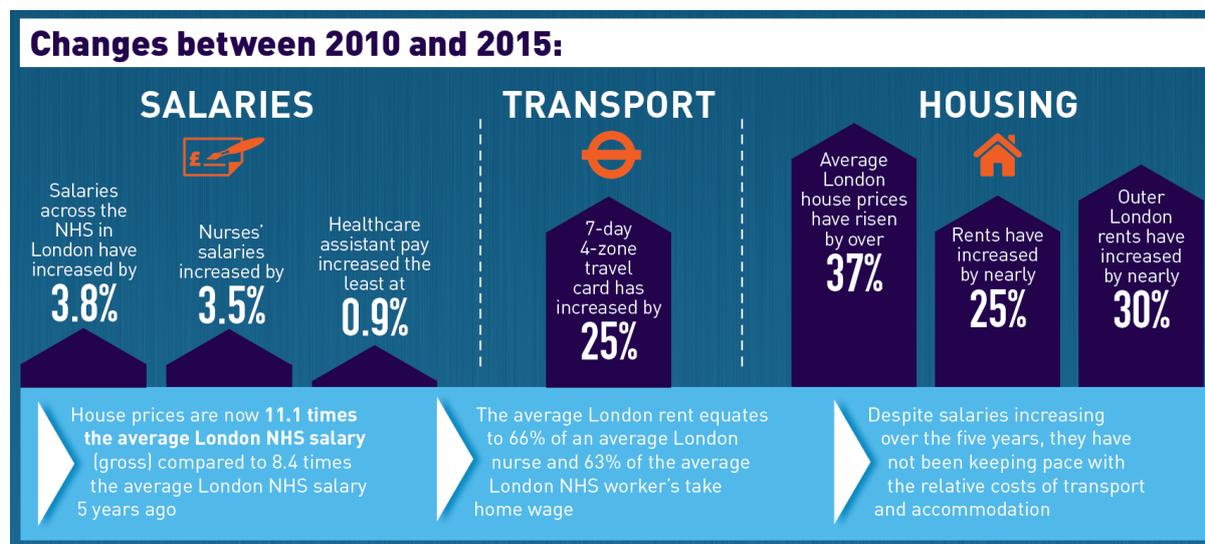
Of the variables available, this modelling shows that a reduction in turnover is the most cost-effective way to address the gap between the supply of staff and the demand for staff. The red line on the graph shows the modelled impact of reducing the turnover rate by 1% per annum over five years, maintaining all other variables as per trusts' returns to HEE in the 2015 workforce planning round for adult nursing in acute trusts:

- Vacancy Rate - 15.4%
- Leavers - 12.9% per year
- Joiners - 17.9% per year
- Commissions in Education - 632
- In-course attrition and failures - 23%
- Uptake rate - 75%

Reduce Leavers 1% per annum



2.6 Key factors affecting our workforce:



We need to do more to support our workforce with factors that impact on their employment such as housing and transport. The rapid increase in property prices over the past few years prevents many staff from owning their own homes in south west London. Over the last five years there has been a significant increase in the travel to work distance of all London based NHS staff, compared to a decrease in travel distance of private sector staff.

3. Emerging STP solutions - what this means for workforce

The key findings from the STP have implications for the workforce, which are detailed in the table below:

Workstream	Solutions	Workforce implications
Prevention and Early Intervention	<ul style="list-style-type: none"> Empowering and supporting people to make healthy lifestyle choices Identifying the people most at risk of developing long term conditions and acting quickly to support them Supporting people to manage their long term conditions through pathway re-design and self-care supported by education (for patients and those delivering care) and digital technology 	<ul style="list-style-type: none"> Enabling the whole workforce to “make every contact count” and educate and train other key ‘health leaders’ (i.e. teachers) as well as supporting patients to self-care. Enabling staff to work collaboratively across the community, acute, mental health and social care sectors to deliver a care pathway. Using the workforce differently to meet both community and acute setting needs.
Right Care in the Best Place	<ul style="list-style-type: none"> Changing the way we deliver outpatient services and eliminating unnecessary follow up appointments 	<ul style="list-style-type: none"> Enabling health and care professionals to work collaboratively across the acute, community, social care, care homes and private sectors to

Workstream	Solutions	Workforce implications
	<ul style="list-style-type: none"> Using digital technology to change the way people use and deliver healthcare Helping people at the end of their lives to die where they want to. 	<ul style="list-style-type: none"> deliver a care pathway (incl. identifying patients and guiding them to the most appropriate care setting). Enabling health and care professionals to respond to physical and mental health needs equally – developing skills required to assess and diagnose and navigate / signpost / alert others to the care packages required to meet needs. Organisational development to support culture amongst health professionals to work across care settings. Supporting the workforce to use new digital technologies.
Building capacity and capability in the community	<ul style="list-style-type: none"> A transformation of primary care services, with GPs, pharmacists, community nurses, allied health professionals, social care professionals and pharmacists central to coordinating proactive, preventative care that is designed around the needs of patients. 	<ul style="list-style-type: none"> Deploying / extending roles and capacity in the primary care setting to support care coordination.
Acute Configuration and Clinical Networking	<ul style="list-style-type: none"> Closer collaboration between our hospitals to improve quality and outcomes, meet the London Quality Standards and making the best use of our workforce. Reducing unnecessary emergency admissions, particularly for frail and elderly patients Consideration of the best configuration of hospital sites 	<ul style="list-style-type: none"> Enabling health professionals and community and private sector providers to work closely between hospitals. Driving culture amongst health professionals on appropriate care settings. Communication between different settings of care.
Collaborative Productivity	<ul style="list-style-type: none"> Increased collaboration between acute trusts, sharing non-clinical functions to make the NHS more efficient and cost-effective (Areas we have looked at include procurement, bank and agency staff, admin 	<ul style="list-style-type: none"> Enabling staff and health professionals to work collaboratively and across organisational boundaries to improve efficiency.

Workstream	Solutions	Workforce implications
	functions and using our buildings and land more efficiently and productively).	

4. Our workforce hypothesis

We need a radical transformation in our workforce to meet the challenges facing south west London and support our STP.

Demand for health and social care services in south west London is rising significantly due to a combination of population, demographic and other factors. Currently, many different parts of the care system – GP practices, hospitals, mental healthcare, social care, community healthcare, third sector, ambulance and others – are under severe pressure and reaching capacity constraints, and these services feel fragmented (rather than integrated) from the perspective of the patient or service user.

Our current workforce is already unsustainable due to insufficient numbers of permanent staff in post and a heavy reliance on agency workers. Simply expanding the current models of care is likely to perpetuate some of these challenges, as well as being financially unsustainable.

The location of the bulk of our workforce in the acute sector does not support national policy direction, or our local hypothesis - that improved patient outcomes and financial efficiency will be achieved through shifting care out of acute settings and providing more joined up integrated care.

We need a workforce that is configured differently, according to skill mix and competencies, to deliver care differently and across boundaries.

The direction for south west London, as outlined in the STP, is a strategic intent for new locality teams responsible for providing preventative and proactive care.

The workforce will work across professional boundaries to deliver care that is more integrated, better supports and responds to the needs of patients, is safe and of consistent high quality, and offers best value for money:

This strategy will support the development of a sustainable workforce by addressing retention and recruitment issues, and develop fulfilling roles with clear opportunities for progression in order to make south west London an attractive place to work.

5. Strategic approach

5.1 Key principles and priorities

Our workforce strategy is based on the following principles, which are supported by all organisations across the local system:

- A system-wide approach that is agnostic of organisations and settings of care and based on a deep understanding of patient needs.
- A focus on care functions and the competencies required to deliver those functions, rather than on traditional roles and responsibilities.
- Developing our current workforce is key – from redeploying support staff, extending roles and training advanced practitioners.

These principles underpin four core priorities that we propose will address our hypothesis:

1. Securing a sustainable workforce and improving retention and recruitment

We need to support efforts to bridge the affordability gap and improve productivity so we can provide consistently high quality services seven days a week. We will reduce reliance on agency staff by focusing on recruitment and retention of current staff, as well as doing more to retain newly qualified staff and develop apprenticeships within the south west London area.

2. Capacity and skill mix

We need to better support and respond to the needs of our patients by making best use of the capacity of our workforce. We will focus on care functions and the competencies required to deliver those functions to plan our workforce needs and deploy new roles to ensure expertise and skills are targeted where they are most needed. Increasing the roles and skill mix of care delivery will help to make sure that those with greater expertise and technical training have more time to focus on supporting the most complex patients. As a result, the growing number of people with complex conditions can be managed more effectively and efficiently. We will also ensure that our workforce is able to respond to both physical and mental health needs, in order to improve patient outcomes and parity of esteem.

3. Working differently

We are responding to the increasingly complex needs of our population by developing new models of care that are provided by groups of staff working in multidisciplinary teams, focused on the needs of the population rather than individual organisations. To support this, we need to develop and equip our current workforce with the skills and competencies to enable them to respond to change and work closer in integrated teams across disciplines, settings, and organisational boundaries to deliver these new models of care. We will also increase our flexibility by sharing resources and staff across sites to address workforce shortages and maintain safe delivery.

4. A healthy workforce

We need to better support our staff to provide high quality care. We will focus on the health and wellbeing needs of our workforce and do more to make south west London an attractive and positive environment to work in. This will help us to address recruitment, attrition, and sickness absence, as well as better supporting our staff to respond to change.

We have also identified that education and training and training is a key enabler running through each of our priorities in order to ensure we have a sustainable workforce with the right skills and competencies to support new ways of working. Our strategy will also focus on specific programmes of work to support our needs in this area.

6. Driving change

6.1 Driving change – detailed objectives

This sections sets out opportunities for delivering change and supporting the transformation of our workforce in south west London.

Securing a sustainable workforce and improving retention and recruitment

Creating a sustainable workforce is the foundation to be able to deliver new models of care and develop new roles. Developing clear pathways and frameworks for career progression is a key way of addressing retention and creating an attractive work environment. It also creates opportunities to fill workforce gaps at every level as staff progress, and could strengthen staff engagement and belonging to the south west London community.

Objectives	<ul style="list-style-type: none"> • Improve the efficiency and productivity of the workforce and recruitment and retention of staff: • Make the workforce more clinically and financially sustainable; • Reduce agency expenditure by circa £1.2-£1.8m in 2016/17 • Increase retention of staff, including newly qualified nurses.
Initiatives	<ul style="list-style-type: none"> • Implement the approach to reducing agency spend through the south west London staff bank model • Develop proposal for addressing changes in funding for nursing students/ removal of the bursary and ensure we are able to attract sufficient numbers of students more widely. • Develop proposal for south west London approach to increase retention of newly qualified nurses – roll out learning from best practice examples across London and the Capital Nurse programme. • Participate in, identify and implement learning from: <ul style="list-style-type: none"> ○ Capital Nurse programme – specifically on guaranteeing employment for new graduates, developing structured career pathways and reducing agency use ○ The London wide adult nursing retention programme ○ Primary care navigator development programme which looks at career path, education and training requirements (HEE) ○ Development programme for AHPs in management roles (HEE) • Review impact of differential in pay across south west London on recruitment and retention (inner v outer London weighting) • Scope feasibility of transitioning to one payroll provider across the sector with lower cost per payslip

Capacity and skill mix

Deploying new roles can enable more patient-focused care, provide a step towards a longer-term career in health, as well as helping to address professional workforce gaps. Increasing the roles and skill mix of care delivery will help to make sure that those with greater expertise and technical training have more time to focus on supporting the most complex patients. As a result, the growing demand for healthcare can be managed more effectively and efficiently. Development and career progression of staff is key to ensure the sustainability of new roles and ensure they are a long-term solution for south west London.

