NHS
South East London

DRAFT

NHS South East London Cluster

Better for You

Commissioning Strategy Plan

2012/13 – 2014/15

Dear colleagues,

We are all very pleased to introduce to you *Better for You*, our health Commissioning Strategy Plan for 2012/13 to 2014/15 for the people of south east London. As chairs of each of the six Clinical Commissioning Pathfinders in south east London, we are positive and excited about the future for our local health services and about the role that we and other clinical leaders can take to enable more local people to stay healthy and experience joined-up care which meets their individual health needs in the most effective way.

We will continue to work with our local partners, for example across health and social care, to make sure that our plans are fully integrated and reflect the health and well-being needs of local people. We already work closely with our Local Involvement Networks (LINks) and look forward to working with our local Healthwatch organisations as they emerge in order to gain independent perspectives on the patients' experience of their health services. We will use this feedback to monitor current services and improve future services.

There are differing needs within our respective populations and some common ones. In every case our ambition is to meet the same strategic goals which will put patients and carers at the centre of decision making. As Pathfinders, we are collaborating with one another with the aim of maximising health benefits from collective approaches and achieving a sustainable health economy for south east London.

Over the last year we have been supported to take a local leadership role in developing our long term plans and we are confident that we have the right mechanisms in place to ensure delivery of those plans. We are continuing to work with the NHS in south east London to develop our future commissioning capability.

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We would welcome any comments or feedback on our first South East London Commissioning Strategy Plan. You can contact us at [INSERT CONTACT DETAILS]

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1. Introduction

NHS South East London (NHS SEL) is a partnership of Bromley, Greenwich, Lambeth, Lewisham and Southwark Primary Care Trusts (PCT) and Bexley Care Trust.

Better for You, our Commissioning Strategy Plan (CSP) for 2012/13 to 2014/5 is our vision for improving health and healthcare for the communities that we serve over the next three years.

> *"We each have to find our own solutions, and I realise that the health service can't provide all of those, but it could still have a role in helping us find what we need"*
>
> Patient interview, Lambeth & Southwark, 2010

Our population is rising and demands on health services are rising at a faster pace than our income, meaning that we need to be more efficient to meet the health needs of the people of south east London. In this strategy we show how we will meet this challenge. There is a history of collaboration between the six PCTs, and the integrated care initiatives described in this strategy show how the emerging SEL health system is pursuing opportunities to work together to deliver solutions which are tailored to meet the needs of local and, where appropriate, larger populations.

At the same time, we are in a period of very significant organisational change in the NHS. The Government proposes to replace Primary Care Trusts, the current NHS commissioners, with Clinical Commissioning Groups (CCGs) from April 2013. By establishing and developing Commissioning Pathfinders in our boroughs, we are already making the arrangements for this transfer of responsibility to happen effectively. The development of this CSP represents an important step in the development of our Pathfinders towards authorisation as CCGs, planned for April 2013.

Bringing these aspects of our work together, we show in this strategy how we will leverage reform – the increasing accountability of clinicians as commissioners and clinical leaders, the development of viable and innovative providers and the introduction of integrated care solutions – to achieve our commissioning goals as we transition to a new health system.

This CSP is a high-level document which articulates our challenge as commissioners for south east London and describes how we propose to meet this challenge. It is laid out in the following sections:

- Context: The population of South East London, its health needs and associated trends and the landscape of providers currently delivering healthcare services to local patients
- Approach: The steps we have taken to seek input from patients, the public and our providers, leverage pan-London initiatives and formed effective clinically-led governance to oversee the development of a CSP which meets local needs and achieves scale to deliver within available resources.

- Vision and strategic goals: Our ambition for the health and quality of healthcare to be provided for our population and the future performance of our health system

- Case for Change: The current performance of our health system in terms of finance, quality and productivity, and the scale of improvement now required to deliver our vision and strategic goals

- Priorities and Opportunities: A description of our four priorities – integrated care, London-wide programmes, productive care and staying healthy – and respective change programmes, together with their associated sets of opportunities (initiatives), which will deliver our vision and strategic goals

- Enablers: Our underpinning plans for clinical engagement and leadership; a South London commissioning support organisation; workforce; integrated health informatics; estates; and management of our finances

- Impact on the System: The projected outcomes of our strategy in terms of patients and the public, activity and finance; potential implications for key providers

- Implementation: Our overall implementation plan; approach to the governance and monitoring of delivery; risks identified and planned mitigations.

