

**22 May 2019**

**Agenda Item: 5**

**PAPER:** Objectives and Deliverables for OHSEL Clinical Leadership Groups

**Programme SRO:** Julie Lowe

**Report Author:** Vicky Scott

**Presenter:** Vicky Scott

**Summary:**

Project Initiation Documents (PIDs) have been prepared by OHSEL STP Programme Managers setting out the current objective and deliverables for each of OHSEL's Clinical Leadership Group (CLG) workstreams. Development of the PIDs was supported by an analysis of new, changed and existing expectations in the Long Term Plan in relation to our CLG workstreams. The PIDs will form the basis of a refreshed reporting process to the OHSEL Board and will support the development of our OHSEL response to the NHS Long Term Plan which is due in the autumn

**Background:**

At the March meeting of the OHSEL Board we described the process underway to develop a Project Initiation Document (PID) for each of our OHSEL STP Clinical Leadership Group (CLG) workstreams.

OHSEL STP Clinical Programme Managers have prepared a PID for each CLG designed to form the basis of a refreshed reporting process to the OHSEL Board. Each PID includes objectives, deliverables, resources, milestones, dependencies and benefits and have been signed off by the Senior Responsible Officer (SRO) and the clinical lead for each CLG. The PIDs have also been considered by OHSEL's Clinical Programme Board.

In developing these PIDs the Clinical Programme Managers have identified existing, new or changed commitments described in the Long Term Plan (LTP) in respect of each of the CLGs.



This work has formed the basis for a refresh of our CLGs and will feed in to the Integrated Care System (ICS) development plan and our SEL LTP response due in the autumn.

The CLGs are:

- Community Based Care (CBC)
- Prevention
- Mental Health \*
- Children and Young People \*
- Maternity \*
- Planned Care (Orthopaedics) \*
- Urgent & Emergency Care \*
- Cancer

The OHSEL Clinical Programme Board considered and commented on the draft PIDs in light of the direction of travel set out in the LTP and clinical priorities that are being discussed at the London level.

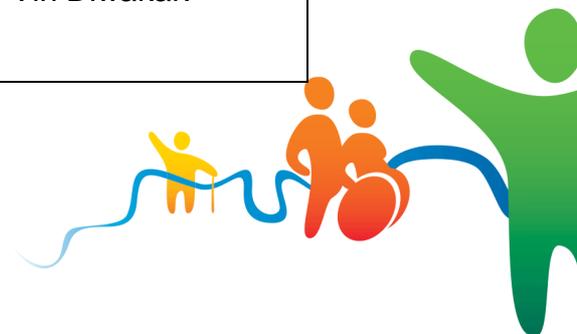
The PID objectives for those CLGs indicated with an \* are summarised in the appendix to this report. The main points raised at the Clinical Programme Board are also highlighted in the appendix.

There is no PID summary for the CBC workstream included with this report as priorities and deliverables for the CBC workstream are currently focused on planning for the establishment of PCNs in SEL. Further work will need to be done on identifying actions on early intervention and the Long Term Conditions agenda which form a key element of the CBC workstream. Similarly as we do not have a separate established Prevention CLG no PID has been prepared on Prevention.

Finally the Cancer Alliance agreed a refresh of its plans at its March Board meeting in response to 19/20 cancer planning guidance so that refreshed plan has already been agreed and is therefore not included here.

### **London priorities**

Work has also been underway since July 2018 on developing a vision for London on behalf of the London Strategic Partnership Board. This emerged from a progress review against the ten Better Health for London (BHfL) aspirations. The Partnership Board requested that a renewed health and care vision for London is developed which would build on the progress made in implementing Better Health for London. This work is being led by the new regional NHS Director for London Sir David Sloman and Dr Vin Diwakar.



A six month engagement and development period in respect of the work on the London vision is proposed. Dr Diwakar came to the May meeting of the Clinical Programme Board and described the London Vision as representing the small number of significant things that councils, the Mayor, the NHS and PHE will work on together at a London level to ensure that London is “the healthiest global city now, for all, for future generations”.

The vision will link with the “life stages” framework set out in the Long Term Plan which will support Londoners to “start well, live well and age well”.

