Our Healthier South East London
Sustainability and Transformation Partnership

NHS

Meeting: **Strategic Planning Group (SPG)**

Date: **Wednesday 9th May, 09:00 – 11:00**

Location: **Blackfriars Settlement, 1 Rushworth Street, London, SE1 0RB**

Chair: **Andrew Bland, STP Lead & Accountable Officer for Bexley, Bromley, Greenwich, Lewisham and Southwark CCGs**

MINUTES

In Attendance:

Andrew Bland (AB) - Chair	STP Lead & Accountable Officer for Bexley, Bromley, Greenwich, Lewisham and Southwark CCGs
Adrian McLachlan	NHS Lambeth CCG
Amanda Pritchard (AP)	Guy's and St' Thomas' NHS Foundation Trust
Anna Jones (AJ)	Healthwatch Greenwich
Helen Smith (HS)	Oxleas NHS Foundation Trust
Ian Smith (IS)	King's College Hospital NHS Foundation Trust
Jamie O'Hara (JOH)	London Ambulance Service NHS Trust
John King (JK)	Patient and Public Advisory Group
Jonty Heaversedge (JH)	NHS Southwark CCG
Julie Lowe (JL)	Our Healthier South East London
Kate Langford (KL)	Guy's and St' Thomas' NHS Foundation Trust
Kate Radcliffe (KR)	Our Healthier South East London
Krishna Subbarayan (KS)	NHS Greenwich CCG
Marc Rowland (MR)	NHS Lewisham CCG
Matthew Patrick (MP)	South London and Maudsley NHS Foundation Trust
Rebecca Rosen (RR)	Greenwich GP Federation
Tony Read (TR)	Our Healthier South East London

Apologies:

Ben Travis (BT)	Lewisham and Greenwich NHS Trust
Shelley Dolan (SD)	King's College Hospital NHS Foundation Trust
Therese Fletcher	Lambeth GP Federation
Gerrard Sammon (GS)	Dartford and Gravesham NHS Trust
Aileen Buckton (Abu)	Lewisham Council
Jade Ackers (JA)	NHS England Specialised Commissioning
Ellen Wright (EW)	NHS Greenwich CCG
Andrew Eyres (AE)	NHS Lambeth CCG
Danny Ruta (DR)	Lewisham Council
Rikki Garcia (RG)	Healthwatch Greenwich
Sid Deshmukh (SD)	NHS Bexley CCG
Andrew Parson (APa)	NHS Bromley CCG

LIST OF ACTIONS

ID	Risk / Issue / Action / Decision Description	Owner	Agreed Date	Due Date	Status	Comments
JAN18_2	Via Andrew Bland, Peter Gluckman will write to provider organisations about their representation in the Stakeholder Reference Group.	PG	26/01/2018	08/03/2018	In progress	Letter drafted for Provider Federation
MAY18_1	Circulate written answers to members of the public that submitted questions following the meeting	TW	09/05/2018	03/07/2018	Complete	
MAY18_2	TR to consider how to communicate percentages within future finance updates	TR	09/05/2018	03/07/2018	Open	
MAY18_3	TR to review how to link work going on across the partnership with financial targets	TR	09/05/2018	03/07/2018	Open	

1. **Welcome and introductions**
   The Chair opened the meeting, welcoming attendees and members of the public. Introductions from meeting attendees were made and apologies noted.

2. **Questions from the public**
   The Chair thanked members of the public for the questions that had been submitted to the SPG in advance of the meeting, advising that all of these would be provided with a written answer following the meeting.

   Action: Circulate written answers to members of the public that submitted questions following the meeting

   The questions and answers given were as follows:

   Question 1a - Gay Lee, Keep Our NHS Public Campaign
   In order to avoid too many patients choosing to be referred to the state-of the art facilities at GSTT - given the investment there by Johnson and Johnson - what steps are being taken to improve the quality, and if necessary the capacity, of the other elective orthopaedic network sites in order to provide genuine choice?

To answer the question AP referred to the establishment of the Orthopaedic network, which has been set up to allow the three acute hospital providers in South east London to work together towards the GiRFT aspirations. The overarching aim of the network was to ensure that patients have the same quality of care, experience, and outcomes, regardless of which hospital they choose to visit. The programme of work was expected to move at pace following the appointment of a network lead, as well as managerial support.

Question 1b - Gay Lee, Keep Our NHS Public Campaign
Conversely, given that capital has been provided by Johnson and Johnson to build the 8 new theatres at GSTT, how will you ensure that there will be sufficient patients chosing to go to GSTT for surgery, in order to generate sufficient income to repay Johnson and Johnson in what sounds like a PFI arrangement?