At the date of initial submission – 30 November 2011 – there remain some key uncertain actions which will impact how we deliver our vision and strategic goals and, in particular, the shape of the delivery agenda in years two and three. These include the development of:

- a viable and sustainable demand-led solution for the provision of acute hospital services for the population in Bexley, Bromley and Greenwich, involving local clinical commissioners and South London Healthcare Trust
- plans by the Bexley Pathfinder and business support unit (BSU) to achieve their required level of QIPP savings for a three-year period
- business cases to support planned estates development and disvestment
- mechanisms to gather structured patient feedback in support of our strategic goals, and a plan to establish an initial baseline and measurable targets
- 3-year trajectories for the metrics specified for our strategic goals relating to:
    - clinical decision-making and healthcare delivery and
    - the logistics of healthcare delivery
- refreshed governance mechanisms to oversee CSP delivery up to the point of CCG authorisation, with Pathfinders operating in shadow form
- our CCGs to enhance their corporate and commissioning capabilities
- plans to establish a commissioning support organisation (CSO) for south London and to reorganise cluster-based resources to best support CSP delivery.

We aim to have made significant progress with these actions over the coming three months, sufficient to produce a refreshed version of this CSP by the end of February 2012.

2. Context

This section describes the population of South East London, its health needs and associated trends and the landscape of providers currently delivering healthcare services to SEL patients

South East London has a population of 1,635,000 people[1]. The population size in each borough ranges from 220,300 in Bexley, to 306,400 in Bromley (estimate for 2011). The total population is projected to grow to 1.73 million by 2016. Greenwich is predicted to see the largest increase in population, with a growth over the next five years of 13%; Southwark will have the second highest at 8%. The biggest increase in births is projected for Greenwich with an 11% increase in the period 2011 to 2016.

South East London contains the extremes of deprivation and wealth with a large percentage of the population being amongst the most deprived fifth in the country while other parts of the sector contain those who are in the most affluent fifth of the population in England.

South East London is served by four acute trusts, two of which are Foundation Trusts and two in the process of application.

Guys and St. Thomas' NHS Foundation Trust (GST) primarily serves the population of Lambeth, Lewisham and Southwark but activity does flow across the whole of south east London and it provides specialist services for patients from much further afield. It is also the integrated community health provider for Lambeth and Southwark.

King's College Hospital NHS Foundation Trust (KCH) is one of London's largest teaching hospitals, providing a full range of general hospital services for over 700,000 people in the boroughs of Lambeth, Lewisham and Southwark and providing specialised services that are available to patients across a wider catchment area.

Lewisham Healthcare NHS Trust, located in the centre of Lewisham, offers medical, surgical and emergency services for the local community and specialised services for south east London and beyond. It is also the provider for community health services for Lewisham. It is in the process of applying for Foundation Trust status.

South London Healthcare Trust (SLHT) provides a wide range of healthcare to the people of south east London, in particular to the communities living in Bexley, Bromley and Greenwich. SLHT is also in the process of applying for Foundation Trust status.

Mental health services are provided by two mental health foundation trusts. South London and Maudsley Foundation Trust (SLaM) provides the most extensive portfolio of mental health and substance misuse services in the UK. The trust serves a local population of

[1] Source for all population data: GLA 2010 Round Demographic Projections and GLA 2010 Round Ethnic Group Population Projection (EGPP) figures, © Greater London Authority, 2011. Figures are rounded to nearest 100 per GLA's requirements