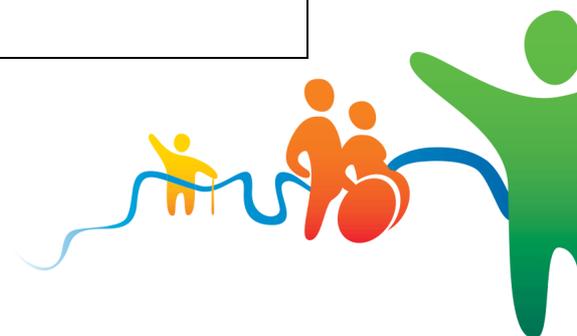
### **Current status of the PIDs**

The PIDs reflect progress in a number of areas, for example

- Children & Young People – improved performance against the CAMHS Access standard and a renewed focus on better management of long term conditions in the community to reduce the need for CYP to access urgent care
- Mental Health - success in securing a second wave of the individual placement support service (to support those with mental health issues into work)
- Orthopaedics – reductions in length of stay for patients treated in SEL
- Maternity – rolling out a resource to support stop smoking work with pregnant women and the development of continuity of carer teams in sites where previously these did not exist
- UEC – the development and implementation of the new NHS 111 Integrated Urgent Care Service which is now in its last phase of mobilisation

The PIDs set out our current objectives and deliverables but can only be a snapshot in time and will evolve to reflect the implications of new or changed commitments in the LTP as more guidance becomes available at the regional or national level. We will also need to respond to the work that is being developed on the London vision.

In light of this we recognise that further work is needed to define the clinical outcomes that we expect our CLG workstreams to help deliver. We will be discussing this with each of the CLG clinical leads over the next two months and this will affect the content of the PIDs.



**Action Required**

OHSEL Board is asked to:

1. Approve the current objectives for the CLG workstreams as set out in the attached Appendix
2. To note that there will be further work on the clinical outcomes for each of the CLG workstreams to align with work on developing the London vision
3. To note that the expected guidance on the LTP may affect the content of the current CLG PIDs

**Date Report submitted: 14 May 2019**

**Vicky Scott**  
**Chief Operating Officer**  
**SEL STP**  
**May 2019**



## APPENDIX

### Mental Health Project Initiation Document - Summary

#### Clinical Programme Board comments

- The CLG should consider what other objectives should be set in respect of dementia in addition to the diagnosis rate
- Transition for CYP needs to be considered a responsibility of the MH CLG and not just the CYP CLG
- The CLG needs to consider how its work programmes link up with/influence/support initiatives at Borough level for example the Living Well Alliance in Lambeth
- The PID needs to acknowledge the work of the South London Partnership

#### Objectives Overview

In SEL, our ambition is to ensure that those with mental health needs are cared for and treated in the same way, with the same aspirations for high quality, as those who require care for their physical health needs.

Underpinning our ambition is a focus on equality. We are committed to ensuring that mental health services in SEL are delivered in an integrated way, close to where people live, and that all SEL communities using our services have equal opportunity to achieve good mental health outcomes.

The STP mental health programme remit is primarily to deliver the transformational developments required to meet the national and regional standards as set out by the Five year forward view for mental health (MHFYFV) and Stepping Forward to 20/21 to meet our ambition.

This includes undertaking improvement support, and system coordination of local, regional and national priorities.

For 19/20, the national MH planning guidance states that achieving the MHFYFV standards is non-negotiable. In addition to this there is an expectation of transformational work to deliver improvements in core areas supported by the additional funding in mental health along with preparation of the STP response to the Long Term Plan.