There are opportunities to develop new roles in all areas of the NHS, examples include care coordinators/navigators to support patients with complex conditions, or those who are frail or elderly, to access care in the community to help them to stay well and out of hospital.

Objectives	<ul style="list-style-type: none"> • Improve the capacity of the workforce to respond to growing demand. • Ensure care is delivered by the most appropriate member of the workforce
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Initiatives	<ul style="list-style-type: none"> • Identify learning from programmes across London/south west London looking at new roles and consider the fit to support new models of care and STP solutions: <ul style="list-style-type: none"> ○ Care coordinator pilots across south west London – including care coordinators in care homes in Sutton and pilots in Merton and Croydon ○ Physician Assistant roles in primary care, including learning from Wandsworth, Sutton and Merton ○ HEE programme on primary care navigators • Testing extended scope of roles in care homes to better support residents and avoid admissions • Extending the role of Health Care Assistants to better support in primary care, including learning from Wandsworth • Skill mix of paramedic staff to facilitate “see and treat” and “hear and treat”
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Working differently

Working differently and providing new models of care provides an opportunity to manage growing demand more efficiently and effectively, with improved coordination leading to fewer visits and conveyances to hospital and improved patient experience. Working in new ways can also provide more rewarding roles for staff, leading to increased confidence and job satisfaction, as well as helping to address potential future gaps in the workforce.

Examples of providing care in different ways include using the role of the pharmacist within primary care to support medicines and prescription management and delivery of medication reviews.

Objectives	<ul style="list-style-type: none"> • Increase flexibility in the workforce and staff groups. • Establish multi-disciplinary teams that can deliver patient-centred care.
Initiatives	<ul style="list-style-type: none"> • Identify learning from Sutton Care Homes Vanguard and Royal Marsden Cancer Vanguard and roll out across south west London to extend skillsets • Identify learning from other vanguard programmes further afield focused on integrated primary and acute care systems, multispecialty community providers, and urgent and emergency care. • Develop and deploy opportunities for clinical networking across sites to make better use of our workforce. • Identify learning from the London-wide work looking at the role of AHPs in different settings and how they can address shortfalls and address high levels of demand by working in different ways – e.g. Physiotherapists as first contact in primary care. • Working in different settings - consider current initiatives implemented in south west London for wider rollout and how these might support our STP solutions: <ul style="list-style-type: none"> • Paramedics in GP practices (Kingston) • Pharmacists in GP practices (Wandsworth) • NAPC – Primary Care Home (Richmond) • Street Triage to support those in mental health crisis (south west London&STG and Met Police) • Joint and integrated care planning (Wandsworth) • Identified health liaison social workers for each locality (CLCH Merton) • Developing ways for all practitioners to develop new skills (i.e in MDT set-

	tings) in order to maximise capacity and “Make Every Contact Counts”
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A healthy workforce

To deliver high quality patient care, the NHS needs staff that are healthy and well (physically and mentally) and at work. Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care. Poor workforce health has high and far-reaching costs to NHS organisations and, ultimately, patients. We need an increased focus on the health and wellbeing of our workforce, including how mental health services can help to support staff absence related to stress, anxiety and depression.

Objectives	<ul style="list-style-type: none"> • Improve staff health and wellbeing • Reduce sickness absence • Improve the working / living environment
Initiatives	<ul style="list-style-type: none"> • Audit of activities across south west London to identify good practice and opportunities to scale up existing initiatives • • Collective south west London approach to working with the Mayor of London to ensure a “London life” for NHS workers including consideration of: <ul style="list-style-type: none"> – Housing – Transport – Salaries • Develop proposal for implementation of a pan-south west London approach to managing sickness absence • Develop proposal for a staff benefits portfolio across south west London • Develop proposal for promoting flexible working to support a wider workforce to stay within employment.

Education and training

The training pipeline is vitally important to ensure we secure a sustainable workforce. We need to ensure we have an appropriate number of training places and that education is focused on developing staff with the right skills to support new ways of working.

We also need to focus on developing our organisations and delivering training and education to our workforce to support culture change, and different ways of working to support new models of care.

Objectives	<ul style="list-style-type: none"> • Ensure south west London has sufficient training places • Ensure staff are skilled and trained to support new ways of working
Initiatives	<ul style="list-style-type: none"> • Developing relationship with HEI providers re AHP and nursing curriculum. • Work across the sectors to open up student placements out of the hospital setting - in community and care homes– learning from work undertaken in Sutton with care homes placements and Richmond with placements for physiotherapists in primary care. • Develop a more collaborative approach to: <ul style="list-style-type: none"> ○ implementation of the apprenticeship levy ○ addressing reduction in education monies • Expansion and roll out of non-clinical apprenticeships (variations across

ESH, Kingston, Merton, Croydon, Wandsworth)

- Community placements for specialist trainees (Richmond)
- Primary care placements including rotating pharmacists (Croydon CEPN)
- Increasing training placements in primary care (Wandsworth)

Appendix G – IM&T Strategy

1) Our digital technology hypotheses

Digital technology is a critical enabler of the hypotheses within the STP.

We know that information sharing, so that clinical information about an individual follows them between different health and social care services, is a critical element of providing more joined-up care.

We also know that a greater use of technology can more efficiently spread the expertise of our clinicians, and patients, across traditional provider boundaries and the home. We also know that not all citizens will embrace digitalised care; we are committed to ensuring that, through education and support, as many citizens as possible will use technology to self-care.

The multiple specific technology requirements that will support our hypotheses are detailed overleaf.

These requirements can be categorised as:

- a. **Digitally-enabled self-care:** using technology to allow patients to capture and share information relating to their condition to their clinician or carer, either by themselves or through an automated monitoring system. Technology can also provide information (such as their record, or dietary advice) to patients through apps and websites, to allow them to make informed decisions about managing their health.
- b. **Channel shift:** giving individuals greater and more efficient access to their clinicians or health services through online, telephone or video conferencing systems. Channel shift can also be used in clinician-to-clinician interfaces, such as allowing GPs to access a specialist consultant's opinion before referring a patient.
- c. **Information sharing for the point of care:** giving clinicians and other health and care professionals digital access to all relevant information about a patient at the point of care, to allow them to make the best decisions about the treatment and management of that patient. This includes clinical records, capturing past treatment, and care plans, capturing future treatment. This may include A&E doctors viewing an individual's GP record to see their allergies and current medication, to avoid administering a drug which may be harmful to them.
- d. **Information sharing for whole systems intelligence:** combining clinical, operational and outcomes information in order to derive insights into the effective delivery of health services, allowing continual improvements to be made to how they are commissioned. The value of this information increases considerably the more accurately it reflects the full journey of the individual patient across different settings of care, particularly for managing how that patient journey can be best integrated to avoid crisis or deterioration in their condition.
- e. **Mobile infrastructure:** the use of digital technology to support the points above must be made available to clinicians and care professionals in a manner which suits their ways of working, and maximises their contact time with patients. This includes being available in the community, reducing the need to travel 'back to base' to input key information.

Technology requirements to support delivery of the STP

STP strategic theme	Operational or clinical objective	Supporting technology capability
Preventative and proactive care	Promote self-care	1. Provision of digital content to support individuals to take a more active role in managing and maintaining their own health and wellbeing.
		2. Support for roll-out of consumer health apps through publication of relevant data and facilitating link to clinical systems
Right care in the best place	Deliver primary care at scale	3. Write-access to GP record wherever primary care is delivered including extended hours and new models of care
		4. Expansion of Patient Online including increased uptake
		5. Virtual GP clinics for patients using phone or video conferencing
		6. GPs can electronically place orders for all diagnostic tests and receive the results in real-time, including: <ul style="list-style-type: none"> a. Cardiac Investigations b. Endoscopic Procedures c. Nuclear Medicine d. Radiology e. Pathology f. Respiratory Tests
	Proactive, locality-based MDTs	7. Risk stratification technology to identify patients
		8. Shared care plan with write-access across relevant services/organisations, including social care. Data sharing agreements to enable care record sharing across all south west London providers within the footprint agreed and signed
		9. Access to a patient's up to date clinical record is available to support community and mental health settings. This should include all relevant settings of care
	UEC: right place, first time	10. GP and SCR records sharing with all 111/OOH, UCCs and EDs
		11. Direct booking functionality from our single integrated urgent care provider to the wider UEC system including dentistry, ED etc.
	Dying in setting of choice	12. Maximise utilisation of Coordinate My Care shared EoL care plan to provide better access for clinicians to important and timely patient information regarding treatment choices
Acute configuration & clinical networking	Potential clinical networking across acute sites	13. Acute records follow the patient from OP or IP referral, in time to support decision making at the receiving trust
Productivity	Reduce unnecessary outpatient	14. Expand the use of e-advice services for GPs and specialist clinicians. Develop joint e-consultation clinics with GPs and specialist clinicians

	appointments	
	Reduce staff travel time and administrative overheads	15. Mobile working solutions for community services <ul style="list-style-type: none"> a. Devices which are portable and usable b. Live connectivity to cross south west London patient record with ability to update/order/prescribe as appropriate
		16. Mobile agile working solutions for acute services, including digital vital signs
		17. WiFi infrastructure is enabled in all south west London locations for staff and citizens. Shared networks to allow access back to professional core system with the appropriate security. This includes: <ul style="list-style-type: none"> a. GPs, hospitals, community health centres, UCCs, social care etc b. Connectivity for any south west London approved health or social care worker in any south west London care setting
Future system architecture	Move to capitation and integrated, outcomes-based contracts	18. Population health platform incorporating near-real time data and a whole-system longitudinal health and care record, with analytics to support population health management and effective commissioning, clinical surveillance and measure outcomes

2) Our current digital capabilities

There are pockets of good practice across south west London relating to all five of the categories identified above, which gives us a positive basis for expanding the use of these technologies to the scale required to deliver the ambitions of the STP.

1. Kingston Health Passport

The Kingston Health Passport is improving information sharing between health practitioners in Kingston. It is an electronic health record for patients registered to a GP in Kingston that allows healthcare practitioners to access an electronic summary of an individual's health records, with their consent, to make sure they can give the best possible care with accurate, up-to-date, clinical information.

