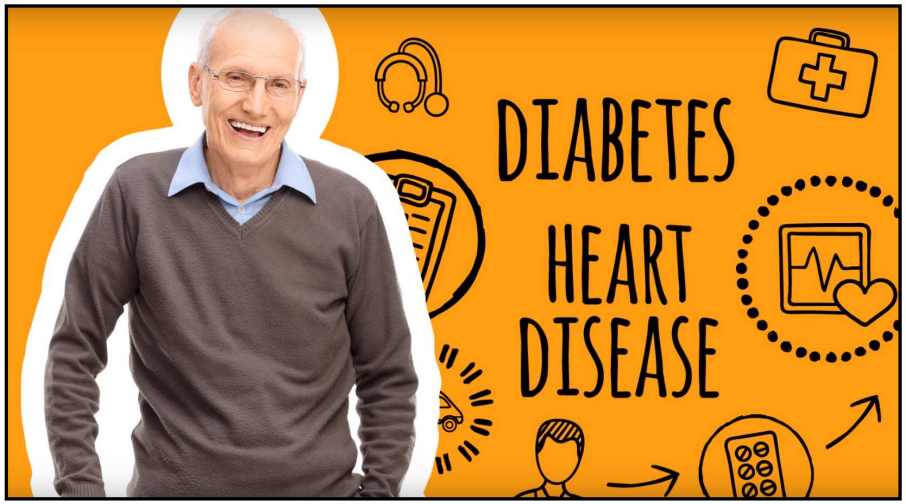
South West London Collaborative Commissioning



Our five year forward plan for south west London

Start well, live well, age well

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

About our five year forward plan

- Following the NHS Five Year Forward View, all regions of the NHS in England are required to produce five year Sustainability and Transformation Plans (STP)
- Our plan is the product of genuine collaboration between all NHS commissioners and providers in SW London, working with our six local authorities and GP federations
- An initial draft was submitted to NHS England on 30 June - now undergoing assurance from NHS England
- Full draft STP will be shared following assurance and further public and stakeholder engagement will take place. Next draft due to be submitted to NHS England in October 2016

We are clear about the challenges we face

- We have a life expectancy gap of 9.4 years from most affluent areas to most deprived.
- Our population is growing and ageing, with increasingly complex mental and physical healthcare needs – we need to do more to help people live healthy, independent lives for as long as possible
- Services in SWL are not set up to achieve this. Too often people are admitted to hospital in an emergency or to inpatient mental health beds when they could have been treated earlier or elsewhere and not needed to be in hospital
- Quality of care varies enormously across SWL depending on where and when patients access services
- None of our acute hospitals meet all of the London Quality Standards for acute urgent and emergency care and we over-rely on agency staff to support acute services
- These pressures on the NHS are compounded by cuts to local councils and social care budgets
- As a result of these pressures, the cost of providing care are rising far quicker than inflation and the money we are allocated

Our principles

- Doing nothing is not an option – we need to act now to improve standards and outcomes for people in south west London, whilst making sure services are clinically and financially sustainable

- Our draft plan sets out how we can work together across south west London to support people to keep healthy and well – and to intervene early and deliver the right care in the best place to support them if they do become unwell

- To do this we propose to shift more care from hospitals into the community, so we can provide care that is closer to home, tailored to people's individual needs and supports them to stay as well as possible for as long as possible

- We will work with local people and organisations across south west London over the next few months to develop a detailed plan for high quality, sustainable services for our population

The SWL Vision

Our Mission

To help South West London's residents to

Start well, live well, age well

Our Vision

People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality, joined up health and care services when they need them that deliver better health outcomes at a lower cost of provision to the system

Service Design Principles

1. Care is patient centred & holistic

•Inclusive & recognises the role of family, friends, communities & voluntary organisations

•Joined up and crosses organisational boundaries, encompassing people's physical, mental and social care needs

•Easy to navigate

2. Care is proactive & preventative

•Focussed on enabling people to stay well and avoid healthcare instances

•Prioritises early detection – people have access to early support mechanisms

•Promotes self management – people are encouraged to take responsibility for their healthy lives

3. Care supports the quality of life and the outcomes people value

•People are supported to live life as fully as possible for as long as possible

•People are aware of the choices available and have greater control

4. Care is financially sustainable

5. Our staff and care givers feel supported and able to do their roles

Service Development Principles

1. We focus on **better health outcomes at lower cost of provision to the system**

•We work in partnership across all health and social care organisations including the third sector to design and deliver the solutions

•We make better use of resources, irrespective of the organisation

•We plan for a changing environment

2. We will rapidly adopt **evidence based care** (where possible)

3. We maximise the use of **digital technology,** for the benefit of all stakeholders

The three big challenges we need to meet

Gap 1: Improving health and wellbeing

•Growing and **ageing population**, but also an unusually **young population**.
•**Inequalities** with pockets of deprivation that are linked to poorer health and wellbeing outcomes
•**Prevention in early years** could be improved (focus on childhood obesity)
•The number of **people living with dementia** is rising and embedding high quality dementia care into services is key.

