This executive summary provides an overview of the Our Healthier South East London Commissioning Consolidated Strategy. It will summarise and provide key highlights from the programme.

This section provides:
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2. Introduction to south east London
3. Introduction to the Our Healthier South East London Strategy and the approach taken to developing it
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10. What is needed to deliver our vision for south east London
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Introduction

- In south east London, we have some very good health services. People are living longer and many people are healthier. But we also have some services that could be better. We have services that people find hard to access and some people do not get the help they need to keep themselves and their families well. We also have wide varieties in life expectancy and too many people die early from preventable diseases.

- Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs, working with NHS England as co-commissioner, are working in partnership with local authorities, local providers and other key stakeholders to define a five-year strategy for health and integrated care services across south east London.

- The strategy complements and builds on local work and has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together. It seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. The approach is commissioner led and clinically driven, and informed by wide engagement with local communities, patients and the public.

Purpose of this document

- It brings together the context of the south east London health and social care economy and details the potential initiatives that could be implemented to have transformational impact.

- Every CCG in the country is required to produce a strategy. In south east London, commissioners want to make sure that the strategy reflects local needs and aspirations. The first draft of the south east London strategy was sent to NHS England for review on 20 June 2014. This was a national deadline. The strategy runs for five years, so it is very much a work in progress. Through local and wider clinical and public engagement, potential ways to improve services have been identified, but considerable further work and engagement on the thinking and implementation of these plans is now taking place.

- This version has developed significantly since June 2014 and brings together the proposed initiatives and their potential impact. It remains a work in progress and is under review by a wide range of stakeholders.
Introduction to south east London

- This commissioning strategy focuses on six NHS Clinical Commissioning Groups in south east London covering a population of approximately 1.8 million people:
  - Bexley CCG
  - Bromley CCG
  - Greenwich CCG
  - Lambeth CCG
  - Lewisham CCG
  - Southwark CCG
- Each of these CCGs works in partnership with a number of organisations and providers. In particular the key providers which the CCGs have worked with to develop the strategy are:
  - King's College Hospital NHS Foundation Trust
  - Guy's and St Thomas’ NHS Foundation Trust
  - Lewisham and Greenwich NHS Trust
  - Dartford and Gravesham NHS Trust
  - South London and Maudsley NHS Foundation Trust
  - Oxleas NHS Foundation Trust
  - Bromley Healthcare Community Interest Company
- To develop the best possible care models and interventions for the strategy it is important to understand the current health of the population of south east London. To do this a model called the ‘Christmas tree’ was used.
  - The segmentation model summarises the population segments which are detailed below: You can view the diagram on page 36.
    - Approximately 16% of people in south east London are in the health and wellbeing group
    - Approximately 50% of people in south east London are experiencing inequalities or putting their health at risk. For example this could be people who drink too much or don’t take enough exercise or are living in poverty.
    - Approximately 25% of people in south east London are in the early stages of long term conditions. For example, a long term condition could be, diabetes, poor mental health or high blood pressure.
    - Approximately 9% of people in south east London are living with 3 or more long term conditions.
    - Approximately 1% of people in south east London are at the end of their life
- Through understanding our population better the strategy is able to focus on developing care models and innovations that best address the needs of the people in south east London. A key component of this is to develop a strong foundation of Community Based Care to support people to live healthier lives and reduce the number of people exposed to risk factors either by birth or behaviour.
- A central part of the vison for the strategy is to be able to provide person centred care in a proactive and integrated way. In order to do this Local Care Networks are being developed across south east London. These Local Care Networks will deliver community based care to local populations through patient focused, proactive, accessible, coordinated services and through making every contact count. Further detail of Local Care Networks are provided in the following slides and on pages 66 onwards.
Introduction to the Our Healthier South East London Strategy and the approach taken to developing the strategy

- This programme is led by the six NHS Clinical Commissioning Groups in the south east London with commissioners from NHS England (London), working in close partnership with local authorities, local providers of care and other partners.

- They have identified six priorities for improvement to deliver better care for the south east London population. These are referred to as Clinical Leadership Groups and focus on:
  - Community based care
  - Planned care
  - Urgent and emergency care
  - Maternity
  - Children and young people
  - Cancer

- The groups are formed from clinicians, commissioners, social care leads and other experts, Healthwatch representatives and other patient and public voices from across south east London.

- Each of these groups has developed a model of care which forms part of the integrated whole system model described on page 13. Each Clinical Leadership Group has developed a number of interventions and assessed the impacts of these interventions in terms of delivering improved quality, better and less variable outcomes for people across south east London, and that they provide value for money and support a sustainable whole system health and care economy.

Aligning our Strategy with London and National Policy Agendas

- We know that a 'one size fits all' model will not work for the NHS, which is why we are responding to local needs. However, we have taken the insight, evidence and direction provided by London and national policy agendas and embedded this into our design. This includes the:
  - NHS Five Year Forward view
  - Better Health for London

- South east London leads are represented across the 13 London Transformation Programmes and our work is enabled by the learning from others and our collaborative work on a “once-for-London” basis, where appropriate.