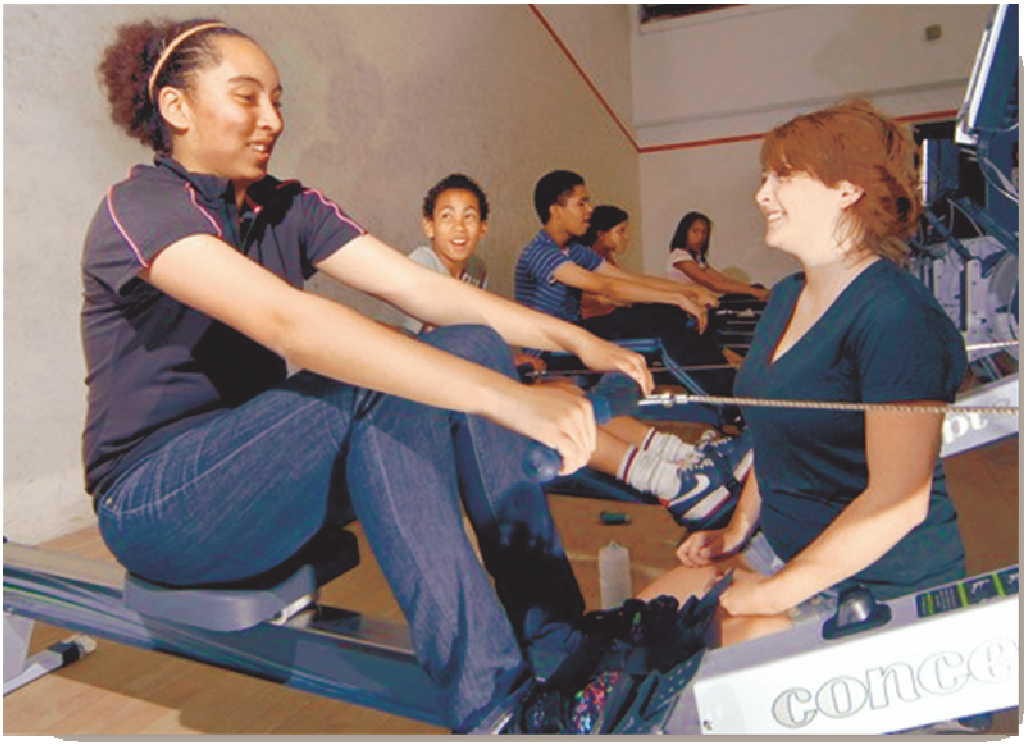
1.1million in south London and offers specialist expertise nationally resulting in an annual turnover of approximately £350 million.

Oxleas NHS Foundation Trust provides a wide range of health and social care services and specialises in caring for people with mental health problems and learning disabilities. The main provider of specialist mental health and adult learning disabilities services for Bexley, Bromley and Greenwich as well as forensic mental health locally and to HMP Belmarsh. It is also the provider of community health to Bexley and Greenwich.

Bromley Healthcare, a newly created social enterprise provides a range of community healthcare services for the people of Bromley.

Across south east London there are over 200 GP practices made up of Personal Medical Services (over 140), General Medical Services (over 50) and Alternative Provider Medical Services (over six) contracts.

We have one of only five Academic Health Sciences Centres (AHSC) in England. King's Health Partners (KHP) is a partnership between King's College London, Guys and St. Thomas' Foundation Trust, Kings College Hospital Foundation Trust and South London and Maudsley NHS Foundation Trust.



NHS Lambeth and NHS Southwark Health Promotion Training

3. Approach

How the development of this CSP has been governed and what engagement has taken place with representatives of the patients, public, providers and other stakeholders

NHS South East London's role is to enable our clinical leaders to balance the importance of meeting the needs of local populations in our six boroughs with the need to be effective commissioners of services from the major providers of acute and mental health care in our area. As part of the London health economy, we actively participate in, and extract value from initiatives delivering for the whole of the capital.

> *"Thank you for a good meeting and we must have more! It's all to do with communicating concerns, strategy and policy for patients of the wonderful NHS."*
>
> Peckham and Camberwell workshop for community organisations, October 2010

Our starting point for the development of this CSP is that it should serve as:

- a coherent commissioning plan for south east London
- an umbrella for the CSPs developed for each of our six boroughs and under the leadership of Pathfinder clinicians , and
- a vehicle to articulate and deliver the impact of pan-London initiatives for our communities.