Developing cross partner prevention plans
The development of this plan has been welcomed as an opportunity to improve collaboration between the NHS and local authorities.

Gap 2. Improving care and quality

Our care and quality base case demonstrates:
•We are failing to meet minimum standards for acute urgent and emergency care
•More could be done in the community to reduce the amount of care delivered in hospitals
•We can do more to improve the quality of general practice
•We are not consistently meeting the needs of people who have mental health needs or dementia

Underlying factors
Two main factors underpin these gaps in the quality of our services:
•The lack of an available workforce to provide safe, effective care in the existing configuration of services
•The provision of preventative and proactive care, including primary care and services supporting earlier discharge from hospital, is inadequate.

Gap 3: Improving finance and efficiency

•The cost of delivering services is rising much faster than inflation due to rapidly increasing demand; this is creating a financial gap which will make current services unaffordable by 2020/21 if we do not make changes now.
•Our initial analysis suggested that if we do nothing, the financial gap in five years would be £900m.
•We believe that making changes to the way in which services are delivered can deliver changes that improve the quality of care as well as making services more cost-effective to the taxpayer.

Our draft plan suggests we should:

- Set up locality teams across south west London to provide care to defined populations of approximately 50,000 people. The teams would align with GP practice localities and have the skills, resources and capacity to deliver preventative health and support self-care
- Address both mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people with long term conditions
- Introduce new technologies to deliver better patient care (e.g. virtual clinics and apps)
- Use our workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospital admissions
- Make best use of acute hospital staff through clinical networking and/or consolidating activity on a smaller number of sites
- Review our acute hospitals to ensure that we meet the changing demands of our populations and to ensure that acute providers deliver high quality, efficient care.

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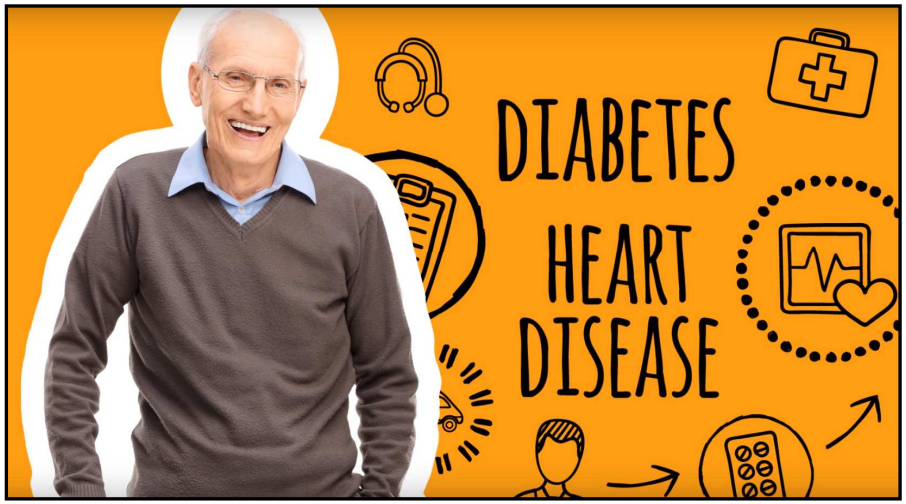

Summary of suggested changes

Start well, live well, age well

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Prevention and early intervention

- We need to better support people to live healthy, active and independent lives for as long as possible: this includes advice and support to stop people getting ill and to help patients to manage their long term conditions
- Where people do get ill, we need to ensure they are diagnosed and supported at an early stage
- Mental and physical health issues must go hand in hand: support for people with long term conditions like diabetes, medically unexplained symptoms and chronic pain should take into account mental as well as physical health needs
- We need to do more to identify people at risk of developing long term conditions and use modern technology and a modernised workforce to develop proactive care to support them at home and in the community
- Much closer work between the NHS and local authorities, who provide social care, is critical to supporting the prevention agenda
- Modern technology can support the prevention agenda – e.g. online, apps and text-based services, Skype consultations
- We need to improve the uptake of health checks

Transforming access to outpatients

- We want to deliver more consistent outpatients services across SWL, stop patients having to attend unnecessary appointments and bring outpatient care closer to home
- We aim to stop unnecessary follow-up appointments by only providing annual reviews when clinically necessary, ideally in a primary care setting, stopping automatic follow-up appointments and making it easier to be re-referred
- We want to reduce variation between GP practices by expanding the use of referral management systems, setting up one-stop clinics and standardising protocols in our diagnostic services
- Better use of technology – eg Skype or telephone appointments, remote monitoring via smartphone apps, online services (eg for sexual health), better sharing of information between GPs and hospitals, text reminders for appointments
- More community-based clinics (e.g. musculoskeletal and dermatology), upskilling primary care work force to support community-based care, more ambulatory care in the community.