AP explained that the capacity development work at GSTT is based on future demand, which is predicted to increase in line with the aging population. Building extra capacity was said to take a number of years. Once built, the Trust hoped to be in a position to meet the expected needs of the population.

Question 1c - Gay Lee, Keep Our NHS Public Campaign
Might these financial pressures affect the decisions to be made in Aug 2019, when the elective orthopaedic services come up for review?

JH explained that the recommendation of a previous two-year review was to consolidate Orthopaedic services in South east London to help reduce variation in outcomes. With the support of the Clinical Senate, the partnership agreed to pursue the Orthopaedic network as an alternative option to consolidation. If in 2019, the network is unable to demonstrate that members of the public are having timely access to Orthopaedic care and positive outcomes, the partnership would need to reconsider the original recommendations.

Question 1d - Gay Lee, Keep Our NHS Public Campaign
We are concerned about the lack of information in the public domain about this GSTT Orthopaedic Centre. Given the importance of the Johnson and Johnson initiative to the future landscape of orthopaedic care, is there on-going work by the Clinical Senate and are there plans to revive the consultative group which apparently ceased to meet after 2016?

JL confirmed that the consultative group ceased to meet in 2016, because it was expected that the network would take the work programme forwards, with a focus on outcome measures. In response to the answers provided, Gay Lee asked about the conflict between estimating future demand and offering choice to patients in other parts of the network. The committee were asked if they were concerned about patients using the new service, to the detriment of services in other parts of London. AP responded by saying there was already choice across London. Patients were said to choose a particular service for multiple reasons, such as speed of access and proximity. Experience to date would suggest that patients will choose a local service, over a newer service that is less accessible to them. The aim of the network would be to ensure that the quality of services across providers was consistent, allowing patients to choose where they would like to go based on other factors, such as ease of access. JH

explained that the partnership wanted to continue to offer services in different areas in South east London, to ensure that patients can make a local choice. This would only be achieved through a collective endeavour, such as that of the network.

Question 2a - Jane Mandlik, Save Lewisham Hospital Campaign
This question relates to Agenda item: Paper C – SEL Finance Update and in particular to the figures for planned saving given in 2nd and 4th bullet points under Headlines 18/19 plans on page 3.

While recognising that the date of this meeting does not fit with the finalisation of the 17/18 accounts or the completion of submission of the 18/19 plans and therefore that it is expected that there will be some finessing of the figures given in this report.

The Kings Fund Report on STPs in London (2017) warned that savings of 3 – 4% in the provider sector are unlikely to be achieved and cautioned against overstating potential savings. The recently published Interim Darzi Report suggests that productivity growth above the long term trend of 0.8% can no longer be relied on.

Can you nevertheless explain the basis of your confidence that savings in the order of the very ambitious QIPP efficiencies of approximately 4% and provider savings averaging 4.4% can be achieved.

Question 2b - Jane Mandlik, Save Lewisham Hospital Campaign
Have savings of this magnitude been achieved in SEL since 2015? Even if that is the case it is likely that the growing demands on NHS budgets not least the "year long Winter" crisis and the relaxing of the 1% public sector pay cap will make securing such levels of savings more difficult in the future.

TR explained that the national planning guidance had been issued later than in previous years. All organisations were said to be drafting their accounts for 2017/18, which would be going to auditors in the coming weeks. The efficiency projections (4.4% for providers and 3.9% for CCGs) were in line with the previous year for providers, and approximately 1% higher for CCGs. All the plans had gone through individual organisational governance processes. The CCG target aligned with the expectation of 4% for CCGs set by NHS England (London region). On deliverability there was good alignment in terms of contracts between CCGs and providers and there had been a positive level of dialogue between both. In terms of winter difficulties, the cost of activity – towards the end of the planning process, NHS England announced additional funding for CCGs of around 0.8%. This was intended to help the system pay for additional activity and covered emergency and outpatient attendances.

In response to the question regarding the 1% pay cap, TR explained that pay was still being negotiated nationally between pay bodies and the NHS. The expectation of the partnership was that any pay award will be funded through NHSE to CCGs. Verbally this was understood to be the case, however confirmation was still needed.