The first thing the KHP achieved was to support GP out-of-hours services by providing access to GP records. The KHP has since been extended to A&E (including Liaison Psychiatry) and other community practitioners – community pharmacies and dentists. The model for KHP is being extended in Sutton with the Sutton Integrated Care Record, with some GP practices now live.

2. Kinesis

Kinesis GP is a secure (N3), web-based software system that directly links GPs to a trust consultant for rapid access to expert advice on referral questions. It enables the exchange of clinical advice between a hospital consultant (within a chosen specialty) and GP.

There are now 14 specialties live that are able to provide expert clinical advice. These include: Gastroenterology, Gynaecology, Paediatrics, Rheumatology and Urology.

Wandsworth CCG is using Kinesis as an online advice service, which currently gives GPs access to specialist consultants at three local providers: St George's Hospital, Chelsea and Westminster Hospital, and Kingston Hospital NHS Trust.

Other CCGs, including Merton and Sutton, are now working with providers to implement the service.

By allowing learning to take place, the system is effectively reducing outpatient referrals.

3. Myhealthlocker

Myhealthlocker allows individuals to have control over their health information. They can access their care plan from the South London and Maudsley NHS FT, keep track of how they are feeling, access resources and tips on staying well and manage their health and wellbeing.

Myhealthlocker has recently introduced the clinical portal that allows clinicians to view the data an individual has entered and shared, such as PROMs, Rate My Day and many more. The website works with Microsoft HealthVault, a privacy-and-security enhanced online service.

4. Paper-light working across Mental Health

South West London & St. George's NHS Trust implemented RiO in 2006. Now 95%+ of a patient record is captured in an electronic care record; the remaining 5% mainly consisting of drug administration charts and physical observation charts which are collected manually and later scanned into the RiO record. The drug charts will be replaced this year by an electronic prescribing and medicines management system.

South West London & St George's has no paper medical records (the old libraries have been scanned to digital format) and 100% NHS Number coverage for current/recent patients. This puts mental health services in a very strong position to take early advantage of interoperability opportunities with other care providers.

5. South West London Pathology

South West London Pathology (SWLP) is an NHS partnership set up by St George's University Hospitals NHS Foundation Trust, Croydon Health Services NHS Trust and Kingston Hospital NHS Foundation Trust to provide a single, integrated pathology service across south west London and beyond.

SWLP offers a wide range of diagnostic and clinical support services to GPs across London, as well as to other NHS institutions and private organisations. The service covers 3.5 million people across south west London via three hospitals, 200 GP practices and 30 healthcare centres.

It is based on an Orion platform that allows orders to be placed digitally, and results rapidly communicated, integrating directly into the GP record.

Earlier in 2016 all acute and community providers, CCGs and local authorities completed digital maturity assessments, detailing how advanced the technology currently in use across NHS and social care is, against a standardised national benchmarking tool.

However, the results from the assessment demonstrate that we still have some way to deliver full digital maturity in south west London, particularly in how we share clinical information within the NHS, across the NHS and social care boundaries, and also how we better make information and support available directly to patients. A selection of findings from the assessment relating to the STP requirements is set out below:

Excerpts from south west London providers' digital maturity assessment, January 2016

STP category	Question	South west London average (% maturity)
Info for the point of care	Healthcare professionals in your organisation have digital access to the information they need from other local healthcare providers?	42.5
	Healthcare professionals in your organisation have digital access to the information they need from local social care providers.	22.5
	Other local healthcare providers have digital access to the information they need from your organisation	42.5
	Local social care providers have digital access to information from your organisation	20
	Healthcare professionals have access to a consolidated view of their patients' local health and care records	25
	Healthcare professionals can contribute to a consolidated view of their patients' local health and care records	17.5
	Patients are able to view and download information from their digital care record	10
	What proportion of patient information relating to hand-overs of care within your organisation is shared by Healthcare professionals digitally?	62
	Care summaries are routinely sent digitally to all other local healthcare providers	35

STP category	Question	South west London average (% maturity)
	What proportion of care summaries are generated in real time and shared digitally with other relevant care providers as soon as completed?	44
Self-care and channel shift	Remote/virtual clinical consultations and clinical advice are available to patients using tools such as online meetings, videoconferencing, skype, email or instant messaging	40
	You are able to remotely monitor groups of patients who have been discharged home but are at high risk of readmission	36.1
Mobile infrastructure	Healthcare professionals are equipped with mobile devices to access clinical applications and information at the point of care	62.5

Our own work in mapping clinical information flows also shows that where clinical records are shared, this is confined to borough boundaries, meaning they cannot be accessed by providers in south west London that a patient may visit outside of their borough.

3) Our strategic priorities to close the digital gap

Clearly, a significant investment into IM&T in the future will be required to close the digital gap and enable the delivery of the STP. This includes both the cost of technology, and, more significantly, the resources required to collaborate across organisations to effectively implement new technology and change the way we work.

However, it is important that significant investments made into digital technology to date are not lost, and that we get the best from our current assets as we move to a greater level of digital maturity in south west London.

Alongside the STP, the NHS and local authorities in south west London will be publishing a Local Digital Roadmap, which includes further detail on the plan for digital technology over the next five years.

The roadmap incorporates three phases to deliver a significant increase in digital maturity across CCGs, and health and care providers over five years; this builds on progress already made in south west London:

Phase	Characteristics
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Phase	Characteristics
<p>1. Developing a Collaborative Future - a south west London collaborative capability that supports the successful delivery and utilisation of the tactical and strategic solutions (years 1 to 5)</p>	<ul style="list-style-type: none"> • Implemented in parallel to (2) and (3) • Requirement for south west London IM&T PMO to manage e.g. information governance model, provider contract schedules, adoption of national standards
<p>2. Building on the Current Position - a tactical foundation that achieves establishes proof of concept in information sharing across south west London in the short term (years 1 to 2)</p>	<ul style="list-style-type: none"> • Achieve 'proof of concept' in sharing clinical information across south west London in rapid timeframe • Focus on clinical record sharing only • Overcome IG, cultural, financial barriers within manageable scope • Maximise value of current investments, including national systems
<p>3. Delivering a Strategic Platform - a strategic solution that achieves the long term aims of the <i>Five year forward plan</i> (years 2 to 5)</p>	<ul style="list-style-type: none"> • Move to 'full' strategic solution, including sophisticated requirements concerning self-management and prevention • Predicated on greater collaboration between CCGs and providers • Design principles agreed, e.g. move to 'open' architecture to reduce costs and enable choice

Each phase is defined with a set of actions that supports the delivery of the priorities above:

Figure 3: High-level roadmap for digital priorities



4) How we will progress our priorities

South west London has an effective and engaged IM&T community across the NHS and social care. The actions detailed above will build upon this engagement to create the practical capability required to deliver our digital priorities. This includes significant potential barriers to progress such as information governance, and demonstrating benefits from existing digital investment, before moving towards more complex and costly initiatives.

South west London intends to secure resource from the Estates and Technology Transformation Fund for Phases 1 & 2 of the Roadmap over years 1 and 2. Precise costs will be determined ahead of submission to the Fund on 30th June. We will also work with the Healthy London Partnership digital programme to ensure we adopt digital solutions and processes that support patients wherever they are treated across London.

Moving to a strategic solution and population health platform will be a significant cost for south west London. Funding will be sought from national funding earmarked for the ‘paperless NHS’ initiative. These costs will be defined further depending on the level of digital maturity achieved in existing systems over years 1-2, and the specific requirements of new commissioning and provision models in south west London, e.g. the number and scope of outcomes-based contracts in place.

Appendix H - Engagement and Equalities Plan

Purpose of this chapter

This chapter summarises the initial engagement approach to the south west London Sustainability and Transformation Plan (STP) including the South West London and Surrey Downs Healthcare Partnership. It covers the **calendar year 2016**, during which the STP will be published.

This strategy should be viewed as a 'roadmap' for engagement during 2016, rather than a detailed plan, as a good deal of engagement activity will need to be responsive and reactive to events. Elements of the strategy, including messaging, will need to be revised and refreshed as things develop. For this reason, the timeline includes placeholders for review. It is also suggested that the strategy should be evaluated and renewed at the end of 2016, when we will have a clearer idea of what the next steps are (including whether a public consultation on any proposed changes is likely). A strategy with a longer lifespan is likely to lose relevance and focus as events unfold.

1) Our responsibilities

There has been a step change in what constitutes good engagement in recent years. 'Old style' engagement, where public bodies developed ideas behind closed doors and then shared them with the public for discussion, is regarded as poor practice. Best practice means **involving the public at every stage** and using their input to **co-design solutions**.

We want to engage local people and stakeholders in our plans because it is the right thing to do. Strategic plans are improved by engaging the public in them as they take shape. This also makes their eventual implementation easier.

Guidance from NHS England sets out a requirement to engage and involve the public and stakeholders in the development of any NHS service change plans. Best practice includes early engagement and involving local people in the development of plans.

We also have statutory responsibilities on engagement, set out below.

Health and Social Care Act 2012

Patients and carers to participate in planning, managing and making decisions about their care and treatment through the services that are commissioned, as set out in section 14Z2 of the NHS Act 2006.

Equality Act 2010

Legally protects people from discrimination in the workplace and in wider society. Engagement activity must have due regard to the Equality Act and the protected characteristics set out within it.

2) Public engagement

2.1 We will follow best practice

Listening is a key element of successful communications and engagement. We are committed to listening to and working in partnership with local people, local organisations and each other.

Public engagement has moved on in recent years. The 'top down' approach, where public bodies develop solutions and 'sell' them to the public, is no longer acceptable. Best practice engagement means involving the public and stakeholders at every step of the process.

This means:

- early engagement on the issues before any decisions are made
- the public and stakeholders help to devise solutions
- decision-making is transparent and people know what to expect when
- each stage of process is informed by an ongoing dialogue.

This approach is more likely to lead to solutions that have considered input from public, which will make eventual implementation of any changes easier.

2.2 We are in a strong position in terms of early engagement in south west London

- The whole of the south west London NHS published an **Issues Paper** in June 2015, setting out the challenges we face, emerging ideas to address them and questions for local people to consider.
- An independently-facilitated **deliberative event was held in each of the six south west London boroughs**. The independent report from these events captured local views and is published on the south west London Collaborative Commissioning web-site.
- In addition, we wrote to **over 1,000 groups** on our database to tell them about the Issues paper and offer to discuss it with them – CCGs have met with local groups as requested.
- An independent **Equalities Analysis** has been carried out for south west London and one has been commissioned for Surrey Downs. The findings will inform our strategy.
- There is a **long history of engagement in south west London** from previous programmes; this has been collated and tested with stakeholders and has been praised by organisations such as The Consultation Institute (and the previous south west London Joint Health Overview and Scrutiny Committee).
- **Surrey Downs CCG** has also engaged widely with the public as part of its review of community hospitals.