New models of care

- **Maternity**: Support women's choice in place of birth, increasing availability of home births and midwife-led care. Safe an sustainable hospital services for women who need obstetric-led care. More personalised antenatal and postnatal care, including reviewing consistency of carer and provision of perinatal mental health support.

- **Children's services:** Most children who are unwell should be treated in primary care and the community; better access to and availability of community-based care will reduce the need for hospital attendances. Children who need hospital care for a short period to be assessed, observed and treated in paediatric assessment units sitting alongside A&Es. Quick access to specialist inpatient care for the small number of children who need it. Increased networking between hospitals and between GPs/primary care and hospitals.
- **Urgent and emergency care**: An integrated service which achieves the core standards is a high priority. 24/7 integrated urgent care access, treatment and advice via an improved 111 service. Priorities include mental health crisis care, self-care support and 'see and treat' models for London Ambulance Service.

New models of care (2)

- **Ambulatory emergency care (AEC)**: Treatments such as deep vain thrombosis or cellulitis are delivered in hospital but need not require hospital admission. AEC provides timely treatment and improved experience for patients, avoiding unnecessary admissions. All 6 CCGs have signed up to further delivery of AEC. We also need to improve support outside hospital for people with mental health conditions, who are three times more likely to attend A&E at present.

- **Care for the frail elderly:** We want to improve care in the community for frail older people, building on existing work, for example in Croydon where acute hospitals work with other NHS and social care providers to support older people. We might consider converting parts of our acute sites to provide specialist elderly care. We know more older patients could be treated in the community, including dementia patients as well as those being treated in acute hospitals.

Primary care

- **Locality teams** to be set up across SWL to support defined populations of approx. 50,000: role will be prevention/public health, early intervention, working closely with the voluntary and community sector, aligning with GP localities and supported by GP federations. There will be a single point of access for professionals.
- Commitment to **accessible, coordinated and proactive** primary care
- **Investment** in primary care will be higher than baseline core contract allocations, to cover cost of developing primary care hubs, continued federation development and increased workforce costs
- **Community Education Provider Networks** (CEPNs) to deliver a range of training to practice staff
- More **Care Navigator** roles; explore recruitment of practice-based clinical pharmacists, mental health therapists and others
- **Sutton Care Home Vanguard** rolled out across SWL
- **GP federations**: 6 established and have formed a collaborative. Kingston & Wandsworth already have contracts in place (eg diabetes, ophthalmology, dermatology and musculoskeletal outpatients); Richmond has 8am-8pm GP access 7 days a week

Acute hospital services

- We want to improve quality and optimise our workforce, in particular meeting the **London Quality Standards** (LQS). Since LQS were introduced, there has been more emphasis on multi-disciplinary teams and drawing on skills of a wide range of staff, so there may be other ways of delivering the outcomes the LQS aim for.

- We need to make the best use of clinicians, increasing **clinical networks** across the trusts OR **consolidate services** on a smaller number of sites.

- We are considering a shared cancer centre, pooling the resources of St George's, Epsom, St Helier and Royal Marsden. We would only look to move routine cancer surgery , with Kingston and Croydon to a new centre if this would deliver demonstrably better outcomes.

- Every hospital does not have to provide every service. We will explore which services are provided on each site and how we might use clinical networks, get remote support from specialists or a lead site providing shared cover at quiet times.

Acute hospital services (2): specialised commissioning

- NHS England has announced a review of specialised services in south London
- We will work with south east London, NHS England and all stakeholders across both areas (providers trusts, CCGs, local councils and the public) as this develops
- South London has some similar services being provided in close proximity – need to consider long term sustainability of specialised services at Guy's and St Thomas', King's College Hospital and St George's. Other providers such as Epsom & St Helier will also be involved in the review.
- Four projects are in development: children's oncology, neuro-rehabilitation, HIV services and Tier 4 child and adolescent mental health services. Work also underway to address local challenges in cardiovascular care and haematology. Cancer was agreed to be out of scope as it was important to follow through on existing proposals
- Formal governance structures being developed for all specialised commissioning across London, including creation of a Specialised Commissioning Planning Board
- Collaboration expected between specialist mental health providers in south London (South London and Maudsley, Oxleas and SWL & St George's) to transform adult secure services

Acute hospital services (3): hospital configuration

- Demand for services is likely to increase by 2020/21, so we need to plan for this. Moving more care into the community will offset growth in demand to some degree: intermediate beds can be delivered in a range of ways in different places. Changes to specialised commissioning may potentially impact the numbers of beds needed in SWL

- All our hospitals have areas of estate that need improvement and investment. St Helier is not currently compliant with modern standards for safe and high quality care and St George's has significant estate problems requiring investment.