Our approach, described below, has therefore been to:

- Engage systematically with the public, our patients and clinicians across our six boroughs to gain qualitative insight into local needs, building on public health assessments
- Maintain on-going dialogue with stakeholders, such as Local Government, Local Involvement Networks (LINks), NHS Trusts, independent and third sector organisations, in a variety of forums, ensuring that CSP plans and their potential impact are anticipated
- Engage with the London Specialist Commissioning Group (LSCG) and owners of other pan-London initiatives to ensure alignment of plans
- Ensure strong governance and leadership at cluster level and across our Pathfinders to pull together coherent and ambitious plans which meet local needs within available resources.

3.1 Engagement with the public and patients

We believe that engagement is vital in helping us to deliver local services that are right for local people and we have a record of effective engagement in south east London. We have robust arrangements that involve the public and patients, staff, clinicians and stakeholder organisations, such as Local Authorities, NHS Trusts and the voluntary sector.

Over recent years major programmes such as Healthcare for London, A Picture of Health and local PCT strategies have benefited from the views of the public and patients and produced the "Peoples' Principles" governing our approach to change. The role of clinical leaders has been instrumental in designing and delivering our service improvements.

We have a tailored approach to involving the public at borough and pan borough levels, including deliberative events, borough-wide public conversations and targeted engagement activities, with active LINks networks and an effective stakeholder reference group. We actively seek to engaged traditionally hard to reach and hard to hear groups and expand our ways of communicating to reach a wider audiences. In 2009 we won the Department of Health award for best communications leadership.

We have developed our approach to engagement at cluster level, with three stakeholder reference groups. These groups bring together local councillors, Links, council officers and partners from the voluntary sector to ensure that public engagement and patient choice are included in all service change proposals. The NHS South East London Stakeholder Reference Group provides the overarching framework for pan-south east London clinical service change programmes. The Bexley, Bromley and Greenwich Stakeholder Reference Group and the Lambeth, Southwark and Lewisham Stakeholder Reference Group operate alongside this group to offer guidance on change to services that cuts across more than one borough.

The establishment of shadow Health and Well-being Boards within each borough is progressing well. Each Pathfinder has engaged with council representatives of the HWB with regards to the development of their CSP and QIPP plans.

Working in conjunction with local social care organisations, Pathfinders are developing local methodologies for engaging patients. Some are built up from patient participation groups, and in Bexley a patient council. These structured forms of engagement are a central part of how Pathfinders ensure the patient voice is at the centre of what they do.

3.2 Dialogue with providers

Across South East London we have engaged with our providers to discuss and develop a number initiatives:

- In Lambeth and Southwark, we participate with King's College Hospital and Guys and St. Thomas' Foundation Trusts in joint steering groups for planned care and an urgent care network, and we are working jointly with King's Health Partners on an integrated care pilot, delivery of which is a priority within our CSP.

- In Lewisham, we have ensured that Lewisham Healthcare Trust's application for foundation trust status contains activity and finance assumptions which are aligned with commissioning plans.

- Bexley, Bromley and Greenwich commissioners have been working jointly and with South London Healthcare Trust in a cross-borough urgent care network and on estates initiatives at Queen Mary's Sidcup, Orpington and Elmstead.

3.3 Engagement on pan-London initiatives

To ensure that our patients have access to high quality specialised care, such as neonatal intensive care, complex arterial surgery and rare cancers, when they need it, we work closely with the London Specialised Commissioning Group, clinical networks such as the cancer and the cardiac and stroke networks, other London PCT clusters and London Health Programmes. Our clinical leaders are involved in developing cases for change, setting priorities and in ensuring that the interface between local services and specialised services is designed and operates effectively. They are active members of London's Clinical Senate and also the London-wide Clinical Counsel.

A separate commissioning strategy for London is published by the London Specialised Commissioning Group on behalf of all London PCTs.

3.4 Governance and leadership at cluster and across boroughs

NHS SEL's strategy has been developed through our GP Pathfinder leaders within each of the six boroughs, working both as local leaders and as members of the SEL Clinical Strategy Group. This will ensure that our plans are clinically led, patient focussed and owned by the clinical commissioners who will assume responsibility for its delivery.

At cluster level, the joint Board of the five PCTs and Bexley Care Trust and its committees have overall responsibility for the development and delivery of this strategy. This Board includes the Clinical Chairs of Pathfinders. At borough level our local Clinical Commissioning Committees operate with significant delegated responsibilities, including delivery of borough based Quality, Innovation, Productivity and Prevention (QIPP) initiatives. The committees build on existing Clinical Commissioning structures and are the place where local commissioning issues are considered with GP colleagues and key stakeholders. The committees also support the development of consortia and lead on relations with each Borough's Health and Well Being Boards.