2.3 The next period will require significant public engagement

During the next phase, we will need to build on our engagement to date by:

- publishing **all feedback** received to date and our response to the feedback received on the issues paper
- holding further **public-facing events** for a general audience – public engagement is required as part of the STP
- a **grassroots engagement** programme aimed primarily at groups with 'protected characteristics' and supported by the seven **Healthwatch** organisations
- use of **local authority community engagement networks to facilitate discussion** about the strategy and feedback public reaction
- responding to developments regarding the **Epsom and St Helier Estates Review**

- continued **direct involvement** of patients and the public in developing our plans
- publishing **clinical reports** from each clinical workstream
- **social media** and online engagement
- working with **Surrey Downs CCG** where appropriate to support their local approach, ensuring that we are treating all stakeholders equally.

2.4 Publishing feedback to date and our response to it

We will summarise and publish all of the feedback received to date. This will be accompanied by our response to the substantial feedback received (The feedback report from the six deliberative events supporting the issues paper is already on the south west London Collaborative Commissioning website).

This is an important step in keeping stakeholders informed about where we have got to and what the likely next steps are.

2.5 Public engagement and events

Engagement on the development of a strategy for south west London has been going on for a number of years and includes engagement around our Issues Paper last year. While the STP is being produced, we will write to the voluntary and community sector bodies on our database (over 1,000 local organisations), inviting them to comment on the feedback we received on the Issues Paper and on emerging areas of focus in the STP. This feedback will be taken into account as the STP is developed.

We also recommend holding **four place-based events for the public during summer 2016**, following the publication of the STP. The purpose would be to continue our public engagement by updating people on all areas of our work and taking their questions and feedback. We would take the **'World Café' approach** to these, meaning people get the chance to talk individually at tables/stalls rather than in a public meeting setting. This is recommended as a good practice approach by The Consultation Institute, as it ensures that everyone's voice is heard.

Feedback from these events would be collated and published, as happened with the south west London deliberative events last year, and would feed into the next phase of strategy development.

Events should be 'place-based', meaning that they are recruited around sub-regional 'hospital-based' populations rather than by borough, with all workstreams covered.

The public and stakeholders are expected to feed into development of the **options appraisal process**. We suggest **an options appraisal event for stakeholders and public representatives in December 2016** (provisionally) and wider engagement with stakeholders as we develop our process.

2.6 Grassroots engagement programme

NHS England is funding a grassroots engagement programme in south west London and Surrey Downs. Each Healthwatch will manage a pot of funding (£10k) that local grassroots organisations can apply for, to run events or activities suitable to their population. Healthwatch will promote this opportunity to local groups, particularly those with **protected characteristics/seldom heard voices**.

During the event or activity, the NHS is given a **dedicated slot** to discuss local health issues and listen and record to the views of participants. We have so far held 48 events (up to the

end of October 2016) with a further 28 planned over the next quarter. We are looking at extending this programme for a further year.

Events have reached all of the groups with protected characteristics, plus carers and those suffering social and economic deprivation. We have conducted a gap analysis to ensure that there is a balance across groups with protected characteristics and STP workstream areas. All feedback received is passed to the clinical workstreams for discussion and consideration and we will produce regular 'You Said We Did' reports updating on feedback received and our response to it. Participants will be invited to continue to be involved and grassroots organisations will be added to our contacts for potential future engagement.

This grassroots engagement programme forms part of our response to the early **Equalities Analysis** carried out in south west London in 2015. In order to ensure equity, an equivalent analysis for Surrey Downs is being carried out because Surrey Downs residents may be impacted by the programme. We will publish a formal **action plan** in response to the Equalities Analyses once this has happened.

2.7 Facilitating discussion via local authority engagement networks

Each borough has its own arrangements for community engagement. Where possible, we will use these networks to facilitate discussion about the strategy and emerging ideas, feeding back reaction from the public. This would not necessarily mean that local authorities would use their community engagement forums to 'sell' proposals that councils had not yet taken a formal view on – but they might be able to play a facilitative role in gathering and feeding back public views.

2.8 Direct involvement of patients and the public in the programme and our decision-making processes

It is important that our plans are developed in partnership with patients and the public. This means that we need to engage as widely as possible and also to directly involve patients and the public in our clinical workstreams. All our clinical groups will have patient representatives; we have successfully recruited and trained patient reps across all boroughs and we will have a minimum of **three public reps plus one Healthwatch rep** per clinical workstream.

These patient reps will meet in a quarterly forum, which we have also agreed to extend to local Healthwatch organisations, so that people with a specific interest in workstreams can attend.

The **Patient and Public Engagement Steering Group (PPESG)** which supports south west London Collaborative Commissioning will be extended to include representatives from Surrey. Membership comprises local CCG lay reps (7), local Healthwatch (7) and local voluntary sector umbrella bodies (7). PPESG will be represented on the Programme Board, Clinical Board and Collaborative Leadership Group.

STP sub-regional planning groups and groups guiding the work on CCG prevention plans should also include **2-3 public and patient members**.

2.9 Clinical reports

Each clinical workstream will be required to produce a public-facing **clinical report** setting out its thinking. By publishing these reports on our website, we can ensure that the public and stakeholders are kept informed of the development of our ideas, following the successful publication of the south west London issues paper in 2015. The headlines from the clinical reports will also be used to develop **key questions** for us to discuss with the public and stakeholders. This process will be supported by the programme's communications team, working with clinical chairs, SROs and programme leads.

2.9.1 Focus of our engagement

As the programme develops, the focus of what we will ask as part of our engagement will change. In 2015, there was a focus on the south west London Issues Paper. The next phase, up to publication of the STP, will focus on testing the current position statement, sharing the work of each clinical workstream to date and our response to feedback received on the Issues Paper for comment and feedback. Key questions will be developed for our public events and wider public engagement.

Once the STP is published, we will be discussing its content, recognising that strategy development is an iterative process that will be co-designed with local people and stakeholders. This will continue as ideas emerge and are discussed. It is difficult to be more specific at this stage without knowing the likely outcomes.

We will continue to produce regular reports of feedback received, together with the programme's response to it.

3) Assurance and best practice

We are committed to meeting best practice. A range of mechanisms are in place to assure that our strategy meets best practice and its statutory duties. These are set out below.

Advice from the Consultation Institute

We have access to best practice advice on public engagement and consultation from the Consultation Institute, who will also provide training on consultation law for key staff. Should the programme go to public consultation, we will seek formal Consultation Institute approval of the consultation process.

Scrutiny of the programme

Local authorities have set up a **Joint Health Overview and Scrutiny Committee (JHOSC)** to scrutinise the programme. The programme will also be subject to NHS England's assurance process in the event of any proposals for acute reconfiguration.

The 'four tests' for NHS service change

In November 2015, NHS England produced revised guidance on the 'four tests' for NHS service change set by the previous Secretary of State, Andrew Lansley. <https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf>

These guidelines update the assurance process for achieving the four tests, which are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base.
- Support for proposals from clinical commissioners.

Should proposals emerge for significant service reconfiguration, the four tests will be applied as part of the NHS England assurance process. In the meantime, the programme will need to ensure that its public and clinical engagement processes are robust and follow best practice and ensure that any proposals have a strong clinical evidence base and take account of patient choice.

Plain English

As part of our commitment to best practice, all key public-facing papers should be in Plain English. We suggest using the Gunning Fog Index as a measure of readability and offering Plain English training to key communicators. <http://www.readabilityformulas.com/gunning-fog-readability-formula.php>

Appendix I. Finance Appendix

- Financial Challenge
- Growth Rate Assumptions
- Closing The Gap
 - Overview of Savings
 - Preventative and Proactive Care
 - Demand Management and De-Commissioning
 - Provider Cost Improvement Programmes (CIPs)
 - Provider Collaboration Productivity
 - Collaborative Commissioner Savings
 - Regular Commissioner QIPP not captured elsewhere
 - Accident & Emergency (A&E)
 - Public Health
 - Sustainability and Transformation Funding (STF)
- Transition Costs
- Capital Requirements

1. Financial Challenge

1.1 Overview of financial challenge

The way services are currently provided is unsustainable – the south west London health system is already overspending by around £140m a year and our projections show a rising gap of up to £828m by 2020/21 if action is not taken.

From November 2015 to March 2016, commissioners and providers in south west London and Surrey Downs carried out an analysis to determine the financial gap in 2020/21 (the “Financial Diagnostic”). The task was to project the financial gap for each organisation on a “Do Minimum” basis; a scenario where a minimal level of standalone productivity savings by providers is achieved.

The Financial Diagnostic concluded that the total financial challenge was £583m for south west London and Surrey Downs, broken down as in Table I1 below.

Table I1: Breakdown of the Financial Diagnostic challenge

Normalised, £m	2020/21	2020/21 - challenge
Total CCG challenge to breakeven	(236.3)	-9.7%
Total primary care challenge to breakeven	-	0.0%
Total commissioner challenge to breakeven	(236.3)	-8.7%
Total acute challenge to breakeven	(223.9)	-12.4%
Total community services challenge to breakeven	(0.0)	0.0%
Total mental health challenge to breakeven	(18.8)	-10.6%
Total provider challenge to breakeven	(242.7)	-11.2%
Plus specialised commissioner challenge to 1% surplus	(74.4)	
Plus CCG commissioner challenge to 1% surplus	(24.4)	
Cost of capital to finance additional bed requirement due to activity growth	(5.1)	
TOTAL LOCAL HEALTH ECONOMY CHALLENGE (in year)	(582.9)	-12.0%

Source: South West London & Surrey Downs Financial Diagnostic, April 2016

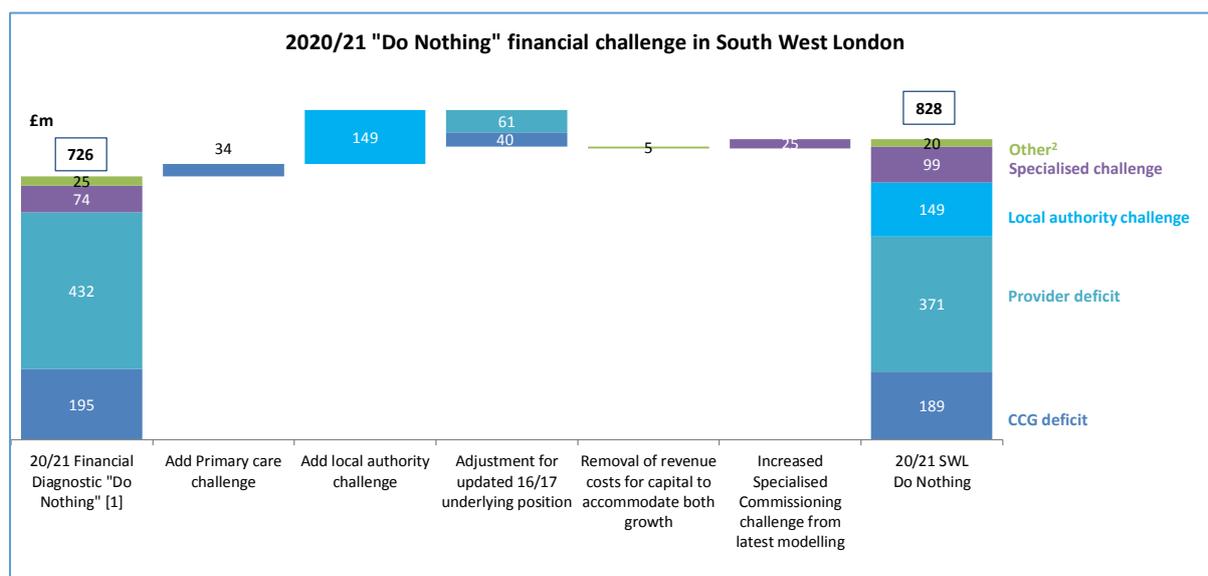
The figures above include £199m of “Do Minimum” provider efficiency from Cost Improvement Programmes (CIPs).