In this context the MH programme overarching objectives for 19/20 to achieve the above are as follows

- Improve STP performance against MHFYFV deliverables (*See Detailed Objectives for MHFYFV standard objectives and deliverables*)

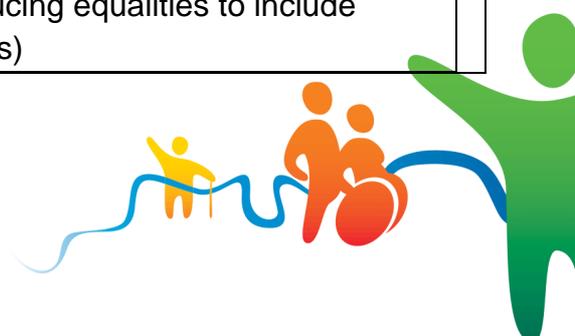


- Achieve the number of skilled MH workforce that is agreed in provider contracts and assured to deliver the activity required to meet the MHFYFV standards by March Q4 19/20.
- Provide funding to transform/ expand access to core existing and/or new services via successful bids for investment when national funding opportunities become available.
- Implement routine equality data collection and reporting processes to be able to understand the impact of local services on communities, e.g. what are the outcomes for people with protected characteristics, experiencing poverty and social deprivation?
- Increase the number of patient and public members in each of the STP MH steering and task and finish groups.
- Increase oversight of projects being undertaken to improve performance against MHFYFV performance at local CCG, STP and South London Partnership via a clear governance structure with robust monitoring, tracking and reporting processes (including the management of risk of delivery with appropriate escalation processes) in place for 19/20.

The programme timeframe for delivery of the following objectives is 2019- 2020, with some aspects relating to the LTP spanning into 20-21 financial year. Success of the programme will be measured by performance against the MHFYFV standards as listed below.

Detailed objectives

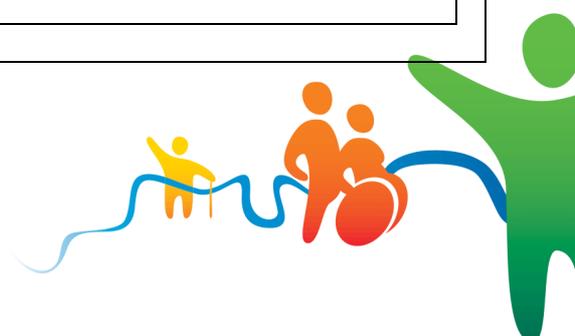
MHFYFV Standards/deliverables	Programme Objectives – 19/20
<p><b>IAPT</b> (including digital IAPT)</p> <ul style="list-style-type: none"> <li>• STP achieve 22% access rate, 50% recovery rate, and 95% 6 &amp; 18 week wait rates by Q4 March 2020.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the number of patients with Long Term Conditions accessing IAPT services for therapeutic intervention from 18/19 baseline (all CCGs to provide contract variation for growth)</li> <li>• Reduced unwarranted variation in access and recovery performance when benchmarked internally (SEL CCGs) and regionally (London CCGs) by Q4.</li> <li>• Increase the number of IAPT staff co located in primary care. (linked to workforce)</li> <li>• Increased number of therapists working in IAPT (linked to workforce)</li> <li>• Implement standardised process for reporting of equalities data for older adults and BAME. (pending STP framework for reducing equalities to include protected characteristics)</li> </ul>



	<ul style="list-style-type: none"> <li>Increase utilisation of existing IAPT digital services to agreed efficiency levels to align with service license contract</li> </ul>
<p><b>Physical Health Checks (PHC)</b></p> <ul style="list-style-type: none"> <li>STP boroughs to achieve 60% performance in PHC of their SMI registered population (incl 10% from secondary care)</li> </ul>	<ul style="list-style-type: none"> <li>Hold scheduled engagement with primary and secondary care colleagues via SEL physical health check strategy group.</li> <li>Roll out standardised process (incentive driven aligned to national contracts) for delivering improved PHC performance.</li> <li>Reduce the gap (Baseline Q3 18/19) for all 6 CCGs to achieve a green rating status by Q2</li> <li>Achieve a green performance rating by Q4.</li> </ul>
<p><b>Out of Area Placements (OAPs)</b></p> <ul style="list-style-type: none"> <li>STP to achieve zero out of areas placements (acute placements) by Q4 20/21</li> </ul>	<ul style="list-style-type: none"> <li>Continued reduction in OAPs.</li> <li>Female PICU provision for BBG/Oxleas patients agreed and not counted in OAPS targets.</li> <li>To agree protocols at national level which enables care placements which cross internal SEL borough geographical boundaries to be recorded as in area.</li> </ul>
<p><b>Psychiatric liaison (core 24)</b></p> <ul style="list-style-type: none"> <li>40% of Psychiatric liaison services to meet core 24 standards by 19/20</li> <li>All age psychiatric liaison services in 100% of acute hospitals 19/20</li> </ul>	<ul style="list-style-type: none"> <li>All acute hospitals to have developed plans to provide all age psychiatric liaison plans</li> </ul>
<p><b>Crisis pathways (CMHT &amp; COMPACT)</b></p> <ul style="list-style-type: none"> <li>Access to 24/7 mental health support in the community.</li> <li>Waiting time targets (compact) for emergency mental health services will be in effect by 2020</li> </ul>	<ul style="list-style-type: none"> <li>24/7 crisis access in the community (CRHTT) across BBG (Oxleas) and LSL (SLAM)</li> <li>Home Treatment Team provision across SEL to provide assessment and intensive home treatment as an alternative to admission when measured against UCL fidelity scale (2017) by Q4</li> <li>Plan for implementation of COMPACT</li> </ul>
<p><b>Workforce</b> Continue with workforce expansion including training</p>	<ul style="list-style-type: none"> <li>Hold SEL MH workforce event in Q1</li> <li>Implement collaborative working across the STP to develop response to the LTP MH workforce targets.</li> </ul>