4. Vision

Our ambition for the health and quality of healthcare provided for our population, within available financial resources, as informed by our engagement

> ***"Now I see my consultant regularly at my GP surgery - he does an outpatient clinic there which is much more convenient. I'd rather not visit hospital unless I need to even though I don't live far away ... It would be good to have a more responsive service as sometimes I have appointments in the summer when I feel well and don't really need to see anyone, while in the winter my health can deteriorate pretty quickly. Luckily my GP is excellent and has been great referring me to whatever specialist advice I've needed. I get a great service there"***
>
> Patient Interview, 2011

4.1 *Better for You* – Our vision for 2015

More people In South East London will stay healthy, and every patient will experience joined-up healthcare which meets their needs in the most effective way.

4.2 Our strategic goals

In South East London we commission physical and mental healthcare across home, primary, community and acute settings from a variety of NHS, voluntary and independent sector providers.

In every case, our ambition is to meet the same strategic goals, that:

1. In every contact with the NHS and local public service partners, people are encouraged and enabled to positively manage their own health, in partnership with health professionals and their carers.

2. Patients experience the NHS as a joined-up personalised service, rather than a disconnected set of services they are required to navigate.

3. Patients are treated with dignity and the respect due to them at all times.

4. Clinical decision-making and healthcare delivery is in line with evidence-based best practice and takes account of value for money.

5. The logistics of healthcare delivery, within and across different care settings, are designed to meet patient needs, whether long-term or acute, in the most effective way.

In setting these goals we have taken account of both the views of local stakeholders (see Section 3) and of lessons learnt more widely across the NHS, such as the quality issues at Mid Staffordshire and recent Care Quality Commission audits of care of older people.

More effective clinical decision-making and healthcare delivery logistics will drive a significant increase in productivity and enable the health and social care system in South East London to manage increasing levels of demand without an equivalent increase in resources. We have set an ambitious target for our health economy of productivity improvement to the value of £117m over four years. Through monitoring execution of this

plan and the achievement of our strategic goals, we will be able to ensure and demonstrate to our population that we have been able to make savings without compromising our ambition, or patients expectations, for care quality.

South East London is home to a highly diverse population living in many local communities, each with their own needs, priorities and expectations of the NHS. Our SEL strategic goals are informed by the work of our Pathfinders to develop their local strategic health goals and QIPP plans as part of borough based commissioning plans. These build on local joint strategic needs assessments and local stakeholder engagement, and are set out in the individual borough CSP summaries at Appendix A.

Proposed measures for each strategic goals are currently being developed. We will seek to develop baseline positions and include final agreed measures and trajectories as part of our February refresh of the Strategy.

Strategic Goals	Proposed Measures
In every contact with the NHS and local public service partners, people are encouraged and enabled to positively manage their own health, in partnership with health professionals and their carers	Structured patient feedback, e.g. On whether patients are treated with dignity and respect Patient expectations around their role in managing their own health Compliments and complaints, e.g. about duplicate tests and giving personal information multiple times Number of Long-term Conditions patients with care plans Care Quality Commission (CQC) reports
Patients experience the NHS as a joined-up personalised service, rather than a disconnected set of services they are required to navigate	
Patients are treated with dignity and the respect due to them at all times	
Clinical decision-making and healthcare delivery is in line with evidence-based best practice and takes account of value for money	Improved primary care performance Reduced variation in prescribing Reduced variation in Trauma and Orthopaedics length of stay Reduction in low value procedures Reduction in emergency readmissions Adoption of referral management processes, informed by best practice Take-up of new “better value” alternatives in the community Results of clinical audit Compliance with NICE guidance
The logistics of healthcare delivery, within and across different care settings, are designed to meet patient needs, whether long-term or acute, in the most effective way.	Reduction in unplanned admissions Reduction in unnecessary and/or repeat outpatient appointments and diagnostic tests Improved access to primary care

5. Case for Change

The performance of our current health system in terms of quality and productivity, progress made to-date and the scale of improvement still required to meet our ambition

5.1 Local population needs

The tables below summarises the most significant local health challenges across SEL with illustration of specific local needs.