Principles and governance

- In addition, as part of implementing and developing the strategy, the programme follows a number of principles which have been reflected in the governance and delivery structure. This structure entails the five key governance elements of the programme:
  - Senior joint forum for strategic direction and decision making (equivalent to a Programme Board) – the Clinical Commissioning Board
  - Collaborative forum for partnership working – the South East London Partnership Group
  - Clinical forum to guide design work – the Clinical Executive Group
  - Delivery focused forum to manage design and implementation activities – the Implementation Executive Group.
  - Collective forum for patients and public voices to contribute to shaping the strategy's content – Public and Patient Advisory Group
Stakeholder Communications and Engagement is a core part of the strategy development process

• Our approach to developing the strategy has been strongly focused around communicating and engaging and working in partnership with our stakeholders.

• Commissioners continue to design and develop the strategy with partners, patients, local people and key stakeholders, with thinking and planning being developed and amended through the engagement process.

• The strategy is clinically-led and developed, with over 300 clinicians, nurses, allied health professionals, social care staff, commissioners and others developing ideas through the six Clinical Leadership Groups. These Clinical Leadership Groups also include Patient and Public Voices and Healthwatch representatives to make sure that these voices are heard at all points in the development of the strategy.

• In addition to ensuring that patient and public voices feed directly into the Clinical Leadership Groups and supporting work streams, commissioners have been engaging widely from the beginning by building on existing local borough-level work.

• A series of deliberative events were held in June 2014, December 2014 and February 2015 looking at people’s current experiences of care and particularly at the more recent events, how people’s experiences might be enhanced in the future by these new models of care. Capturing feedback from engagement activities is systematic and transparent. All contributions are recorded and fed back into the strategy via programme managers - ensuring that local views influence strategy development. Examples of feedback and how it is being used are published via ‘You Said, We Did’ reports which are published on the website as well as the full reports of deliberative events and other activity.

• Engagement and communication is led by Clinical Commissioning Groups via the Communications and Engagement Steering Group which has met at least monthly since May 2014. The group consists of Clinical Commissioning Groups Communications and Engagement leads. Leads from NHS providers and local councils have also been invited to attend.

• Engagement at local level and through local channels is on-going. This was primarily focused on the case for change during 2014, with a wider focus on the whole system model and emerging ideas in the spring of 2015. This included gathering patient stories and using materials developed by engagement partners, the Innovation Unit, Local engagement on the Issues Paper commenced in May 2015.

• A variety of methods have, and will be, used to gather the views of a broad spectrum of patients and the public. Activities will include:
  – borough level deliberative events
  – focus groups with specific communities
  – utilising the existing mechanisms and opportunities identified through our Clinical Commissioning Groups’ engagement colleagues.
There is a strong case for changing the way current health and care services are provided in south east London

- This strategy identifies that outcomes in south east London are not as good as they should be: The longer we leave these problems, the worse they will get. We therefore recognise that we all need to change what we do and how we do it. The case for change has identified and investigated these problems, helping to target our aims. Nine key issues have been identified as detailed below:

Too many people live with preventable ill health or die too early
- About 11,000 people died prematurely across south east London between 2009 and 2011, with four of our boroughs being classed in the worst category for premature death in England.

The outcomes from care in our health services vary significantly and high quality care is not available all the time
- Too often, the quality of care that patients receive and the outcome of their treatment depend on when and where they access health services.

We don’t always treat people early enough to have the best results
- Our services are often not set up to detect problems soon enough, meaning that people with long term conditions or mental illness often have to be admitted to hospital in crisis.

People’s experience of care is very variable and can be much better
- While patients are very happy with some services, surveys tell us that their experience of the NHS is inconsistent and that they do not always receive the care they want.

Patients tell us that their care is not joined up between different services
- Patients and carers find it frustrating to have to continually provide the same information to different people. This is because different parts of the NHS do not always communicate effectively with each other or with social services.

The social care system is under increasing pressure
- Many Local Authorities are facing unprecedented pressures due to growing demand in some areas, with increasing numbers of older residents, residents living much longer with complex care and health needs and increased mental health needs. New laws and duties are also leading to additional implications and uncertainty for councils.

The money to pay for the NHS is limited and need is continually increasing
- NHS funding currently increases in line with inflation each year. However, the costs of providing care are rising much faster because the NHS is now treating more people with more complex conditions than ever before and the costs of care often grow faster than consumer inflation.

It is taxpayers’ money and we have a responsibility to spend it well
- We know that by providing services in a different way, it is possible to improve outcomes, to help people to live healthier lives, to deliver services which are consistently of high quality and get more for our money.

South east London’s acute, community and mental health providers face a similar and interrelated set of challenges and drivers
- Providers in south east London share key issues and drivers, such as workforce and regulatory requirements and London’s ambulance service is facing increasing and changing needs for care.
Vision for the future of health and care services in south east London

• To solve the problems outlined in the case for change, we have developed a collective vision for south east London. In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:
  – Supporting people to be more in control of their health and have a greater say in their own care
  – Helping people to live independently and know what to do when things go wrong
  – Helping communities to support one another
  – Making sure primary care services are consistently excellent and have an increased focus on prevention
  – Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
  – Developing joined up care so that people receive the support they need when they need it
  – Delivering services that meet the same high quality standards whenever and wherever care is provided
  – Spending our money wisely, to deliver better outcomes and avoid waste.
The strategy proposes model(s) of care: to deliver better care for our south east London populations

Care Model Design

- To develop the initiatives to focus on these aims, the Clinical Commissioning Groups and NHS England – London region have identified the six Clinical Leadership Groups to deliver better care for our population.

- Each of these groups has developed a model of care which forms part of the integrated whole system model described on page 13. Each Clinical Leadership Group has developed a number of interventions and assessed the impacts of these interventions in terms of delivering improved quality, better and less variable outcomes for people across south east London and that they provide value for money and support a sustainable whole system health and care economy.