Question 2c - Jane Mandlik, Save Lewisham Hospital Campaign
In addition I am requesting that campaigners be given:

i) *An update on the Credo Report and the subsequent bid submitted to NHSE*

AB explained that a wave two ACS application had been invited by NHSE, but the process was halted. The ACS programme has now been redeveloped as an integrated care programme. The partnership has a clear vision of what local integration looks like as presented at the last meeting. This takes into account the complex landscape and interplay of organisations in South east London.

ii) An update on the current status of the SEL STP position regarding the Capped Expenditure Process (CEP)

TR responded by saying that the CEP related to 2017/18 and does not apply for 2018/19. There is a collective control total for CCGs in line with a standard annual process undertaken every year.

iii) A copy of the latest structure chart of the STP Programme team and other charts that help explain the refreshed STP delivery programme.

A copy of the latest structure chart of was added to the OHSEL website in advance of the meeting.

Question 3 – Paul Brown, Patient and Public Advisory Group
Following the pre-submitted questions, Paul Brown explained that he had attended a recent CBC delivery group presentation on GP at scale. He asked the committee about some of the implications of the at scale programme and whether or not anything was being done to test the approach with patients.

JH highlighted the importance of looking at GP functions instead of organisational form. The GP at scale programme would enable practices to deliver some functions – that are hard to deliver in isolation - in collaboration with others (e.g. back office functions). The programme would require practices to have a collective voice in order to negotiate and develop services around their communities. In Southwark, there were said to be a number of different models of collaboration, such as mergers and federations. None had resulted in the closure of a practice. JH noted that it was becoming harder for members of the public to see their own GP. Part of the at scale programme would seek to alleviate this, by giving choice to patients that want to see their GP, and those that do not mind who they see. RR highlighted the importance of patient participation groups, and their role in engaging with practices to start a dialogue and feed into the development of the at scale programme. MR iterated this point, referencing his positive experience of bringing patient participation groups together in and outside of Lewisham.

3. Minutes from the last meeting 26 January 2018

3.1 The minutes of the last meeting held on 26th January 2018 were agreed as an accurate record.

3.2 All actions were reported to be closed with the exception of item JAN18_2 regarding organisation representation at the Stakeholder Reference Group, which was said to be in progress.

3.3 The Chair extended sincere thanks to colleagues who had left the partnership since the last meeting in January. Nick Moberly, former Chief Executive at King's College Hospital NHS Foundation Trust, and Tim Higginson, former Chief Executive at Lewisham and Greenwich NHS Trust, were both thanked for their contribution to the STP in recent

years. Ben Travis, the new Chief Executive at Lewisham and Greenwich NHS Trust, was welcomed, as was Helen Smith, who is acting as interim Chief Executive at Oxleas NHS Foundation Trust, until a substantive Chief Executive is recruited.

3.4 The Chair apologised for cancelling the Strategic Planning Group meeting scheduled for March, which was due to challenges with attendance.

4. STP programme update

4.1 Members received the spring partnership update and the highlight reports for each of the partnership's programmes. Financial sustainability would be covered under the next agenda item.

4.2 JL highlighted that the partnership continued to look at strategic options for ICS, at both borough and sub-borough level. Further discussion was needed around how to link boroughs with providers that work across boroughs, nationally and even internationally, particularly in the context of GP at scale. In spite of these complexities, the partnership was committed to the "system of systems" presented at the last meeting. This would allow patients to get the care they need at local level, with the option of tapping into the wider specialist system as required.

4.3 The Acute Based Care programme, currently in development, would review demand and capacity across both the clinical and provider productivity programmes, to ensure capacity is in the right place to meet the demand in the system.

4.4 KS requested that hyperlinks to anything in the public domain be included in the partnership update in future.

4.5 RR highlighted a piece of work being undertaken at Nuffield Health in relation to additional GP appointments and the need to balance those appointments with continuity of care. RR also raised the interface between NHS 111 and primary care and the fact that 111 will be better suited to cases of lower complexity. JH made reference to the Local Health Care Record, citing technology as an enabler for enhancing continuity of care and matching patients with the appropriate care.

4.6 MP agreed with the points raised, noting that a lack of continuity of care in mental health can result in patients presenting in crisis.

4.7 AB explained that the latest data shows GP appointments are being utilised more. Minor A&E attendances however are not going down. The partnership is hopeful that LCNs will support the delivery of the 5YFV targets, whilst ensuring patients are receiving the care they need. More broadly, this is about delivering both business as usual with transformation, a "wicked issue" affecting other parts of the system across London.