Figure 1: Key Health Challenges across SEL

Challenge	Detail	Example of local needs	Related Priority *See Section 6*
Cancer	A major cause or premature mortality with variations in the outcomes for different people	• Breast: high incidence in Bexley and Bromley. High Mortality in Lambeth. • Lung: incidence and mortality rates are high. All age mortality higher than England average in Greenwich, Lambeth, Lewisham and Southwark • Prostate: higher incidence in more deprived areas. High mortality in Bexley	London-wide
Cardio-vascular Diseases (CVD)	Major cause of premature death and some rates higher than the national average	• CHD: Lambeth, Southwark, Lewisham and Greenwich have higher mortality rates than London and National average	Integrated Care
Long Term Conditions (including Diabetes, COPD and HIV)	High rates of diabetes across SEL Many COPD deaths are preventable and can lead to excess demand on hospital beds if not managed well.	• COPD: standardised mortality rates are significantly higher than the national average in all areas except Bexley and Bromley • Diabetes: Black African, Black Caribbean and South Asian ethnic groups are at higher risk of developing diabetes, so a considerable percentage of SEL population at high risk. • 25% of HIV cases in England are in Lambeth and Southwark	Integrated Care & Productive Care
Mental Health	A significant cause of disability and distress	• Reported mental illness prevalence in higher than average in most areas (highest in Lambeth and Lewisham) • Demand on mental health services by children in south east London is more than double the national average and higher than the London average.	Integrated Care

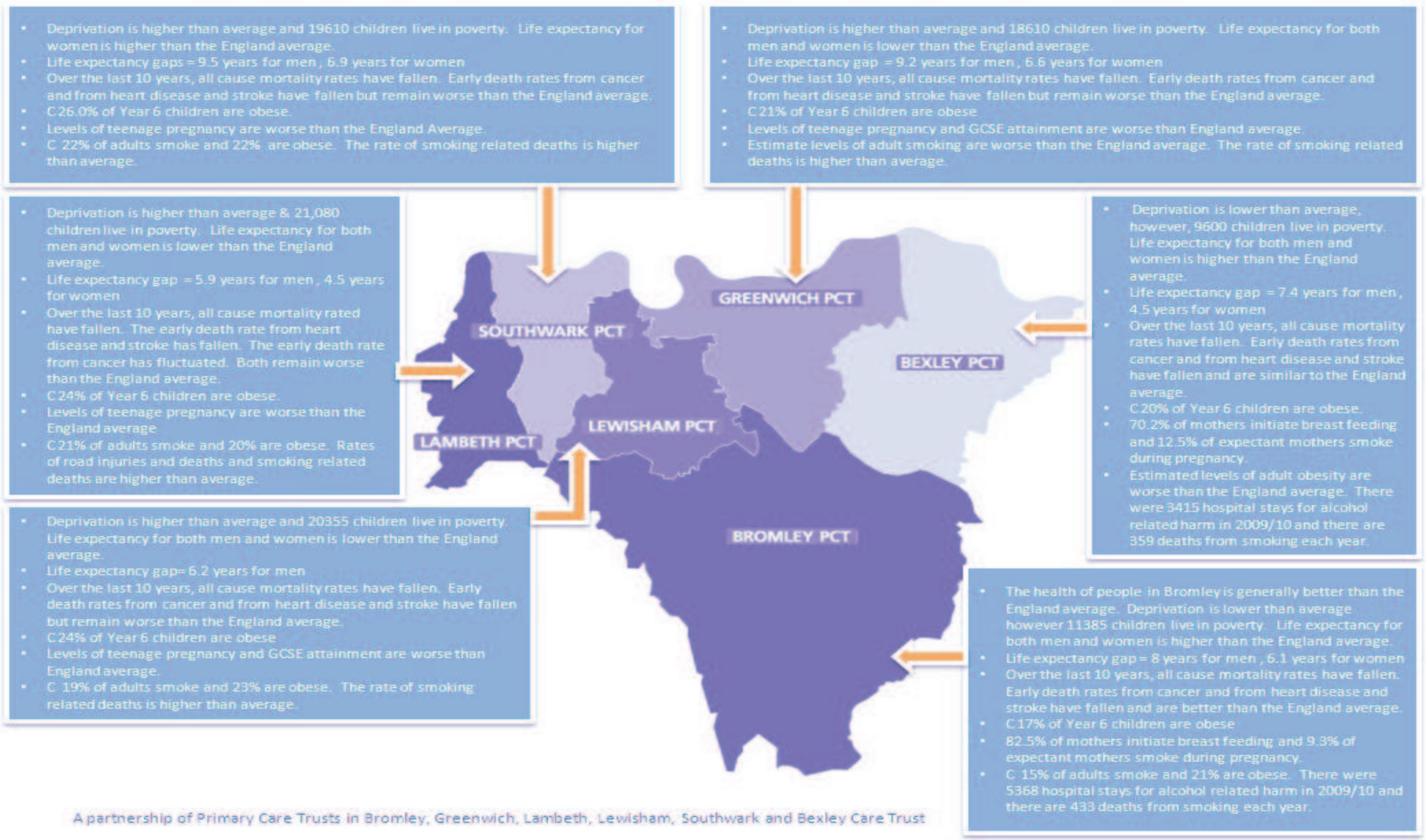
Challenge	Detail	Example of local needs	Related Priority *See Section 6*
Healthy Living	Many of the factors driving ill health are due to how people eat, drink and take exercise	• Smoking: identified as a leading risk factor for the top causes of early death in south east London. • Obesity: high rates of obesity for young people at Reception and Year 6 • Preventable infections: immunisation rates do not reach the necessary target levels to protect children from the spread of disease.	Healthy Living