Local Care Networks

- Local Care Networks are the centrepiece of the strategy and sit within Community Based Care.

- The Community Based Care Clinical Leadership Group aims to support people to live healthier lives and reduce the number of people exposed to risk factors either by birth or behaviour. For people with a long term condition, Community Based Care will take a rehabilitative/re-ablement approach, supporting people to manage their own health positively, prevent deterioration wherever possible and reduce risks on these people. For those people with complex long term conditions or who are in the last year of life, support will be available to enable them to continue to lead as full and active life as possible.

Clinical Leadership Group initiatives

- Community based care will be delivered through Local Care Networks. The services available will be proactive, accessible, coordinated and provide continuity; with a flexible, holistic approach to ensure every contact counts. This will be primary care delivered to geographically coherent populations, at scale, whilst still encouraging self-reliance.

- 24 local care networks are being developed to support whole populations across south east London. This will be a universal service covering the whole population ‘cradle to grave’. A local care network will involve primary, community and social care colleagues working together and drawing on others from across the health, social care and the voluntary sector to provide proactive patient centred care. Services will be delivered in ways that respond to the varied needs and characteristics of our communities.
The Community Based Care Target Model

The strategy sets out an agreed target model for local care networks that will deliver community based care. It is intended that each Local Care Network across south east London delivers the target model. However, the target model will have to be tailored to the local community that it serves.

Integrated Single System Leadership and Management

‘The Core’ (as a minimum all LCNs should encompass)

- Leadership team
- All general practices working at scale (federated with single IT system and leadership)
- All community pharmacy
- Voluntary and community sector
- Community nursing for adults and children
- Social care
- Community Mental Health Teams
- Community therapy
- Community based diagnostics
- Patient and carer engagement groups

Working with…

- Strong and confident communities
- Accessible hospital outpatient treatment clinics and acute oncology (urgent and emergency and cancer care)
- Specialist opinion (not face to face) and clear specialist service pathways
- Pathways to Multi Disciplinary Teams
- Integrated 111, London Ambulance Service and Out of Hours system (interface with Urgent care centres co-located with emergency department model)
- Housing, education and other council services
- Community based midwifery teams
- Private and voluntary sector e.g. care homes and domiciliary care
- Cancer services
- Children’s integrated community team and short stay units
- Rapid response services
- Carers
- And there will be others...

Big hitters

- Supporting patients to manage their own health (Asset Mapping, Social Prescribing, education, community champions etc)
- Prevention – Obesity, Alcohol and Smoking
- Improved Core general practice access plus 8-8, 365
- Enhanced call and recall – improves screening and early identification and management of long term conditions
- Reduction in gap between recorded and expected prevalence in long term conditions
- Supporting vulnerable people in the community including those in care homes and domiciliary care
- Reduction in variation (level up) primary care management of long term conditions
- Reablement – Admissions avoidance and effective discharge
- Multi Disciplinary Team configuration – main long term conditions
- groups (incl. mental health) and Frail elderly
- End of Life Care

Integrated Pathways of care

A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England
Community Based Care delivered by Local Care Networks

**Strong confident communities**

- Self care
  - Health coaching
  - Self management tool kits
  - Social prescribing
  - Optimising neighbourhood assets

**Managed care**

- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes

**Population needs & budget**

**Local Care Network**

- GP practice
- Family/social network
- Health visiting
- Voluntary sector
- Practice nurses
- Community Nursing
- Community Mental health
- Social care
- Therapies
- Community Based Care delivered by Local Care Networks
- Care co-ordination
- Family health
- Diagnostics
- Pharmacy

**Specialist input shared between LCNs**

- Pulled into care delivery from outside the network:
  - Virtual clinics
  - Specialist nurses
  - Consultants
  - Geriatricians
  - End of Life expertise
  - Specialist rehab

**Wider community infrastructure**

- Police
- Fire service
- Schools
- Housing

**Affordable high quality outcomes**

**Urgent and emergency**

Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care

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A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Draft in progress | 11
A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Our integrated whole system model

Community Based Care delivered by Local Care Networks is the foundation of the integrated whole system model that has been developed for south east London. This diagram provides an overview of the whole system model, incorporating initiatives from all 6 Clinical Leadership Groups.

- This is our integrated system model.
- Local Care Networks are the foundation of the whole system model providing person centred services to populations.
- The petals are the pathways providing services to cohorts of people and drawing on specialised services.
- The orange circles represent key features.
- Mental health is embedded throughout the whole system model. It is considered within Local Care Networks and each of the petals.

Our Healthier South East London
Improving health and care together

Draft in progress | 12
Key Features of the model

1. **Standardisation**
   Reducing variation across the planned care pathway from referral practice to discharge through to co-development of high level standards.