and retention to meet existing demand	<ul style="list-style-type: none"> <li>Improved robust governance for the MH task &amp; finish group with revised TOR, Membership and project plan.</li> <li>Engage with non-NHS providers to include contribution to MH workforce plan</li> </ul>
<b>Suicide Prevention</b> <ul style="list-style-type: none"> <li>10% reduction in suicides across all SEL boroughs by 20/21</li> </ul>	<ul style="list-style-type: none"> <li>Zero suicide approach implemented in SEL MH Trusts in line with Trust plans.</li> <li>Improved robust governance and programme support for STP Mental health Public health (MHPH) group and coordination of borough and Trust reduction in suicide strategy to achieve 10% target.</li> </ul>
<b>Individual Placement Support (IPS)</b> <ul style="list-style-type: none"> <li>Achieve a 50% increase in IPS access</li> </ul>	<ul style="list-style-type: none"> <li>Launch of new IPS services in Bexley by Q2; Lambeth, Lewisham and Southwark by Q3.</li> <li>Set up a SEL IPS network group with representatives from IPS service providers.</li> <li>Develop a forum within the IPS network to link with non IPS employment support providers such as DWP and recovery colleges.</li> </ul>
<b>Perinatal</b> <ul style="list-style-type: none"> <li>Improved pathways to see more women accessing specialist community perinatal services</li> </ul>	<ul style="list-style-type: none"> <li>Develop perinatal pathways for women to receive therapeutic intervention via IAPT services. (linked to IAPT - LSL/SLAM &amp; BBG/Oxleas specialist perinatal community services)</li> </ul>
<b>EIP</b> <ul style="list-style-type: none"> <li>Achieve 56% access for part 1 of the national standard.</li> <li>All EIP services to achieve the 2<sup>nd</sup> part of the national standard by achieving Level 3 performance by March 2020</li> </ul>	TBC
<b>Dementia</b> <ul style="list-style-type: none"> <li>Achieve a Dementia diagnosis rate for 66.7%</li> </ul>	TBC



## Children & Young People Project Initiation Document – Summary

**Clinical Programme Board comments - none**

### Objectives Overview

The priorities for the programme were established in 2018/19 and include children and young people's (CYP):

- mental health and wellbeing
- urgent and emergency care and long-term conditions
- Special Educational Needs and Disability (SEND) and Autism

If successful we will see better physical and emotional support for families, more joined-up health and care services, easy access to the right services first time, shorter inpatient stays in hospital, straightforward transition into adult services for young people with long-term conditions and fewer emergency admissions.

As our five-year strategic plan develops, we anticipate an ongoing focus on these priority areas given the strong emphasis on each in the NHS Long Term Plan. The development of a national CYP transformation programme will also impact on our priorities and the structures within which we govern the programme.