- We are awaiting the modelling of bed numbers, the specialised commissioning review and further info on estates costs at St George's before deciding whether we need to consider potential scenarios for configuration of acute sites.

- Transformation of services outside hospital would be a major consideration if acute hospital reconfiguration was proposed; any major service change would also subject to public consultation.

Estates

- Fundamental change is needed in the way we manage SWL health and social care estate
- New models of care will increase primary care provision location of acute and mental health services in primary care/community settings
- 20 multi-specialty community hubs providing an integrated range of services – mainly through repurposing existing premises where possible, with small amount of new build
- Future acute estate will depend on bed audit/bed volumes, future configuration and review of specialised services
- We are working with local authorities and across the local NHS to develop an Estates Strategy for south west London

Workforce

- We need to develop our health and social care workforce across organisational and clinical boundaries, delivering integrated, patient-centred care that is high quality and value for money
- 25,000 NHS staff and 32,000 in social care. Over 18,000 of NHS staff work min acute sector and only 2,500 in community settings. Without improved recruitment and retention, demand will outstrip supply
- National shortage of qualified staff such as GPs, nurses and paediatricians. Currently over-reliant on agency staff. Some staff roles likely to change as services are delivered differently.

Four core priorities to develop our workforce:

- Securing sustainable workforce and improving recruitment and retention
- Capacity and skill mix
- Working differently
- A healthy workforce

Education and training is a key enabler running across all priorities. We will work with local academic institutions/education providers to ensure sustainable workforce and right competencies.

Delivering an information revolution

- Technology is a critical enabler for many of the recommendations set out in our draft plan. It is critical that clinical information about patients follows them between different health and social care services
- **Self-care** for patients can be supported by digital technology, enabling patients to get information about their condition, or provide information such as their record, to help them make informed decisions about managing their health
- Technology such as **video conferencing** can help break down barriers between patients and clinicians and help clinicians get rapid specialist input when needed
- **Information sharing** which combines clinical, operational and financial data can help us take a 'whole system' approach to improving the way services are delivered
- **Digital technology** should be available to all clinicians and care professionals when they need it
- There are pockets of good practice already in SWL: these will need to be expanded significantly if we are to achieve our ambitions

Closing our financial gap

- By organising services better and delivering the initiatives set out in our plan, we can close our financial gap with **no reduction in the quality of care**
- An audit of acute hospital beds suggests that we could substantially reduce the number of days people spend as inpatients by delivering improved models of care
- By changing outpatient services, we could reduce unnecessary appointments by 20%
- By reducing the use of procedures which have limited clinical effectiveness, we could reduce elective surgery by 13%
- Programmes to increase acute provider productivity by sharing non-clinical 'back office' functions are underway: areas being looked at by hospitals include procurement, a shared staff bank, reduction of corporate and administrative costs and more efficient management of our estates
- CCGs have also identified that they can make significant savings by working together more closely, including sharing 'back office' functions internally and with providers or councils.
- Pharmacy teams across SWL are working together to identify opportunities for medicines-related savings: for example by reducing use of medicines that are less clinically effective or significantly more expensive than alternatives

Involving local people

- We published an Issues Paper in 2014 which was widely distributed across SWL and discussed at large scale events with the public and stakeholders in each borough – feedback from these informed our five year forward plan
- In May, we wrote to over 1,000 local voluntary, community and campaigning organisations in SWL setting out our emerging thinking and asking for their views – these views were considered as our plan was being developed
- All feedback received to date and our response to it will be published shortly. We will produce regular 'You Said We Did' reports summarising feedback received and our response
- We plan further public events later in 2016, where we will discuss the content of our draft plan and seek people's views
- We are running a large grassroots engagement programme with local Healthwatch organisations, leading to 7-10 events in each borough for groups whose voices are seldom heard. The feedback will continue to inform our thinking
- Patients and the public are directly involved in each of our clinical workstreams and we have a Patient and Public Engagement Steering Group which oversees our public engagement

Our plan for the next six months

- Our initial draft plan (STP) was submitted to NHSE at the end of June 2016
- Once national assurance is complete, the final plan will be published and further public engagement will take place
- We anticipate a series of public events in the autumn, which will help inform the next iteration of our plan
- Should any proposals emerge that require public consultation we would envisage this would take place in late 2017
- A number of plans are already underway – for example plans to improve primary care, better preventative care, a more joined up approach between services and development of a SWL Estates Strategy.
- Further modelling work, further information and further public engagement will be needed before we can finalise our strategy.