2. **Diagnostics**
   - Enhance patient management by GPs
   - Rapid access to diagnostics for GP’s
   - Evidence based standardised Clinical pathways
   - Shared results across the system supported by integrated IT systems

3. **Elective Care Centres**
   Provider collaboration to create centres of excellence for high volume specialities that drive up quality of service provision and improve outcomes for patients
   - Orthopaedic (hips and knees)
   - Ophthalmology

4. **Pathway Review**
   - Urology
   - Neurosurgery
   - Nephrology
   - Gynaecology
   - Dermatology
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Our Healthier South East London
Improving health and care together

Maternity model

Key Features of the model

1. Primary prevention and targeted wellness programmes within the Local Care Network

2. Assessment of pregnancy risk before 10 weeks to assign the most appropriate midwife team from the outset:
   1. Local Care Network community based midwife teams for low risk
   2. Specialist condition focused teams for high risk

3. Easy access to acute assessment clinic for unexpected problems during pregnancy and assessment unit for assessment of onset of labour

4. Culture of birthing units to encourage straightforward birth and improve the experience for low risk women

5. Achieve the London Quality Standards

6. Better co-ordination through postnatal and neonatal phase to improve mother and baby flows and experience

7. Smooth handover to Local Care Network with continuing advice and support on healthy choices.

It is our intention that through this strategy we will meet the London quality standards. The above interventions aim to address this.
Children and Young People model

Key Features of the model

1. **Primary prevention and wellness:**
   - Within the local care network, focusing on the well child.
   - In the context of the family setting, looking after the child or young person’s physical, social, emotional and mental well being.

2. **Children’s integrated community team delivering:**
   - A range of proactive services for children with long-term conditions and care needs
   - Early intervention for acute illness and supported early discharge
   - Management of short-term conditions
   - Signposting and navigation through the system and navigate through the system

3. **Extended GP hours**
   - For general practice from 8 to 8
   - With closer links to short stay paediatric units and emergency departments, to enable better co-ordination and to help prevent unnecessary hospital admissions
   - To be delivered via the Community Based Care model.

4. **Short stay paediatric units**
   - Designed to ensure that children and young people are returned to the community as quickly as possible and unnecessary hospital stays are avoided
   - With close links with the Children’s integrated community team

5. **Planned care pathways**
   - With referral advice and guidance tools
   - Specialist advice and support back into the community

6. **Supported transition to adult services**
   - As part of community based care, within the local care network

It is our intention that through this strategy we will meet the London quality standards. The above interventions aim to address this.
Executive Summary

Key Features of the model

Achieving the London Quality Standards in all areas:

- Acute medicine
- Emergency general surgery
- Emergency departments
- Critical care
- Fractured neck of femur

A Improving access in Primary Care, in hours and out of hours, to unscheduled care.

GPUs, UCC and ED functioning in a closely linked co-ordinated way; responsive community care, including specialist response teams, will prevent unnecessary hospital admissions with easy access to specialist advice for GPs as an alternative to ED referral

1. 8am – 8pm 7 days a week
2. Standalone Urgent Care Centres with the same standards
3. Community based rapid access teams including a home ward.

B Specialist advice and referral

4. Access to specialist advice
5. Access to a specialist response clinic

C Improved 111 capability and LAS onward referral

6. LAS will be able to redirect to appropriate services, such as the rapid access team, home ward or hospital based specialist clinics and excel in navigating patients to the right part of the system
7. 111 are able to give advice, provide internal triage and coordinate onward referral to other parts of the system other than the ED

D An enhanced single “front door” to the Emergency Department.

8. Bringing together UCCs and the ED in a single governance structure and providing expert streaming across all sites

E Emergency Department interface with Mental Health services

9. This will also allow for earlier identification of MH cases (including Dementia) reducing length of stay and enabling quicker streaming to specialities for mental health patients by having Psychiatric Liaison nurse (PLNs) and Triage joint assessments.
10. Quicker interface with specialist services like drug and alcohol
11. Quicker interface with under 18 mental health liaison teams
# Key Features of the model

## A Primary prevention: Best delivered in the Local Care Network Early detection
1. Increased screening rates to national benchmark through targeted engagement
2. Diagnostics: Pilot project – serious but unspecific symptoms pathway
3. Promotion of early diagnosis and equal access to treatment for older people
4. Professional development for all staff within Primary Care

## B Treatment
Provider collaboration to create networked centres of excellence:
5. Non complex cancer treatments and support closer to home
6. Access to appropriate information and support for patients and carers
7. Acute Oncology Services – networked and supported by integrated IT
8. Consistently meet the access time scales on our cancer services
9. Routine use of the recovery package

## C Living with and Beyond Cancer
10. Stratified follow-up
11. Support for people living with the adverse consequences of cancer treatments
12. Comprehensive support for carers
13. Psychological support for people living with Cancer
14. Inclusion of Cancer as a criteria for referral to exercise/physical activity on prescription schemes
15. Support to return to work, study or volunteering
16. Routine use of the recovery package

## D End of Life: Best Delivered in the Local Care Network
17. Ensure a dignified death irrespective of setting
18. Ensure consistent use of coordinate my care
19. Advance Care planning

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**Diagram:**
- **Strong Confident Communities**
- **Local Care Network**
- **Treatment**
- **Early detection**
- **Living with & Beyond Cancer**
- **End of Life**
Approach to identifying the outcomes the strategy aims to achieve

- The primary aim of delivering the Our Healthier South East London strategy and vision is to develop ways to improve the health and care outcomes for south east London communities and people. A framework which sets out measures to monitor the impact of the strategy and interventions on outcomes has been developed through engaging with our partners across health and care providers, Public Health, clinicians and public and patients. This framework sets out the measures that demonstrate the effectiveness of the strategy in achieving the outcomes allowing us to quantify the strategy’s impact.

Focusing on the achievement of outcomes

- By implementing the strategy and its care models the aim is to reduce the variability in outcomes we see today as outlined in the case for change and to improve the overall health and care outcomes for people across south east London.