### Detailed objectives

#### **1. Mental health**

- Drive forward initiatives to achieve the CAMHS access standard
- Support extension of current service models with adult services to create a comprehensive offer for 0-25 year olds that delivers an integrated approach across health, social care, education and the voluntary sector
- Agree a South East London (SEL) minimum offer for CYP and families to access age-appropriate and consistent mental health care and support in their community
- Support a SEL network for innovation and collaboration across SEL to improve work with schools, early intervention and self-care e.g. use of digital and workforce planning and development
- CYP prevention strategy for SEL including links to early help, public health, youth and education services and develop leadership to take forward
- Develop and expand the SEL mental health crisis pathway to provide 24/7 services with a CYP specific workforce



- Support work to ensure eating disorder services can meet demand and effectively use the extra investment to achieve the 95% standard beyond 2020/21
- Develop a Social Prescribing model for CYP by working closely with primary care
- Use of evidenced-based conceptual model to inform and organise the system
- Evaluate the SEL wide online counselling service Kooth provided by Xenzone.

## **2. Urgent and emergency care and long-term conditions**

- Agree a SEL minimum offer which delivers better care and outcomes for CYP e.g. Hospital at Home and a paediatric telephone consultation service for GPs
- Build awareness, capability and empowerment in staff, patients and communities to increase self-care including through workforce development to manage LTCs
- Strengthening connections and relationships between hospital, home and GP to provide better care e.g. building clinical leadership and ownership
- Communicate effectively to help children, families and wider stakeholders understand and have confidence in the community offer
- Support roll-out of clinical networks for LTCs such as epilepsy, diabetes and asthma and help build on the offer provided in primary care and the community e.g. pharmacy
- Use of digital for self-management and data sharing across partners including NHSGo, digital Health Passport for CYP and the electronic Personal Child Health Record.

## **3. Special Educational Needs and Disability and Autism**

- A standardised neuro-developmental pathway across South East London that includes:
  - Service user involvement at every stage
  - Single point of access to improve quality and consistency of referrals
  - Information and resources to help empower parents and CYP
  - Jointly developed support with health, social care, education and the voluntary sector which continues from 0-25 years old.

## **4. Additional commitments in the Long-Term Plan**

- The plan includes a package of measures for improving care, treatment and prevention of cancer in children e.g. from September 2019, vaccination of all boys aged 12 and 13 against HPV-related diseases, such as oral, throat and anal cancer
- Plans are set out for improving paediatric critical care and surgical services over the next five years so that children and young people can access these services. This includes using paediatric networks, which will involve hospitals, NHS staff and patients and their families, to coordinate the approach to critical care and surgical services.
- The plan stresses that the roll out of integrated care systems “will provide stronger foundations for working with local government and voluntary sector partners on the



broader agenda of prevention and health inequalities”. It sets out a number of commitments on preventative interventions, indicating an intention for the NHS to be more actively involved in public health services. Most notably, the plan states that “Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses”

**Maternity Project Initiation Document – Summary**

**Clinical Programme Board comments - none**

Objectives Overview

The south east London Better Births implementation plan was formulated in January 2017 in response to the National Maternity Review and subsequent publication of the National Better Births (2016) report. The SEL plan involved a wide range of stakeholders to ensure collaborative objectives were set.

Our ambition is for mothers, babies and their families in south east London to experience joined up, high quality care during and after their pregnancy. They should be supported to make choices that are right for them and be provided with safe care that supports a good outcome.

The NHSE maternity transformation regional team has asked for a refresh of all Maternity Local Implementation Plans for year 4 of the 5 year Better Births Programme and in light of the Long Term Plan. These refreshed plans are due to be submitted to the regional team in June.