5. 2018/19 finances

5.1 TR gave an overview of the 2018/19 financial position across CCGs and providers, including the following highlights:

- Bexley CCG would be the only CCG to report a deficit, as agreed with regulators last year.
- KCH would be reporting to separate timetables to other providers, as also agreed with regulators.
- All CCGs were planning to deliver in year break even or surplus for 2018/19, the QIPP requirement of which was around 4%, as discussed earlier in the meeting.
- All providers had plans in place to meet their control totals in line with regulatory requirements, with the exception of Lewisham and Greenwich where a separate trajectory had been agreed.
- TR explained there was a strong case for reassessing the timescales within which the partnership would return to financial balance. A piece of work had already started

with respective Chief Financial Officers to develop a refreshed trajectory. This would likely be finalised in the coming months.

- JK asked if it would be possible to consider how percentages are communicated within future finance updates, to allow members of the public to have a better understanding. AB explained that GSTT and KCH were multi-billion pound organisations, to help give an indication of the scale being discussed. He agreed for a solution to be reviewed outside of the meeting.

Action: TR to consider how to communicate percentages within future finance updates

5.2 MP and AP iterated the size of the challenge in meeting the proposed CIP and QIPP targets at a provider level, highlighting the fact that what was achieved in 2017/18 required a significant amount of hard work from thousands of people within their organisations. AB agreed with the comments and emphasised the importance of working as a collective to ensure the targets are achieved. Attendees were also asked to note that the finances being described were a sub-set of the system and excluded Local Authorities, Specialised Commissioning and Primary Care.
5.3 JH suggested doing a "deep dive" into the approach taken by provider organisations in order to achieve previous targets. AB agreed more thought could be given to linking work going on across the partnership with financial targets. TR was asked to consider how best to develop this further outside of the meeting.

Action: TR to review how to link work going on across the partnership with financial targets

5.4 Members raised the importance of considering the underlying position as well as distinguishing between revenue and non-revenue, particularly in the context of developing refreshed trajectories. TR agreed to take this into account as part of this exercise.

6. STP 2018/19 priority planning

6.1 Attendees received the STP 2018/19 priority planning paper, which gave an overview of the key areas of focus across the partnership's Clinical Leadership Groups. JL provided an overview of the paper including the following highlights:

- The Mental Health work plan would look at a number of areas, including Out of Area Placements and building capacity in the workforce.
- The CYP programme was said to be in the final stages of agreeing priorities, having held a final workshop with stakeholders the previous week. Priorities were expected to include CAMHS and special educational needs and disabilities.
- In Cancer, whilst the 62 day target would continue to be a priority, more of a focus would be given to earlier diagnosis through screening and how to manage cancer as a long-term condition.

6.2 Meetings were expected to take place with the SROs / leads for each of the programmes in the coming weeks to agree outcome measures. This would help to address a point made by AM, which asked if any of the individual CLG priorities did not complement one another.

6.3 JK raised a point about inconsistency of age definitions for children across boroughs, and the impact it can have on access and quality of care. JK was informed that part of the specialist paediatric programme would be to look at how to improve this, with the potential for a set of criteria to be developed.

7. HEE Workforce Consultation

7.1 JL gave an overview of the HEE workforce consultation, which closed on 23rd March 2018. Workforce was said to be one of the biggest challenges in South east London. In addition to funding, staff availability was said to be a major concern, and something that extra funding would not necessarily resolve. In London, additional factors, such as cost of housing, were said to be having an impact. A higher proportion of staff were also said to be working flexibly, meaning more Whole Time Equivalent (WTE) staff were needed to make up the numbers. JL explained that specific workforce trajectories and plans had been developed for programmes such as Cancer and Mental Health. Further work was needed to think tactically about how to alleviate some of the pressures in the system. JL agreed to circulate the draft consultation document developed by HEE for information.

Action: Circulate draft HEE draft consultation document for information

7.2 JH flagged the importance of wellbeing in developing a workforce strategy, raising a concern that it is not a more central theme in the HEE consultation document. He made reference to a Organisational Development (OD) project undertaken in Southwark around sharing values and leadership. JH urged for this kind of initiative to be included in future work undertaken locally.

8. *Better Births* delivery plan

8.1 KL presented an update on the south east London maternity delivery plan, the final version of which was submitted to NHS England in January 2018. KR explained that the plan was developed in response to a major review of maternity services announced in the NHS 5YFV, and subsequent report entitled “Better Births: Improving outcomes of maternity services in England”.

The Better Births report required Local Maternity Systems (LMS) to be developed coterminously with STP footprints, and for these systems to produce a delivery plan for the recommendations in the report. The south east London delivery plan was therefore developed with the newly established LMS, which evolved from an existing south east London maternity network.

8.2 The delivery plan was said to be a national exemplar, owing to strong partnership working with local maternity voice partnerships.