Structure of the framework

- The framework is made up of the following core elements:
  - Domains: The high-level grouping or classification of outcomes that are measuring similar things. There are a number of existing outcome frameworks which were reviewed and based on those frameworks, four ‘domains’ that are common across them were selected.
  - Outcomes: The overall impact of the strategy on the health and well-being of our populations and individuals in south east London
  - Indicators: The measures selected to demonstrate the achievement of the outcome. These are as outcome focused as possible but in some cases a process/structure measure has been used as a proxy.

Eight outcomes have been identified

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

Indicators

- There are a number of indicators that have been identified and these are still undergoing review from stakeholders and Public Health
The NHS faces a growing affordability challenge

- NHS funding currently increases in line with inflation each year. However, the costs of providing care are rising much faster because the NHS is now treating more people with more complex conditions than ever before and the costs of care often grow faster than consumer inflation.

- The NHS Five Year Forward View outlines a £30 billion financial challenge nationally by 2020/21. Consistent with this, in the absence of action, the scale of the affordability challenge in south east London is forecast to grow to over £1 billion by 2019/20. The graph to the right and the table below demonstrate how this challenge grows over this period.

- Local authorities, who are responsible for social care services, are also looking to save over 30% of their current expenditure over the next 3-4 years. Therefore we need to get better value for money for all that is done in the NHS and social care services. We need to get the best possible outcomes for patients and make the most of resources that are under increasing pressure. This means we need a more integrated approach between different services.

### Absolute challenge

Over the period from 2014/15 to 2019/20, the south east London expenditure (without efficiencies) will grow by just over £1 billion more than the projected budget of £5 billion. This is comparable with the £30 billion national challenge set out in NHS England’s Five Year Forward View.

### Annual challenge

On average, the south east London healthcare system will need to make efficiencies of £218m each year (from a budget which will grow to £4.8bn) between 2014/15 and 2019/20.

An estimated breakdown is shown below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings (£m)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/15</td>
<td>251</td>
<td>6.0%</td>
</tr>
<tr>
<td>15/16</td>
<td>228</td>
<td>5.3%</td>
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<tr>
<td>16/17</td>
<td>154</td>
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<td>17/18</td>
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<tr>
<td>18/19</td>
<td>141</td>
<td>3.0%</td>
</tr>
<tr>
<td>19/20</td>
<td>156</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

### Percentage challenge

On average, the south east London healthcare system will need to make efficiencies of 4.2% each year between 2014/15 and 2019/20.

An estimated annual breakdown is shown below.
Closing the affordability challenge

- The graphs on this page demonstrate how the benefits from the programme can be combined with savings within individual organisations to close a substantial amount of the £1.1 billion affordability challenge. The benefits shown are as follows:

1. **Programme central case (gross benefit):** As described previously.
2. **Provider efficiencies at 2.5%:** The provider finance leads feel that a 2.5% CIP may be reasonable in addition to efficiencies generated through the programme.

- It is important to note that both of these savings are presented **gross of investment requirements** (which total £90 million in the programme central case). It is expected that these investment requirements will, at least in part, be satisfied through additional funding requested through the Five Year Forward View and committed by the Government. Taking south east London’s proportionate share of the £8 billion committed would imply that £248 million is available for this purpose.

- The resultant position is a £266 million affordability challenge for the South East London health care economy.

NB: Profiling of benefits shown above may significantly change as implementation plans are developed.

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Using historical NHS bed occupancy data for the acute providers and our projections of bed demand considering demographic/non-demographic growth assumptions we have estimated the bed gaps/increases show in the table below.

- We have modelled the impact of the strategy on overnight bed days to be a net reduction of 140,000 and a net increase in day case bed days of 25,000. This translates directly to a number of beds using various occupancy rates as shown in the table below.

### Initial estimate of acute bed requirement

<table>
<thead>
<tr>
<th></th>
<th>Baseline bed days/beds</th>
<th>Strategic impacts bed days/beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>Growth (2019/20)***</td>
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<tr>
<td></td>
<td></td>
<td>Gross change (2019/20)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Net change (2019/20)</td>
</tr>
<tr>
<td>Overnight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overnight bed days</td>
<td>1,178,000</td>
<td>198,000</td>
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<td></td>
<td></td>
<td>(339,000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(140,000)</td>
</tr>
<tr>
<td>Overnight beds (current occupancy rates*)</td>
<td>3,571</td>
<td>601</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1,015)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(414)</td>
</tr>
<tr>
<td>Overnight beds (85% occupancy rates)</td>
<td>3,571</td>
<td>861</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1,092)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(231)</td>
</tr>
<tr>
<td>Day case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day case bed days</td>
<td>181,000</td>
<td>30,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5,000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25,000</td>
</tr>
<tr>
<td>Day case beds (current occupancy rates*)</td>
<td>595</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(15)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>84</td>
</tr>
<tr>
<td>Day case beds (68% occupancy rates)</td>
<td>595</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(19)</td>
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<td></td>
<td></td>
<td>235</td>
</tr>
<tr>
<td>Total</td>
<td>1,359,000</td>
<td>228,000</td>
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<tr>
<td></td>
<td></td>
<td>(343,000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(115,000)</td>
</tr>
<tr>
<td>Total beds (current occupancy rates*)</td>
<td>4,166</td>
<td>700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1,030)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(330)</td>
</tr>
<tr>
<td>Total beds (revised occupancy rates****)</td>
<td>4,166</td>
<td>1,115</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1,111)</td>
</tr>
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<td>4</td>
</tr>
</tbody>
</table>


** These figures have been fixed at current occupancy levels and 2013/14 activity.

*** These figures relate to a level of increased demand as shown above and an additional number of beds due to requiring lower occupancy levels.