Detailed objectives

Workstreams	Objectives	Deliverables
Continuity of Carer	All vulnerable women will receive CoCarer across the maternity pathway. To cover social, medical and obstetric factors	20% of women on continuity pathway by March 2019
		35% of women on continuity pathway by March 2020
		50% of women on continuity pathway by March 2021
		75% of BAME women on continuity pathway by 2024



Choice and Personalisation	That there is a range of providers offering a range of styles of care, whilst at the same time being safe and sustainable	100% of women to have the choice of 3 places of birth eg, home birth, midwifery led unit, obstetric unit by March 2021
		100% of women to have a Personalised Care Plan (PCP) by March 2021
		100% of women to have received a birth 'choice offer' by March 2021
Maternity Voices Partnership (MVP)	To ensure the voices of service users shape the work of the programme	For co-production and design to remain a high priority throughout all work stream. Eg pilot studies and focus groups for Choice and Personalisation
Halve It and Newborn	To achieve the government recommendations of halving the rates of stillbirth, neonatal death, maternal death, serious brain injury and reducing preterm birth	Reduce stillbirth, neonatal death, maternal death and serious neonatal brain injuries by 50% by 2025
		Reduce preterm birth from 8% to 6% by 2025
Public Health	To support the health of pregnant women and their babies	Reduce number of women smoking during pregnancy to 6% by the end of 2022 Reduce obesity in pregnancy Increase breastfeeding initiation and continuation rates Increase uptake of immunisation
Sharing and Learning from incidents	To ensure the safety of maternity services within the LMS and take effective targeted action to ensure there is a robust mechanism to share learning across the LMS in order to prevent and reduce recurrence of harm	To share experiences and knowledge across the sector to reduce harm
Digital	To optimise digital interoperability between the LMS trusts and MSDS reporting to support safe and effective care for pregnant women	Interoperability between Trusts with the LMS
		MSDS reporting



Workforce *	TBC	Establish maternity workforce skill mix including utilisation of non-registered staff
Postnatal Care *	To improve postnatal care across the sector – awaiting NHSE deliverables	To improve postnatal care and education for women and babies To improve timely referral of women to appropriate specialist services dependant on need (mental health services, pelvic health services, infant feeding services)
Preconception Care *	TBC	Formulation of co- production plan with primary care services around pregnancy planning and optimisation of health before becoming pregnant
Maternal Medicines Network *	TBC	Agree lead commissioner for the LMS March 2019
		Contact Trust data leads to provide activity and prevalence data March 2019

\* New focus in Long Term Plan

### Orthopaedics Project Initiation Document – Summary

#### Clinical Programme Board comments - none

#### Objectives Overview

This programme has been designed to improve the consistency and quality of care provided and to reduce the cost of delivering elective orthopaedic services in South East London through identification and implementation of benefits resulting from horizontal integration between the three service providers.

The three service delivery partners will demonstrate improved patient outcomes and patient experience, as well as increased efficiency and productivity in delivery of financially sustainable services adhering to NHS Improvement GIRFT Orthopaedics programme guidance. The first review of performance will take place in August 2019 assessing selected performance measures in 2018/19 against a baseline of 2017/18.



The Programme is moving into a new phase, considering how to move to a network for orthopaedics across the three provider Trusts from which SEL can commission elective orthopaedic care.

#### Detailed objectives

1. Identify, challenge and reduce unwarranted variation in quality and experience of SEL provider-delivered secondary care orthopaedic pathways experienced by patients.
2. Ensure secondary care orthopaedic pathways enable differentiation of services to deliver appropriate care which meets each patient's individual need. This is particularly relevant to patients who suffer from common co-morbidities of rheumatoid/ osteo-arthritis, diabetes, heart disease, depression/ anxiety, obesity, cognitive disability and frailty.
3. Monitor and evaluate the outcomes that matter to patients following surgical intervention to inform service improvement which narrows health inequalities experienced by different patient socio-economic and demographic groups.
4. Access, share and adopt national, regional and local experiential learning between service providers to implement national best practice consistently across SEL.
5. Use the guidance provided by the NHS Improvement Get It Right First Time (GIRFT) 2015 National review of adult elective orthopaedic services in England report and provider specific dashboard reports to deliver continuous improvement to the quality, efficiency and financial sustainability of elective orthopaedic services.
6. Work with local patients who have experienced elective orthopaedic surgical interventions to co-design and inform service improvement activity, particularly with respect to patient information & communication.
7. Monitor and report key performance indicators (KPIs) which support the measurement of progress being made in improving the delivery of services.
8. Identify the benefits and opportunities available through horizontal system integration and develop an organisational form to deliver these benefits.