8.3 The contents of the delivery plan was said to follow the areas mandated by the Better Births programme, including: co-production, public health, continuity of carer, choice and personalisation, perinatal mental health, serious incidents, newborn care, achieving the ‘halve it’ ambition, postnatal care, digital, and finance.

8.4 KR gave an overview of the key outcomes as per the below:

1. Reducing stillbirth rates
2. Improved preventative care / support
3. Increase in unassisted deliveries
4. All vulnerable women receiving continuity of carer - with 20% of women in receipt of continuity of care by 2019

5. Improved experience of maternity services (CCG Improvement and Assessment Framework indicators)
6. Working with Neonatal Operational Delivery Networks to improve neonatal outcomes by: a) reducing admissions of full term babies into neonatal units and b) decreasing % <27 week babies not delivered in a unit with level 3 NICU
7. Increasing consultant obstetrician presence on labour wards to give consistency between units
8. Increasing out of obstetric unit births
9. Increasing early bookings

8.5 The stillbirth reduction outcome was said to be developed in line with a national ambition to reduce stillbirths across the country. KR explained that parity of stillbirth rates would be achieved by sharing good practice and reducing variation across all areas.

8.6 To achieve continuity of carer, the LMS would initially focus on increasing the number of vulnerable women looked after by small midwifery teams. The first task of this would be to establish which vulnerable groups are prioritised. KR iterated that continuity of care would include pre and postnatal care.

8.7 KR explained that equity of access and consistency of service quality would be the key to achieving the objectives outlined within the delivery plan.

8.8 Digital developments would include joining up patient care records across different providers and a postnatal postcode tool. In response to a questions from the group, KR explained that care record sharing and a wider link into the Local Care Record – which primary care has access to – was in progress. More challenging however was the introduction of Badgernet and linkage into the Cerner patient information portal.

8.9 KR highlighted a number of challenges to the programme including:

- Smoking reduction - an additional target area not previously within the remit of the LMS. The approach for this would again seek to work with partner organisations to share and implement best practice examples across the footprint.
- Housing – a pan-London issue impacting the ability of midwives to live in south east London, thus impacting the deliverability of continuity of carer. A solution to this had not yet been developed and would require further consideration.

8.10 In response to a question from AM, KR highlighted opportunities for learning from other systems at the pan-London Transformation Group. KR also referenced the importance of wider health determinants, before women enter pregnancy, such as weight and smoking, as well as women with known mental health issues. Booking early appointments or the use of pre-pregnancy counselling were cited as examples of responding to such determinants pro-actively.

8.11 KS flagged a study which highlighted the difference in outcomes for women from an African background, asking for it to be considered in the overall approach.

8.12 In response to a question from HS, KR explained that the Perinatal Mental Health Network had been involved in the development of the plan and that there was an awareness of a wider cohort of patients with mental health support needs, in addition to perinatal. KR explained that there was strong evidence to suggest the continuity of carer approach would improve outcomes for patients with broader mental health needs.

8.13 JH informed the group that feedback from his patients suggested continuity of care from a team perspective was the most important factor in them having a positive experience. Continuity of care from an individual carer would potentially be more challenging to achieve. JH agreed with the approach proposed for vulnerable patients and identifying those most at risk.

8.14 In response to a question on increasing the percentage of under 27 week babies delivered in a unit with level 3 NICU, KR explained that a piece of work was needed to change the approach taken historically within obstetric units. More ownership was needed, particularly for patients visiting south east London from another boroughs.

9. Any other business

No items of any other business were declared. The Chair thanked everyone for attending and closed the meeting.

Abbreviations used

A&E	Accident & Emergency
CAMHS	Child and adolescent mental health services
CBC	Community Based Care
CCG	Clinical Commissioning Group
CEP	Capped Expenditure Process
CIP	Cost Improvement Programme
CLG	Clinical Leadership Group
CYP	Children and Young People
GiRFT	Getting It Right First Time
GP	General Practitioner
GSTT	Guy's and St Thomas' NHS Foundation Trust
HEE	Health Education England
ICS	Integrated Care System
KCH	King's College Hospital NHS Foundation Trust
LCN	Local Care Network
LCR	Local Care Record
LMS	Local Maternity System
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICU	Neonatal intensive care unit
OD	Organisational Development
OHSEL	Our Healthier South East London
PFI	Private Finance Initiative
QIPP	Quality, Innovation, Productivity and Prevention
SPG	Strategic Planning Group
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Partnership
WTE	Whole Time Equivalent
5YFV	Five Year Forward View