**** The total revised occupancy rates are blended across the inpatient overnight bed and day case bed rates shown earlier in the table.
Summary of where we have reached in developing the strategy

The aims of the consolidated strategy are to make a difference to the health and well-being outcomes of the people and communities in south east London and to create a sustainable health and care system as a foundation for the future.

To date, the consolidated strategy brings together the case for change, the care models and their anticipated impacts on outcomes for the people and communities in south east London. This is combined with an assessment of the potential impact these models may have on how people use services and the extent to which it will support the future financial sustainability of the system.

Taking into consideration growth assumptions over the next 5 years, and not changing our clinical models of care would mean that too many people would continue to be admitted to hospital where better Community Based Care models could provide improved outcomes. We have calculated the increase in bed capacity that would be needed across south east London to respond to the rise in population and aging population using our current approaches to delivering care. The projected demand would increase so much that the number of beds needed would be enough to fill a new hospital site and this is not possible or affordable. Applying the initial impact of the strategy's care models work on the projected demand levels for hospital beds, shows that by implementing the care models in the strategy, we would reduce the need for additional hospital beds by providing an alternative high quality model of care that is focussed on improved outcomes for the population we serve.

This is because,

- The care models are focused on prevention and early intervention and keeping people healthy. Therefore keeping people out of hospital
- Community Based Care is the foundation of the whole system and is intended to keep people closer to home, treating them in the community and enabling people to only visit hospital when they really need to

- Pathways and professionals will be more integrated
- Productivity is expected to increase and there will be greater efficiency in the south east London system
- The plan will be for bed occupancy to meet the national guidance (which is not the case now) which will improve safety, quality and efficiency

Recent programme updates include;

- The whole system affordability gap has been defined
- The Clinical Leadership Groups design guides are being finalised and potential impacts of the care models reviewed
- Supporting strategies of Estates, Workforce and IT continue to be developed

Whilst the strategy programme has progressed a long way to achieve its aim, there is still much work to do

Further work is required on

- Ensuring that progress and plans for the London Quality Standards are embedded into the strategy and exploring options on how they can be achieved
- Further developing the supporting strategies of Workforce, IM&T and Estates
- Refining the indicators for the Outcomes to make sure the best possible ones have been selected so we can measure the benefits or not of the strategy
- Engagement on the options appraisal methodology
- Ongoing communications and engagement
How will we deliver the strategy?

Part of the Clinical Leadership Groups work is to develop the plans to deliver the care models. In addition, three supporting strategies are being developed to support the overall delivery of the care models and changes at a whole system level.

The three supporting strategies are

- **Infrastructure & Estates**
- **Workforce**
- **Information Management and Technology**

**Infrastructure & Estates**

- The Estates Supporting Strategy is an essential element of the strategy programme to support the delivery of our new models of care in a way which ensures they deliver the outcomes we aim to achieve. We must understand the capacity of our capital assets, estates and facilities across south east London to utilise, reduce or develop these in the most appropriate way to meet the needs of our population.

- There is a clear synergy between the south east London need to reconsider estates and the national and London wide direction of travel. ‘The five year forward view sets out an integrated agenda and new care models over the next five years. In addition, Better Health for London outlines the evidence base for re-evaluating the utilisation and value of NHS estate in London.’ (The Healthy London Partnership Estates Programme). Therefore, our Estates Supporting Strategy has made clear links with the work being delivered at a London wide level by the ‘Our Healthy London Partnership - Estates Programme’ being led by London CCGs and NHS England.

- The Estates Supporting Strategy aims to address specific requirements that provide additional support to facilitate delivery of the strategy, building upon London wide programme delivery where the time scales allow. The estates strategy will be built into the delivery programmes for all models of care as appropriate and financial impacts further detailed within the Financial modelling. The three stages of the Estates Supporting Strategy is as follows:
  - Understanding the baseline
  - Understanding the requirement
  - Addressing the gap
Workforce

- Better Health for London, the Five Year Forward View and Our Healthier South East London have all identified the need to focus on developing a modern workforce in order to support the delivery of innovative new models of care. Workforce is therefore a key enabler of the Our Healthier South East London strategy.

- The supporting strategy is identifying the key actions that should take place in order to move the workforce in south east London from where it is today to where it needs to be in the future. For instance, we know that the future care delivery will involve empowering patients and promoting independence; making every contact count; and fostering an environment where colleagues engage with each other rather than refer and hand-over.

- With these significant changes on the horizon, understanding what patients will require in the future and challenging existing ways of working will allow us to plan for a workforce that is fit for purpose and sustainable.

- The workforce supporting strategy will need to clearly articulate how the workforce is going to deliver what south east London needs. This will include new ways of working (i.e. flexibility, rotations, different staff groups doing different tasks to today, team work and collaboration) and different working locations (i.e. more staff working in the community as opposed to acute settings).