"The GP suggested a referral to the STAR clinic who sent me onto the Pulmonary Rehab team at St Thomas. It was a set no. of appointments, 16 I think, and it was absolutely marvellous. They taught me an awful lot about my condition, how and when to use the inhaler, we had specialist talks from consultants and experts in their field. There's a gym there and the nurses and phyios give so much encouragement, they explain how your lungs are muscles that need to be exercised and how you can safely push yourself to improve. To start with I could only do the easiest machines but they don't let you just do the bare minimum; they push you so you're working harder.

At first it feels quite tough, but once you see how quickly you can build up it's amazing for your confidence. Some of the people that were there are incredible. People in their 80s with oxygen tanks and tubes attached, and all doing the most they can. I met a woman, she was 82 and could barely shuffle around on portable oxygen, but by the end of the course she told me she'd been out dancing. It was the lease of life I needed, as to be honest I'd started to give up on myself."

Patient interview, Lambeth & Southwark, 2011

Figure 2: Summary Local Healthmap



A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

5.2 Financial case for change

South East London faces continuing growth in demand and cost of acute services, driven by:

- Population growth
- Demographic changes
- The expansion of available health technologies
- Increased expectations

The rate of increase of funding for the NHS is now below inflation. The underlying rate of deficit will increase if no action is taken and there is an unprecedented level of financial challenge facing the NHS over the next few years.

A step change will be required in the approach to development and delivery of QIPP plans. Redesign of the system, the ownership of the plans by local CCGs and change led by primary care clinicians working in conjunction with acute clinical colleagues to improve care pathways and patient experience, eliminate duplication and improve productivity are required.

South east London commissioners must secure significant efficiency and productivity savings over the next three years to provide the financial resource to support delivery of their vision and the supporting strategies. If no action is taken then the underlying financial positions will deteriorate, resulting in a deficit in 2014/15 across south east London PCTs of £89.4m.

In order to achieve the required 1% surplus in 2014/15, QIPP savings totalling £117.8m will be needed over the three-year period. In order to achieve the 1% surplus in each year, the required QIPP savings will need to be front loaded, with £59.4m of the savings requirement being in 2012/13 as set out below.