For the purposes of this STP, a different definition of the financial challenge is required. The chart below summarises how the “Do Minimum” position has been adjusted to get to a “Do Nothing” financial challenge for south west London as follows:

1. The £199m of “Do Minimum” provider efficiency CIPs are removed
2. The challenge for Surrey Downs CCG who are outside our STP footprint (£45m) is removed
3. The costs of delivering primary care services in line with the standards committed to (The London Primary Care specifications) are added (£34m⁴³)
4. The financial impact of cuts that south west London local authorities have been required to make to their health and social care budgets are added (the “LA Challenge”, £149m)
5. The difference in 2016/17 underlying positions is adjusted for, based on current operating plans versus the original diagnostic and moving one year forward (-£101m)
6. £25m is added to the Specialised Commissioning challenge based on revised figures from NHS England

This gives us a total financial gap of £828m.

Chart I1: Movement from the Financial Diagnostic “Do Nothing” to STP “Do Nothing”



Note: ¹ Excludes Surrey Downs CCG, The Royal Marsden, Your Healthcare and South London & Maudsley from original diagnostic as these are not in our STP footprint

² CCG challenge to meet 1% surplus as required by the business rules

Source: SSHP Financial Diagnostic and south west London STP modelling

1) Specialised commissioning

South west London is also considering ways in which the projected financial gap in specialised services can be addressed. In June 2016, the “Do Nothing” specialised commissioning financial challenge was estimated at £99m. This figure was a high-level, provisional estimate and was presented as a cumulative figure over five years. Since then

⁴³ Accounting for the £11m of baseline surplus, the £45m gross cost of meeting primary care specifications offsets to £34m net cost

there has been an intensive effort to review and refresh this position through the development of a finance and activity model that will estimate at a greater level of detail than the financial challenge associated with pan-London specialised commissioning. South west London is working with NHS England to reconcile the growth assumptions underpinning this model and agree the scale of the challenge. South west London is also working with neighbouring regions as it plans initiatives to address the challenges.

2) Local authority gap

The six local boroughs in south west London have collectively projected their financial gap for social care budgets. In 2020/21, they project a £149m financial challenge. Although the NHS in south west London is not expected to address this challenge, there are implications for the availability of services provided by local authorities.

Growth Rate Assumptions

The financial gap is based on assumptions about the rate of increasing demand affecting south west London health services. This section outlines the growth rates agreed for:

- Demographic growth
- Growth rate by clinical commissioning group (CCG) by activity type
- Growth rate by acute provider by activity type

2.1 Demographic growth rates

A summary of population growth rate assumptions used in defining the financial challenge is set out in the table below.

Table I2: Demographic growth rate assumptions by CCG by year

Clinical Commissioning Group (CCG)	2016/17	2017/18	2018/19	2019/20	2020/21
Croydon CCG	1.10%	1.10%	1.10%	1.10%	1.10%
Kingston CCG	1.10%	1.10%	1.10%	1.10%	1.10%
Merton CCG	1.38%	1.27%	1.30%	1.19%	1.17%
Richmond CCG	1.40%	1.40%	1.40%	1.40%	1.40%
Sutton CCG	1.40%	1.40%	1.40%	1.30%	1.30%
Wandsworth CCG	1.00%	1.00%	1.00%	1.00%	1.00%

Populations are expected to increase by 1-1.4% per year in each CCG over the 5 year period of this plan, based on submissions in February 2016, by each Commissioner (based on Greater London Authority population projections).

2.2 Growth rates by type of acute activity

Growth rates have been estimated for each of the following acute activity types: A&E attendances, non-elective admissions, elective (planned) admissions, outpatient appointments, and maternity. These have been calculated using historical activity trends from SUS (the Secondary User Services dataset), with some adjustments made based on

local contexts and known anomalies. The following three tables show these at a summary level for each Clinical Commissioning Group and Provider.

Table I3: Growth rates for each Clinical Commissioning Group (all providers)

CCG:	All SWL	Croydon	Kingston	Merton	Richmond	Sutton	Wandsworth
A&E	1.7%	0.7%	2.0%	2.6%	1.0%	1.8%	2.4%
Non Elective	3.5%	4.6%	3.1%	3.0%	3.5%	1.4%	3.6%
Elective	2.6%	1.0%	0.5%	4.5%	5.1%	1.6%	2.6%
Outpatient	1.7%	0.3%	3.3%	1.9%	3.6%	1.3%	1.4%
Maternity	0.4%	0.1%	0.5%	0.4%	0.3%	0.6%	0.8%

Table I4: Growth rates for each Clinical Commissioning Group (south west London providers only)

CCG:	All SWL	Croydon	Kingston	Merton	Richmond	Sutton	Wandsworth
A&E	1.6%	0.3%	1.4%	2.3%	2.3%	1.4%	2.0%
Non Elective	4.0%	5.3%	3.1%	3.2%	5.9%	1.6%	4.6%
Elective	2.1%	1.0%	1.3%	2.2%	1.8%	1.5%	3.3%
Outpatient	1.7%	0.0%	3.6%	2.6%	2.9%	1.6%	1.4%
Maternity	0.4%	0.1%	0.5%	0.4%	0.3%	0.6%	0.8%

Table I5: Growth rates for each Provider; south west London Clinical Commissioning Groups only

CCG:	Croydon Health Services	Epsom St. Helier Hospital Trust	Kingston Hospital Foundation Trust	St. Georges University Trust
A&E	0.3%	1.6%	1.4%	2.3%
Non Elective	5.9%	1.8%	4.0%	3.8%
Elective	1.1%	1.9%	1.2%	3.4%
Outpatient	0.1%	1.4%	4.0%	1.6%
Maternity	0.1%	0.5%	0.5%	0.6%

2. Closing The Financial Gap

The STP programme has identified £558m of savings to reduce the commissioner and provider financial gap. This section outlines the savings by each of three core areas – these relate to reductions and shifts in acute activity, productivity measures by our providers, and other savings through CCG collaboration and business as usual savings.

3.1 Overview of savings

A summary of savings opportunities is outlined in Table I6 below. Savings are categorised as either “Business As Usual” (BAU) savings, which are considered to be part of organisations’ regular activities, or “Transformational” savings, which reflect additional initiatives above and beyond BAU efficiency work.

Table I6: Overview of savings

Savings area	Savings Category	BAU Savings (£m)	Transformational Savings (£m)	Comment
Right Care in the Best Setting (£112m)	Preventative & proactive care	5	17	Savings are based on the reduction in non-elective spells and bed-days, with the level of ambition based on the south west London bed audit and agreed across the health economy.
	Demand management and decommissioning	11	43	Benchmarked savings from reductions in outpatient appointments and elective admissions. Based on high-level benchmarking to identify variance in referral rates at a GP, CCG and national level. The size of savings has been confirmed by clinical chairs, and is more ambitious than those indicated by the NHS RightCare benchmarking.
	Elective de-commissioning lists	0	20	Additional savings have been identified from further elective de-commissioning. This is based on draft lists collated by two CCGs, largely involving increases in the threshold to treatment.
	Outpatient radical redesign	2	8	Savings from further reductions in outpatient appointments, 80% of which are re-provided in a community setting with an average re-provision cost of ~60%. Based on evaluation of specific initiatives not widely implemented in south west London across seven pathways, with impacts extrapolated to all pathways.
	A&E avoidance	1	5	Estimated savings of £6m through fewer A&E attendances at south west London and OOA acute providers. Extended GP opening hours all week comprise 77% of the activity reduction that drives the saving, with proactive policies that reduce non-elective admissions delivering the remaining 23%.
Provider Productivity - standalone (£217m)	Basic CIPs	194	-	Basic CIPs savings of 1.6% p.a. agreed to be achievable by acute trusts (£136m). Additional £58m of savings for non-acute providers from Financial Diagnostic.
	Recovery CIPs	-	23	Savings above the Basic CIPs level related to recovery/turnaround.
Provider productivity – collaborative (£55m)	Provider collaborative savings	-	55	<p>Work done by APC on collaborative working and examining Carter opportunities, specifically around:</p> <ul style="list-style-type: none"> • Collaborative procurement & supply chain • Workforce optimisation • Corporate & administration costs • Hospital pharmacy and medicines optimisation • Estates savings based on Carter benchmarking estimate. • Fragile services optimisation

Savings area	Savings Category	BAU Savings (£m)	Transformational Savings (£m)	Comment
Productivity - collaborative (£14m)	Medicines optimisation	-	10	Estimated CCG savings in primary prescribing and high cost secondary care drugs based on work with the south west London Medicines Cabinet. Do not overlap with APC savings above.
	Commissioner running costs	-	4	Opportunities for CCGs to work together more closely, as advised by CCGs. Savings ~10%.
Other/ Finance (£60m)	Other QIPP sources	54	-	Estimate of BAU prescribing QIPP and Continuing Healthcare savings.
	Prevention & Public Health initiatives	-	10	Forecast net savings of £10.2m against 2020/21 "Do Nothing" baseline for south west London. This is driven through six initiatives targeting reductions in diabetes, alcohol misuse, smoking and hypertension, to generate savings for NHS community health services.
	Cost of investment	-	(4)	Interest & depreciation
Specialised Commissioning (£99m)	QIPP	99	-	Initiatives being developed with NHS England
Total (£558m)		367	191	

Accounting for all these measures covering productivity, demand management and changes in the models of care, and after taking into account £101m of Sustainability and Transformation Funds (STF), the 2020/21 "Do Nothing" financial gap is closed.

A detailed graph showing how each of the measures contributes towards closing the gap is shown at the end of the document.

3.2 Right care analysis

The Right Care 'Commissioning for Value' (CfV) insight packs were used initially to focus attention on potential savings areas, identifying high-level opportunities in three main areas:

- Elective admissions: CfV identified £8.5m gross saving based on national benchmarking, which is included in the "Demand Management and Decommissioning" section below
- Non-elective admissions: CfV identified a potential high-level savings opportunity. This was subsequently superseded by the results of a bed audit commissioned specifically for south west London acute providers, enabling more detailed analysis, and a larger total savings value was identified
- Prescribing: CfV identified a potential high-level savings opportunity. This was subsequently superseded by more detailed workstreams with a larger total value.