- For this purpose the programme has so far established:
  - A baseline of the current workforce
  - A methodology to define characteristics of the required new workforce

- These will support the next steps which will take the workforce where it needs to be in the future. These steps include:
  - Articulating the workforce strategy
  - Reaching out to the workforce
Information Management & Technology

- Information and IT will be a key enabler for the strategy. Specifically, it can support staff in new ways of working and empower patients to be active participants in their care.
- Key considerations for understanding the IM&T requirements to support the strategy and any gaps are:
  - National and London initiatives and policies: There are a number of National and local initiatives and policies that may support the implementation of the strategy.
  - CCG IM&T strategies: Each CCG has its own IM&T strategy and implementation plans, which have been reviewed and initial assessments made to determine support for the strategy.
  - Identifying uniformities at a south east London level so there are consistent ways of working. For example, adopting the same data quality standards, and staff identification processes for who should be viewing/editing data and design principles…
  - Gaps and any investment costs: Understanding where these are not currently accounted for in CCG and or provider plans, and are needed to implement the strategy.

A primary requirement to enable the strategy is for health and care systems across south east London to be interoperable

Why is interoperability Important?

Interoperability is important because it will enable south east London health information systems and professionals to work together within and across organizational boundaries in order to more effectively deliver healthcare to people and communities.

Key ways in which interoperability will support the delivery of the vision and care models in the consolidated strategy are:

Care Quality

- Improves the quality of patient care by providing access to complete, accurate, timely information in one location.
- Provides visibility into the "whole" patient by sharing basic medical information across a patient's care providers

Care Efficiency

- Saves time previously used to look for information, i.e. lab results, or repeat tests that have already been performed in another care setting

Patient Safety

- Makes life-saving information available 24-hours-a-day for clinical decision support
- Our findings so far indicate that primary key requirements of interoperability between GP systems and primary and secondary care are planned and/or being implemented at various speeds. All CCGs are moving to GP systems that will enable sharing of records across GP practises supporting Local Care Networks and will be interoperable with acute
- To various extents CCGs have plans in place to align with some of the key IT/Digital guidance in the 5YFP IT/Digital, London Transformation Programme, 2020 Personalised Health and Care and Implementing these guidelines would meet many of the strategy requirements.
- However, additional transformation initiatives that may require agreement and funding at a south east London level have not been explored or agreed at this stage.

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### There are risks to delivering the Strategy which are closely monitored and assessed for impact

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Risk</th>
<th>Impact</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>• Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in south east London</td>
<td>• Possible duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost</td>
<td>• IM&amp;T supporting strategy workstream established. • Utilising existing integration initiatives across SEL to support strategy</td>
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<tr>
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<tr>
<td>2. Workforce Capability</td>
<td>• Existing workforce skills or capability to deliver new models of care</td>
<td>• New models of care may not be implemented • Services may not be delivered safely • Patient satisfaction • Staff satisfaction issues • Quality and effectiveness of care</td>
<td>• Workforce supporting strategy workstream established • Work in hand to identify gaps between capabilities required to deliver new models of care and those available in current workforce • Key characteristics and skills being identified for training purposes</td>
</tr>
<tr>
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<tr>
<td>3. Delivery Timeframe</td>
<td>• It may be challenging to complete required activities and assurances in time to go to consultation, if required, in December, particularly as a result of needing to engage patients and service users in the process</td>
<td>• Delay to programme implementation for those elements which might require formal consultation or loss of support from partners and stakeholders for some or all of the strategy</td>
<td>• On-going dialogue with NHSE to agree assurance process and detailed communications and engagement plan to test critical path</td>
</tr>
<tr>
<td>4. Delivery Timeframe</td>
<td>• Insufficient time for good processes in terms of governance, decision making and ownership</td>
<td>• The strategy and associated documents are not owned by all stakeholders across SEL</td>
<td>• We will maintain four key activities: intensive engagement with partners and stakeholders; ensuring NHS England is engaged; careful mapping of governance and decision making; and meeting with NHSE by mid-June to review the approach</td>
</tr>
<tr>
<td>Title</td>
<td>Risk</td>
<td>Impact</td>
<td>Mitigations</td>
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</tr>
<tr>
<td>5. Clinical Leadership Group Impact Analysis</td>
<td>Modelling: Finance and Activity</td>
<td>The impact analysis does not fully close the identified affordability gap but does make significant progress towards doing so. It is not yet clear if this is sufficient</td>
<td>Explore and incorporate additional QIPP and CIP opportunities and continue to explore options with NHSE</td>
</tr>
<tr>
<td>6. Financial sustainability of health system</td>
<td>New service models do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand</td>
<td>Potential increased system costs through duplication of services • System may not be sustainable</td>
<td>Making sure there are clinical input into the design of care models and that they have sufficient impact on activity</td>
</tr>
<tr>
<td>7. Patient / Public Resistance to Change</td>
<td>If partners and stakeholders are not sufficiently engaged throughout the development of the five year strategy – or if the case for change is not sufficiently convincing - any proposed service change could be subject to significant local opposition</td>
<td>Further engagement required • Possible legal challenge • Delays to implementation of changes leading to increased cost and delay • Need to amend strategy in response to concerns</td>
<td>Engagement activities will be undertaken with a broad range of partners and stakeholders throughout the development and implementation of the strategy • Dedicated communications and engagement enabling workstream to coordinate these activities • Patient and Public voices in all key groups to help shape strategy • Strategy reflects input from partners and stakeholders</td>
</tr>
</tbody>
</table>
Delivering the strategy and next steps

- A number of interventions have been defined and agreed and now the strategy programme must start to consider how these will be implemented and delivered.

- For most interventions implementation planning can commence immediately. There are some interventions where care model delivery options need to be considered. These interventions will have to undergo a robust options appraisal process.

Implementation planning

- The development and implementation of the strategy has involved consideration of options for care model design from the outset.