#### **UEC Project Initiation Document – Summary**

#### **Clinical Programme Board comments**

- Recognised that more consistency was needed around streaming at the front door
- Frailty pathways need to be a key theme in response to the LTP
- Same day emergency services to prevent admission work needs to be supported by accurate recording on a common dataset which has been developed
- Recognised that work on the 111 clinical assessment service is ongoing in SEL, it is an evolutionary process working towards being a single point of access for patients.



People will be encouraged to use the 111 service for community services and GP out of hours

Objectives Overview

The long-term objective of the urgent and emergency care programme is to create and maintain a clinically and financially sustainable urgent and emergency care system in SE London, through which our population has access to the same level of service no matter where they live or where they are cared for. Ultimately the achievement of this objective will be reflected in performance against the 95% A&E four-hour standard, a measure which may be used as a barometer for how well the system is functioning as a whole.<sup>1</sup>

Whilst other benefits such as improved patient flow and patients being seen in the right place and at the right time may be realised more quickly, it is anticipated that achieving the four hour standard will continue to be a challenge and will be addressed as part of the SE London system improvement plan. However the programme also has a number of shorter-term goals, detailed below, to be delivered in support of achieving our long-term objective.

Detailed objectives

The programme has a number of current objectives in support of its long-term goal. Some of these are carried over from 2018/19 whereas others are in response to new programme priorities or commitments within the Long Term Plan:

<p><b>Pre-existing objectives</b></p>	<ul style="list-style-type: none"> <li>• Mobilise the Integrated Urgent Care service. <i>This is also a Long Term Plan commitment for delivery in 2019.</i></li> <li>• Develop and pilot a new syncope pathway / model of care.</li> <li>• Decrease demand on London Ambulance Service for falls patients where an ambulance crew is not required.</li> <li>• Work towards the NHS Improvement target of zero breaches for minors patients.</li> <li>• Facilitate joint working between health and care teams working with frequent attenders / high intensity users across the system.</li> </ul>
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<sup>1</sup> Note: although the four hour standard may be consulted upon – and subsequently amended or abolished – as part of the Clinical Standards Review, it is proposed that the programme continues to use this as an overarching measurement of success until the future use of this target nationally is decided.



	<ul style="list-style-type: none"> <li>• Transition the nine urgent care centres into urgent treatment centres. <i>This is also a Long Term Plan commitment for delivery in 2019.</i></li> <li>• Support system winter planning and performance.</li> <li>• Support the London Ambulance Service Demand Management Group.</li> <li>• Improve wellbeing, recruitment and retention of urgent and emergency care staff.</li> <li>• Improve urgent and emergency care pathways and experience for mental health patients.</li> </ul>	
<p><b>Long Term Plan commitments</b></p>	<ul style="list-style-type: none"> <li>• Provide same day emergency care services 12 hours a day, 7 days a week in all EDs by the end of 2019/20.</li> <li>• Provide acute frailty services for at least 70 hours a week by the end of 2019/20.</li> <li>• Record 100% of patient activity in A&amp;E, UTCs and same day emergency care via the Emergency Care Data Set by March 2020.</li> <li>• Test/implement new emergency and urgent care standards arising from the Clinical Standards Review by October 2019.<sup>2</sup></li> <li>• Further reduce delayed transfers of care, in partnership with local authorities.</li> <li>• By 2023, Clinical Assessment Services will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.</li> </ul>	

<sup>2</sup> Whilst this is a Long Term Plan commitment for delivery in 2019/20 it is not yet known what this will entail; however it is anticipated that Guy's and St. Thomas' NHS Foundation Trust will be a pilot site for testing the clinical standards.



<p><b>New programme priorities</b></p>	<p><i>The below are draft objectives based on new programme priority areas agreed upon in March 2019.</i></p> <ul style="list-style-type: none"> <li>• Increase consistency across streaming models and outcomes within SE London.</li> <li>• Implement consistent access to same day emergency care and acute frailty services in all EDs.</li> <li>• Roll out patient flow initiatives such as Red2Green, SAFER and discharge to assess consistently across SE London providers.</li> <li>• Work with the CBC programme to define the consistent core offer from community based services for urgent care.</li> </ul>	