3.3 Preventative and proactive care

3.3.1 Setting the level of ambition

South west London has agreed an ambition to reduce the number of acute bed-days by 44%.⁴⁴ A key input for this was a bed audit conducted across the four acute providers in February 2016, which reviewed the opportunity for shifting adult non-elective patients into other settings of care.

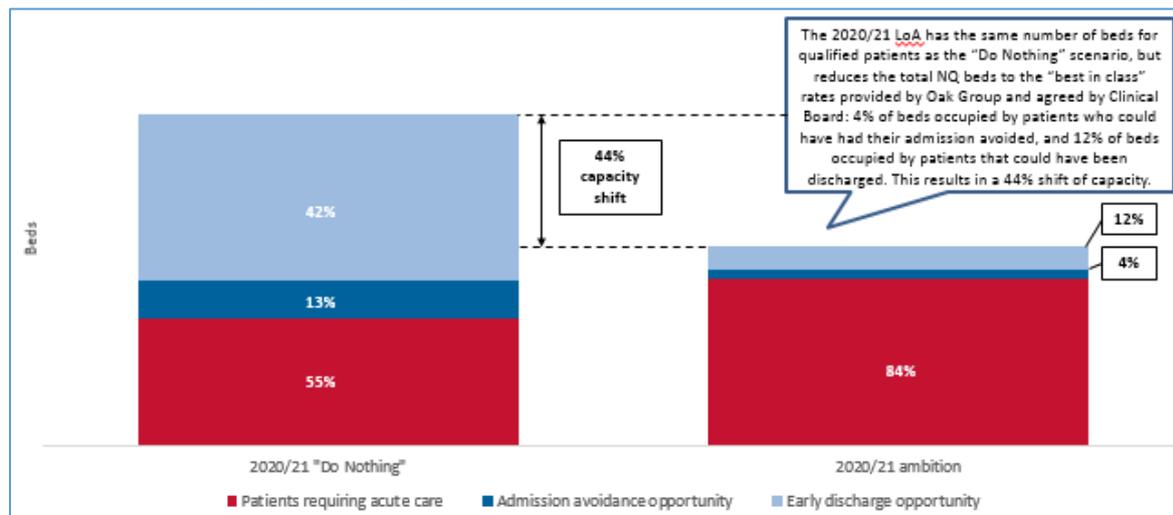
The methodology for agreeing this shift was based on the following:

- The bed audit identified that 13% of hospital capacity is used by patients who could have been seen in a non-acute setting, and a further 42% is used by patients who could have been discharged earlier. The bed audit used a sample of 500 patients across south west London trusts.
- In practice, not all of these patients will be able to access non-acute care immediately. However, international best practice indicates a rate of 4% of capacity occupied by patients who could have been seen in a non-acute setting, with a further 12% of capacity occupied by patients who needed to be admitted, but could be discharged to a non-acute setting of care⁴⁵. Adjusting for growth, this indicates an opportunity to remove 44% of acute bed capacity in south west London⁴⁶.

The audit only looked at medical patients, but it is assumed that the same opportunity applies across surgical patients. This is based on national evidence.⁴⁷ The 44% bed day shift was agreed as the level of ambition for south west London by the Clinical Board in March 2016, with an acknowledgement that:

- The bed audit only identifies the opportunity to avoid admissions or discharge earlier based on the patients' current level of acuity. Further opportunity to deliver the level of ambition would be possible through prevention initiatives;
- The opportunity only highlights moving patients out of a full acute bed and ~30% patients were identified as still needing bedded care.

Chart I7: Summary of activity shift level of ambition



⁴⁴ Bed days = (Number of beds) * (Number of days occupied by patients)

⁴⁵ Source: Oak Group International

⁴⁶ Source: Oak Group International; STP analysis.

⁴⁷ 'Moving Healthcare Closer to Home', Monitor 2015

3.3.2 Re-provision costs and net health economy impact

Based on the 44% level of ambition, a system-wide net saving of £22m was identified from the reduction and re-provision of non-elective activity. This can be broken down into provider and commissioner net savings, and summarised as follows:

Chart I8: Breakdown of P&PC net savings by providers and commissioners

Net savings to SWL health economy: £22m	=	A. Provider net saving: £45m	+	B. Commissioner net saving: -£23m
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Where:

A. Provider net saving: £45m	=	Reduced operational costs: £70m	-	Reduction in provider income: £25m
B. Commissioner net saving: -£23m	=	Commissioner gross saving: £31m	-	Commissioner re-provision costs: £54m

3.3.3 Description of savings

On the provider side, there is a total net saving of £45m. This comes from a significant reduction in non-elective operational costs due to reduced activity, and which is only partially offset by a corresponding £25m decrease in tariff income. On the commissioner side, there is a total net cost of £23m. This is due to the costs associated with re-providing the shifted non-elective activity in alternative settings, including community and intermediate care, which significantly outweighs the reduction in tariff payments to acute trusts. Investment in additional Primary Care provision that is included in the “Do Nothing” baseline is also expected to be a source of re-provision.

As part of the commissioner re-provision costs, the expansion of locality teams giving care oversight and coordination to the highest-risk patients is considered a key enabler of the non-elective shift. It is estimated £1m of the total re-provision cost would be required to allow for this expansion.

It is recognised that under current system incentives the net saving falls very asymmetrically, with acute trusts significantly benefitting and CCGs bearing the costs of re-provision. Accordingly, in order to successfully implement this key initiative, it is anticipated that there will need to be a change in the tariff arrangements which govern payments for non-elective admissions; discussions are expected to address these issues in the next few months.

3.3.4 Key assumptions

- Reduced acute operational costs due to the non-elective activity shift are calculated based on annual ward costs – alongside the numbers of beds per ward and occupancy rates – as supplied by each acute trust
- Commissioner savings and reduced provider income from reduced admissions and excess bed-days are taken from average spell costs (for short and long stays), as

supplied by acute trusts (for CHS, ESUH, SGH), and from national tariffs on SUS (for KUH)

- These tariff values are projected forwards to 2020/21 based on tariff assumptions from Monitor⁴⁸
- It is assumed that spells avoided will be above the Non-Elective Threshold Adjustment (NETA)
- For care re-provision, the alternative settings of care and the activity being re-provided in each is informed by the bed-audit results. Combined with setting-specific costs per bed-day, this is used to calculate the total care re-provision cost
- The setting-specific costs are based either on external estimates (e.g. for intermediate care beds), or calculated based on assumptions over staffing requirements. These assumptions have been worked through with the community provider Your Healthcare CIC.

3.3.5 Summary of savings

The total estimated net saving from proactive and preventative care is £22m in 2020/21. This is based on an agreed ambition to reduce acute non-elective bed-days (both medical and surgical) by 44%, and accounts for the associated re-provision costs. Under current tariff arrangements, the net saving for providers is estimated at £45m, with an estimated £23m net cost to commissioners.

3.3.6 Caveats and further work required

Note that the calculations result in a net cost increase for commissioners, more than offset by a net saving for providers; therefore, further work will be required to establish how savings will be accounted for across the health economy.

Further work is on-going to define the interventions and models of care required to re-provide this level of care in non-acute settings, with plans to date highlighted in appendix E.

3.4 Demand management & de-commissioning

3.4.1 Gross savings from benchmarking analysis

To estimate the potential cost savings from reducing excess demand for outpatient attendances and elective admissions across south west London, benchmarking analysis was performed at three levels:

- a. GP surgery-level variation analysis within each CCG (outpatients only)
- b. CCG-level variation within south west London, by clinical area (outpatients and elective)
- c. National-level benchmarking (using Right Care “Commissioning for Value” packs), comparing each CCG to ‘similar’ CCGs nationally (elective only)

Based on the benchmarking analyses, the estimated gross savings for outpatient and elective are £42m and £28m respectively, compared to the 2020/21 “Do Nothing” scenario.

The south west London Effective Commissioning Initiative (ECI) has worked over several years to identify circumstances under which elective procedures do and do not offer clinical effectiveness. The proportion of the elective opportunity that would be achieved through re-

⁴⁸ CAGR based on Monitor Economic Assumptions 2015/16 to 2020/21 minus the “Tariff efficiency factor” of 2% p.a. (<https://www.gov.uk/government/publications/economic-assumptions-201617-to-202021>)

duced spend on ECI procedures (assuming a 14% opportunity) has been identified separately as it is expected to have a lower investment cost to achieve than other areas of demand management.

Collectively the gross saving opportunity would lead to a ~20% reduction of out-patient activity and a ~13% reduction in elective activity versus the 2020/21 “Do Nothing” scenario.

3.4.2 Re-provision assumptions & net saving from benchmarking analysis

The following re-provision cost assumptions have been made for demand management and decommissioning:

- ECI savings are assumed to have a 0% re-provision cost as the expectation is that current spend will become better assigned
- The remaining gross saving opportunity is estimated to have a 25% re-provision cost.

This implies that a cost of £16m is required to deliver the reduction in acute activity – this could include, for example, additional activity in primary or community settings, software, and medicines costs.

3.4.3 Summary of savings from benchmarking analysis

For elective and outpatient work, a potential net saving of £54m in 2020/21 has been identified through demand management in planned care, and through decommissioning procedures of limited clinical effectiveness. Of this, £31m savings are expected from reduced outpatient procedures, and £23m from reductions in elective procedures.

20% of savings were assumed to be “Business As Usual” while the remainder were considered to be “Transformational”.

Table I9: Gross and net savings in demand management

Care setting		Gross saving	Assumed re-provision cost	Assumed cost scaling factor	Net saving
OP		£42m	25%	100%	£31m
EL	ECI	£5m	0%	100%	£5m
	Non-ECI	£23m	25%	100%	£18m
	EL Total	£28m			£23m
Total		£70m			£54m

3.4.4 Caveats

The analysis to date uses a number of approaches to estimate the opportunity to the health economy in elective and outpatient spend. Though sensible precautions have been made during the analysis, there is still potential that local coding methods and demographic effects could mask the true opportunity (either positively or negatively).

3.4.5 Additional elective de-commissioning

In order to help close the 2020/21 “Do Nothing” financial gap, the south west London CCGs have committed to de-commissioning additional elective services. This de-commissioning is expected to provide a combined £29m gross saving to CCGs against the 2020/21 “Do Nothing” scenario. This estimate is based on example lists collated by two south west

London CCGs, and largely involves increases in the threshold to services (including those services with limited evidence of clinical effectiveness).

Whilst acute providers (including out-of-area) would see a corresponding £29m reduction in elective tariff income, their costs are not expected to fall proportionately. A provision of £9m has been made for potential stranded costs across south west London providers, giving a £20m system-wide net saving overall.