- This is an iterative process which reviews the range of interventions to produce best outcomes for south east London.

- It considers ways to formulate the care models to produce these best outcomes based on a range of qualitative and quantitative evidence. Implementing some of the interventions will require consideration of care model delivery options and these will either be implemented at a local level or at a south east London level.

Options appraisal process

- This approach aims to identify the best way or way(s) of delivering the overarching strategy and realise its full benefits. It filters the many potential options for how the system can be implemented and is designed to identify options that are recommended for further work.

- It is proposed that the filtering of options will occur through two gateways of assessment against criteria; hurdle criteria and evaluation criteria (the diagram on the following page provides an overview of the methodology).

- The criteria against which the options will be assessed will be agreed before commencing the appraisal. Moreover, the likelihood of optimal implementation of options is increased by gathering wide ranging stakeholder contribution to the formation and specificity of criteria.

- Although some interventions do not in their own right require a detailed options appraisal (those that start implementation planning), the result of implementing those interventions could impact on the appraisal of other interventions because they will lead to shifts in settings of care and volumes of activity. As a result, it is important to consider the scope of a detailed options appraisal and how to account for whole system changes within the appraisal of individual interventions.
Options for appraisal methodology

**Case for Change**
- Finance and activity baseline
- Future demand and funding envelope
- Current health outcomes

**Agreed whole system outcomes**

**Agreed scale of affordability challenge**

**Proposed care models and interventions**

**Model the interventions**
Activity shifts identified through a triangulation process using benchmarking, academic evidence and clinical judgement

**CLG consideration of options for delivery leading to agreed care models and interventions**

**Split interventions by implementation or options appraisal**

**Define scope**

**Agree hurdle and evaluation criteria**

**Estate and service baseline**

**Apply hurdle criteria**

**Long List**

**Apply evaluation criteria**

**Short List**

**Evaluation Criteria**: These will be used to develop a short list of options. They will be used to assess the options in terms of impact and feasibility, helping to identify realistic options and those with potentially the best outcomes.

**Hurdle Criteria**: Tests that options either pass or fail. They provide a sense check of the full list of options, identifying options that are feasible.

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Draft in progress | 29
High level programme plan

• The high level plan on the next page shows at high level the next stages of the plan for implementation, option appraisal and consultation if required. It is ambitious and dependent on partners and key stakeholders continuing to engage with and support the work as it develops. Over the next few weeks, CCGs will be testing this with their governing bodies and membership and with key partners and stakeholders. There will be a formal stocktake in late July and the plan will be confirmed or amended. Further stocktakes will be scheduled as appropriate.

• The case for change is pressing and there is much that can be implemented at pace, but it is important to keep the high levels of engagement and support which we have had so far.
## High level programme plan

### Programme Plan

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
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</thead>
</table>

#### Phase 1
- Further refinement of the Whole System Model and the models of care, including testing with providers, partners and wider stakeholders
- Building greater detail into the care models so their impact can be modelled
- Modelling expected impacts for providers and commissioners
- Further development of the supporting strategies
- Clinical model implementation
- Workshops – CO discussion on commissioner models, Provider and CLG

#### Phase 2
- Identification of potential for significant service change.
- Create options appraisal methodology
- Develop options
- Appraise options
- Modelling to support option appraisal and decision making
- Short list of options
- Further support to implementation
- Continued work with partners to ensure ownership and wider engagement to test and develop

#### Phase 3
- Development of business cases. There will need to be agreement as to the business cases required and who will lead them (commissioners or providers).
- Modelling to support development review of business cases
- Decisions making processes for business cases
- Continued wide engagement
- Implementation and continuous quality improvement

#### Phase 4
- Any consultation, if required. Note: In the event that consultation is not required, and for any elements of implementation where consultation is not required, the timetable will be shortened, but for planning purposes this paper assumes that there will be some formal consultation, although the subject of such consultation has yet to be established.

#### Phase 5
- Conclusion of any consultation
- Further modelling if required
- Decision making
- Implementation
- Continuous quality improvement

### Key Activities

- Detailed implementation plan
- Presentation to NHSE
- Provider outline of steps required to operationalise the Whole System Model
- Development of the supporting strategies
- Equality Impact Assessment

- Modelling Impact Assessment
- Publish Equalities Impact Assessment and action plan
- Refinement of implementation plan
- Options analysis

- Refinement of detailed implementation plan
- Gateway review
- Business Case sign off
- Monitoring, evaluation, reporting and improvement frameworks established

- Conclusion of any consultation
- Further modelling if required
- Decision making
- Implementation
- Continuous quality improvement

### Key Outputs

- Detailed implementation plan
- Presentation to NHSE
- Provider outline of steps required to operationalise the Whole System Model
- Development of the supporting strategies
- Equality Impact Assessment

- Modelling Impact Assessment
- Publish Equalities Impact Assessment and action plan
- Refinement of implementation plan
- Options analysis

- Refinement of detailed implementation plan
- Gateway review
- Business Case sign off
- Monitoring, evaluation, reporting and improvement frameworks established

### Live implementation and continuous quality improvement

- Governance Groups
  - Continuous input throughout the process with regular meetings
- Comms & Engagement
  - Continued aligned plan to ensure the programme continues with a high level of engagement
- Finance & Modelling
  - Modelling to establish the baseline position, required investment and quantify benefits to be realised
- Supporting Strategies
  - Continue the commissioning framework, LCN, workforce, IM&T systems and estates configuration needed to realise the change

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