3.5 Outpatient radical redesign

3.5.1 Description of savings

The net savings for outpatient care identified under the Demand Management & De-Commissioning workstream imply a ~20% reduction in activity. The Clinical Board believes that this reduction relates more to incremental improvements than transformational change. Opportunities to more radically transform the provision of specialist input into patients' care pathways include:

- Changing the setting of care
- Using technology to deliver care remotely
- Optimising the roles and responsibilities of different workforce groups (e.g. GPs with a Special Interests [GPwSIs], or GPs managing conditions in primary care settings with remote advice from secondary care colleagues)

The net savings achievable from more radical improvements have been estimated at ~£10m, and are in addition to the outpatient savings identified under demand management & de-commissioning. Combined, these two workstreams give a ~35% reduction in outpatient appointments provided in the current way vs. the 2020/21 "Do Nothing" scenario.

3.5.2 Gross savings

These across-system savings were estimated using a sample of initiatives relating to 7 individual pathways (accounting for 40% of total spend) that were found to have proven impacts on outpatient activity rates, and are not extensively implemented in south west London. Extrapolating to all pathways, these initiatives were estimated to create an additional 14% gross saving in spend vs. the 2020/21 "Do Nothing" scenario (over the demand management reduction), giving £27m in total.

3.5.3 Re-provision assumptions

For appointments re-provided in a specialist non-acute setting, an 80% re-provision cost was assumed, whilst for those avoided via additional interventions (e.g. GP weekly conference calls with a specialist) a 40% re-provision cost was assumed. Given assumptions over the relative proportion of each, this gave a weighted average re-provision cost of 63% - implying a total re-provision cost of £17m, and therefore net savings of £10m.

3.6 Provider Cost Improvement Programmes (CIPs)

Projected CIP figures were submitted by providers as part of the STP process, and are divided into £194m of 'Basic CIPs' (considered as BAU) and an additional £23m of Recovery CIPs (considered Transformational savings).⁴⁹

Acute providers agreed a BAU rate of CIPs savings as 1.6% per annum as reasonable and achievable. Any savings above this level and included in their plans reflect recovery and transformational programmes. For non-acute providers, the level of savings submitted in the Financial Diagnostic has been used, categorised as BAU saving. The value of savings by provider sector is set out below.

Table I10: CIPs in 2020/21 by provider sector, in £m, and as a % of expenditure

Trust	Value (£m)			% of expenditure		
	"Business As Usual" CIPs	"Transformational" CIPs	Total	"Business As Usual" CIPs	"Transformational" CIPs	Total
Total Acute	136	23	159	1.7%	0.3%	2.0%
Total Non-Acute	58	-	58	1.9%	-	1.9%
All providers	194	23	217	1.7%	0.3%	2.0%

3.7 Provider Collaborative Productivity

Savings arising from the work of the Acute Provider Collaborative (APC) are detailed separately in Appendix E.

These transformational CIPs total £55m, which equates to an additional 0.5% of expenditure savings per year, taking provider total productivity savings to 2.5% p.a.

3.8 Collaborative Commissioner Savings

3.8.1 Medicines optimisation

The south west London CCG pharmacy teams have been working together to identify transformational savings – additional to business as usual savings – which could be achieved through collaborative working and additional investment. All these savings are considered to be "Transformational" savings.

Four key areas have been identified:

- Pathway reviews to identify opportunities in high cost drugs in secondary care (with a focus on differences in practice between hospitals and doctors) (£1m)
- Opportunities to reduce or stop prescribing medicines which are considered to be less clinically effective and/or significantly more expensive than their alternatives (£2.9m)

⁴⁹ Provider submissions to STP

- Opportunities to reduce medicines wastage (particularly through changes in doctor, pharmacist and patient behaviours around ordering, dispensing, and repeat prescriptions (£3.9m)
- New models of care – in stoma, wound management, continence, and malnutrition (£2.2m).

More detail is shown below in table I11.

Table I11: Transformative medicines savings

Savings area	Gross Saving	Investment	Net Saving	Scope
Biologic drug pathways	£1.3m	£0.3m	£1.0m	Building upon existing pathway redesign work (in particular for gastroenterology and dermatology) to optimise use of biologic medicines and avoid waste. Savings are against the <u>high cost drugs budget</u>.
De-prescribing	£3.2m	£0.3m	£2.9m	Stopping or switching medicines or products which are considered to be a low priority, poor value for money or where safer alternatives exist. Includes PrescQIPP DROP List & Gluten Free Foods. Savings are against the <u>primary care prescribing budget</u>
Tackling waste	£5.8m	£1.8m	£3.9m	An integrated, multi-agency programme to minimise financial and health consequences associated with avoidable waste through systematically tackling the causative factors. Savings are against the <u>primary care prescribing budget</u>
New models of care	£3.1m	£0.9m	£2.2m	Wound management products, stoma & incontinence appliances and oral nutritional supplements are historically prescribed on FP10 prescription, often by GPs who have limited knowledge of the products. This programme aims to introduce innovative models for the care for patients including the 'off prescription' supply of these products. Savings are against the <u>primary care prescribing budget</u>
TOTAL	£13.3m	£3.3m	£10.0m	

3.8.2 Commissioner running costs

CCGs have identified that there are likely to be opportunities to improve productivity by working together more closely, and have estimated total savings at £4m (~10% of running costs).

Other collaborative opportunities to be explored include sharing 'back office' functions across commissioners, Commissioning Support Units, providers and councils. These options continue to be worked up by CCGs.

3.9 Regular commissioner QIPP not captured elsewhere

The £54m estimated CCG QIPP⁵⁰ saving is comprised of £24m prescribing savings, £18m savings in continuing care, £4m in primary care and £8m in other, non-acute savings.

3.9.1 Prescribing savings

For 2017/18 to 2020/21, south west London Clinical Commissioning Groups are projecting primary prescribing expenditure to grow on an underlying basis by 6% on average. However, typically CCGs have applied annual QIPP schemes on a standalone basis to reduce the growth to ~3%. Carrying forward this trend would imply “Business As Usual” savings of ~£24m by 2020/21. This would be in addition to the medicines optimisation work-stream that involves collaborative working⁵¹. These savings are all captured as BAU.

Table I12: BAU prescribing savings

£m	2016/17	2020/21	CAGR
CCG prescribing expenditure ("Do nothing")	179	226	6.0%
Expenditure if growth at 3%	179	202	3.0%
Difference (savings)		24	

3.9.2 Continuing care

CCGs submitted the following proposed savings estimates in continuing care in year for 2016/17 to 2020/21⁵². Cumulative recurrent savings are £18m by 2020/21 as compared to the “Do Nothing” scenario. These savings are all captured as BAU.

Table I13: Business as usual Continuing Health Care savings

	2017/18	2018/19	2019/20	2020/21
In-year savings	4.8	4.6	4.0	4.7
Cumulative savings	4.8	9.4	13.4	18.0

3.9.3 Primary care savings

A provision of 0.5% p.a. has been made for BAU savings for primary care to reflect expected efficiencies. This amounts to £4m for all six CGs.

3.9.4 Other non-acute QIPP

CCGs are at the early stages of working on operating plans for additional savings to meet control totals. These include other QIPP schemes that will not impact on local NHS

⁵⁰ Quality, Innovation, Productivity and Prevention

⁵¹ Source: SWL Financial Diagnostic; STP analysis

⁵² Source: CCG submissions to STP

providers. To date, a provision of £8m has been for QIPP schemes, but this value may become larger as work progresses.

3.10 Accident and Emergency (A&E)

3.10.1 Net impact to health economy

There is an estimated net saving of £6m by 2020/21 through a reduction in A&E attendances in south west London and other out-of-area providers. Potential savings are achieved through preventative and proactive care policies that reduce non-elective admissions, and also the planned increase in opening hours for GP appointments each day.

3.10.2 Description of savings

For the reduced non-elective admissions, the saving is driven by preventative and proactive care measures, such as rapid response teams and increased community care provision, that remove minor A&E attendances from occurring (i.e. those that do not require significant treatment or investigation). This results in an expected net saving of £2m across south west London, due to 18,000 fewer A&E attendances. As all re-provision costs here are already incorporated elsewhere in the analysis, the gross and net savings are the same.

There is also a larger expected saving from reduced A&E attendances, due to GP surgeries extending their opening hours from 8am to 8pm seven days a week. Based on previous trials in London, Manchester and elsewhere in the UK, a 10% reduction is forecast in A&E attendances from the “Do Nothing” baseline, as people increasingly utilise the longer opening hours of primary care facilities rather than attend A&E. The expected net saving for south west London is forecast at £4m as a result of this extended primary care, which is estimated to reduce activity by 60,000 A&E attendances per year. Again, as the costs of providing this service have been included elsewhere, the net and gross savings are the same.

3.10.3 Key assumptions

- The cost per A&E attendance is assumed to be the lowest tariff, i.e. attendances requiring no significant investigation or treatment, projected forwards to 2020/21 based on tariff assumptions from Monitor⁵³
- Avoided A&E attendances through reduced non-elective admissions are calculated off the bed audit results from February 2016
- It is assumed that 95% of non-elective admissions at acute providers come via A&E
- For GP extended opening hours, a 10% weekly reduction has been forecast based on previous trials in London and elsewhere in the UK - as studied by the Healthy London Partnership/ PwC review of trials
- The effect of A&E reductions arising from extended GP opening hours is not expected to become significant until 1 year after roll-out of the new services, as individuals in the health economy become aware of these services.

3.10.4 Summary of savings

⁵³ CAGR based on Monitor Economic Assumptions 2015/16 to 2020/21 minus the “Tariff efficiency factor” of 2% p.a. (<https://www.gov.uk/government/publications/economic-assumptions-201617-to-202021>)

South west London providers and CCGs are estimated to see a reduction of £4m from their 2020/21 “Do Nothing” baseline position, with an additional £2m apportioned to south west London CCGs from other out of area providers.

As noted, since all re-provision costs are included elsewhere, our gross savings are the same as the net savings for reduced A&E attendances.

3.11 Public health

3.11.1 Summary of initiative

South west London has forecast gross savings of £16m vs. the 2020/21 “Do Nothing” baseline, through the delivery of an array of public health initiatives. These initiatives aim to minimise the effects of six conditions in each borough by:

- Reducing unsafe levels of alcohol consumption to 15%, amongst “high risk” drinkers
- Decreasing the prevalence of smoking to 13%
- Reducing the occurrence of diabetes by 10% for 25% of the population
- Reducing the risk of more serious conditions evolving by 10% for 20% of those with diabetes
- Reducing the average blood pressure for 10% of populace to below 120/80 mmHg
- Reducing the average blood pressure for 10% of hypertensive populace to below 140/90mmHg
- These initiatives are delivered through more frequent intervention in primary care, increased usage of prescriptions and acute NHS services. A bottom-up costing of providing these initiatives totals £6m, bringing the net saving to £10m.

Key assumptions

- The key source for our analysis is the Healthy London Partnership/ Optimity report on public health conditions in south west London, which has made estimates on the prevalence of conditions in each borough
- In apportioning savings to acute providers, the percentage of non-elective spells treated at each trust has been used as a proxy for cost
- The saving will lead to reductions in non-elective admissions to acute providers. As the saving for non-elective admissions has been captured in preventative and proactive care, savings are attributed to the reduced usage of community care as a result of early intervention
- Background quit rates for some conditions, e.g. smoking, have been incorporated into the analysis to avoid double counting reductions.

3.11.3 Summary of savings

The expected net saving of £10m against the 2020/21 “Do Nothing” baseline is delivered predominantly in the later years of the five-year period, as the costs of intervention are invested early on given the time required for public health initiatives to materialise. This is aligned to forecasts made with other STPs on savings generated by prevention initiatives.

3.12 Sustainability and Transformation Funding (STF)

In May 2016, NHS England published indicative allocations for 2020/21 STP funding including Sustainability and Transformation Funding of £101m for south west London.⁵⁴

Table I14: STF Funding for south west London

£m (STF)	2016/17 STP place-based allocation	2020/21 STP place-based allocation	2020/21 indicative STP allocation including STF	Indicative 2020/21 STF
South West London	2,418	2,760	2,861	101

4 Transition costs

A preliminary high-level estimate of the necessary transition costs to support implementation of the STP indicates that a total of £121-140m of non-recurrent revenue costs and an additional £19m of capital cost is necessary, with the latter estimated to generate a £4m of recurrent revenue cost. The costs have been split into enabling costs, covering several of the initiatives, and those relevant to specific initiatives.

4.1 Costs of Key Enablers

Table I15 below sets out the estimated investment in enablers. The capital costs in estates are excluded here, but are addressed below in section 5.

Table I15: Transition costs of key enablers

Description	Non-recurrent revenue cost	Capital cost	Comment
IT	£10m	£17m	Initial estimate. Based on STP transformational costs only – individual organisational costs (e.g. clinical system and infrastructure upgrades) are excluded.
Training	£15m		£3k/head for transferred workforce for training cost and £7k/head for backfill (based on 4 weeks of training + induction period). Based on 1500 staff members transferring
Programme costs	£25m		Average of £5m p.a. potentially front end loaded with higher costs in first 2 years (e.g. £7m) and lower amounts in years 4 and 5 (e.g. £3m)
Total	£50m	£17m	

4.2 Costs of delivering initiatives

For each of the savings areas, there are also expected investment and transitional costs associated with delivering the required initiatives. Our estimates of these are set out in table I16 below.

⁵⁴ 'Indicative 2020/21 STP funding including transformation', NHS England, May 2016

Table I16: Transition costs of delivering initiatives

Description	Non-recurrent revenue cost	Capital cost	Source/Comment
Provider CIPs	£27-41m		Based on 10-15% of forecast savings to include external consulting support and staff backfill costs associated with developing schemes
Provider CIPs – back office rationalisation	£10m		Potential redundancy related costs assuming that corporate/back office costs reduced by ~£20m and that on average redundancy cost = 50%
OOH activity shifts	£20-25m		Based on 3 months double running and assuming costs associated with £70m of activity are transferred to non-acute settings
Demand management	£6m	£2m	Allowance made for £2m of systems/IT costs (e.g. Kinesis) and £6m to support GP and other clinician training. Assumes community-based out-patients will utilize current estate
Medicines management	Minimal		All re-provision costs identified so far as assumed to require recurrent spend
Commissioner running costs	£2m		50% of assumed cost savings
Other QIPP	£0m		Part of BAU, so costs should already be in plans
Clinical priorities	£5m		An allowance of £1m p.a. has been made for initiatives not included in those above. Initiatives have not been specified in detail
Decommissioning	£1m		Project team costs to deliver savings (5% of gross saving)
Total	£71-90m	£2m	

4.3 Sources of funding

No assumptions have been made about specific sources of funding for the investments above. Possible sources could include:

- Commissioners' 1% non-recurrent investment funds (~£75m over 2017/18 to 2020/21)
- Access to central Sustainability and Transformation funds for the balance (~£75m) over the course of 2017/18 to 2019/20 – from 20/21 these funds become a 'recurrent' part of bridging the financial challenge.

5 Capital requirements

The south west London estate will require a significant level of investment over the next five years, and potentially further capital after 2020/21 to support reconfiguration. This section provides further detail on the main capital challenges in the acute sector.

All the acute sites have areas of capital which they must urgently address in response to requirements from the CQC requirements.

In the case of Kingston and Croydon, trusts have prioritised internal funding in order to address the most urgent requirements around safety critical capital and backlog maintenance.

However, south west London expects that there will be a significant capital ask from St George's and St Helier, though the latter will seek to meet requirements within internal funding as far as possible.

St George's

St George's has significant estate problems which are impacting on patient care. The widespread issues are currently being fully assessed but the CQC has issued a Section 29A warning letter requiring further action on patient safety grounds.

The estate issues have particularly affected the renal unit (which the CQC required the Trust to relocate) and theatres where repeated failures have resulted in loss of activity. Given St George's position as the tertiary hub for south west London and areas further south, there is a real risk that estates or IT failure at St George's due to poor infrastructure could seriously disrupt activity across the south west London health economy.

St George's have identified a total funding requirement of £295m over the course of the next five years. Of this £295m, £145m will be funded from internal sources. The remainder is being sought from the Department of Health (DH).

An initial request for 2016/17 has already been submitted to NHSI and a further ask for 2017/18 will follow.

Epsom and St Helier

Epsom and St Helier (E&SH) is facing major problems with its estate particularly at St Helier. The trust's most recent CQC report commented that "The NHS estates and facilities dashboard placed the trust in the lowest (worst) quartile for the amount of functional and suitable space available for the delivery of clinical care."

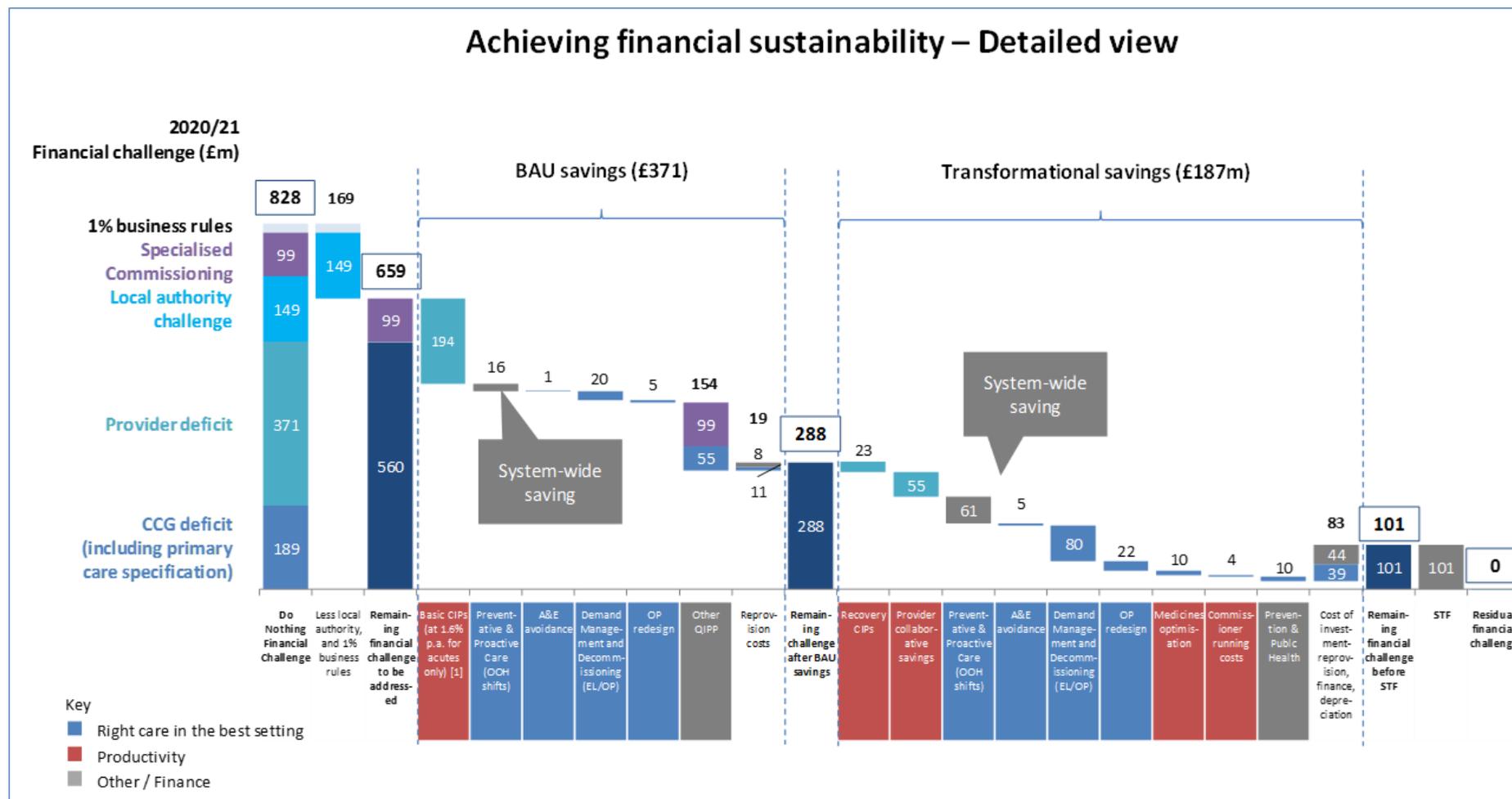
Addressing the issues at St Helier will be in two stages:

Safety critical capital investment in 2016-17 and 2017-18: The main building at St Helier hospital has major problems, including, most significantly, water ingress which has caused the closure of A&E twice over the last year. The Trust is undertaking a new six faceted survey of the St Helier site to get a full understanding of all the immediate priority issues. The trust expects to fund work to address these immediate safety issues in the first years of the STP through land sales and other internally generated funding.

Making the buildings fit for purpose from 2018-19 onwards: South west London anticipates that a decision will be made on reconfiguration during 2017 or 2018. The funding required to improve St Helier will depend heavily on what decision is made around reconfiguration:

- If the decision is to provide services elsewhere (for example on a new site) the costings will be developed as part of the business case.
- If the decision is to continue to provide acute services on the St Helier site, a programme of major works will be required totalling around £236m. This would focus on a new ward block to replace the current medical and surgical wards, which are not fit for purpose as the shape of the building makes it impossible to meet modern infection control requirements.
- E&SH are doing a more detailed piece of work to update the £236m figure, which will be completed in November. E&SH will be seeking to self-fund as much of the work as possible, and most of the ask will be towards the end of the STP period. However, if self-funding proves impossible there will be an ask for capital from to the DH.

Chart I17: Movement from 2020/21 “Do Nothing” financial challenge to financial sustainability



Notes: [1] also includes £58m of "Do Minimum" CIPs from non-acute providers

Source: South west London Financial Diagnostic and STP modelling