Table 1: The Financial Case for Change

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total SEL cluster
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Forecast Surplus/ (Deficit) 2011/12	**0**	**5,992**	**4,612**	**6,605**	**5,375**	**5,857**	**28,441**
QIPP savings requirement 2012/13	(10,778)	(4,710)	(12,419)	(11,974)	(8,469)	(11,043)	(59,393)
QIPP savings requirement 2013/14	(5,145)	(3,140)	(7,817)	(7,562)	(5,278)	(6,636)	(35,578)
QIPP savings requirement 2014/15	(3,161)	(2,426)	(3,911)	(4,635)	(3,909)	(4,789)	(22,830)
Total QIPP savings requirement	**(19,084)**	**(10,276)**	**(24,147)**	**(24,171)**	**(17,656)**	**(22,468)**	**(117,801)**
'Do-Nothing' Forecast Surplus/ (Deficit) 2014/15	**(19,084)**	**(4,284)**	**(19,535)**	**(17,566)**	**(12,281)**	**(16,611)**	**(89,360)**

The financial challenge in 2012/13 is therefore the most challenging and delivery of QIPP savings and the overall delivery of planned surpluses in 2012/13 are key to the delivery of financial balance over the medium term and also in ensuring a sound and sustainable financial legacy to CCGs.

It is important to note that the delivery of the required QIPP savings are not only across the acute/primary care interface but across all areas of commissioning spend including mental health, community and primary care contracts. As commissioning responsibilities are transferred across the new commissioning authorities, QIPP savings requirements will also need to be transferred.

5.3 Quality and performance

We aim to continue to maintain and improve quality and performance across all areas. Across South East London we are performing well on a number of areas including MRSA indicators and stroke, 'proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit'. However, we recognise that there are some quality and performance gaps present in the provision of acute care across SEL:

Table 2: Quality and Performance Gaps

Indicator	Setting	Detail
Healthcare Acquired Infections (HCAIs)	Pan - Cluster	The DH continues to set challenging targets for both MRSA and C. difficile (CDI) reduction for 2011/12. It is expected that SEL Boroughs will achieve targets for reported cases of MRSA. Targets for reported cases of CDI will not expected to be achieved in any of the boroughs
Referral to Treat (RTT)	SLHT / GST	Two Trusts with SEL, SLHT and GST have failed to meet referral to treat (RTT) standards on a continued basis in the current year. Particular areas of concern have been orthopaedics (both trusts), bariatric and gynaecology (SLHT) and plastic surgery and oral surgery (GST). Both trusts are subject to detailed action plans with Cluster review and ongoing monitoring by the DH.
Cancer waiting times	GST	GST has consistently performed below the 85% standard for the 62-day target for time from urgent GP referral. A significant proportion of the breaches are due to late referrals from cancer units, including SLHT and outside London.
Mixed Sex Accommodation (MSA)	SLHT	Reduction in the number of MSA breaches with step change in July and August, however September has shown an increased number of breaches

Indicator	Setting	Detail
Ambulance handover	Pan-Cluster	Performance against the KPIs is variable, and the issue of most concern is the number of 60 minute patient handover breaches. The Cluster is meeting with each trust to review their action plans, trajectories, and numbers of 60 min breaches

We aim to continue to maintain and improve quality and performance across other areas. The following quality and performance gaps are present in the provision of community care and health promotion services across SEL.

Table 3: Quality Gaps - Health Promotion

Indicator	Setting	Detail
Immunisation	Lewisham	Lewisham Borough has the lowest immunisation rate across all indicators, especially for children at 5 years of age where the rate is significantly below the target as well as the London and sector average.
Breast-feeding	Lambeth	In Lambeth data coverage and hence reported continuation of breastfeeding have been below trajectory for some years.
Smoking quitters	Southwark	Data quality and data capture is a known issue due to a reduction in resources and lack of clarity around processes

Improving the standards and reducing variation in performance across primary care is a continuous priority across south east London.

5.4 Summary case for change

Demands are increasing on the healthcare system in South East London due to a combination of our changing and growing population, worsening health risk factors and increased identified need. We know that too many of our patients are dissatisfied with their healthcare experience, and there are many examples where performance of our NHS providers and the health outcomes that we are achieving fall short of our expectations. Economically, the demand for, and costs of healthcare are both rising at a rate than our income, creating a position where doing the same things as before is not an option. We therefore need to achieve step changes in the way in which healthcare is delivered, the outcomes that we achieve and create the circumstances to ensure that our healthcare system is effective and clinically financially sustainable.

6. Priorities and Opportunities

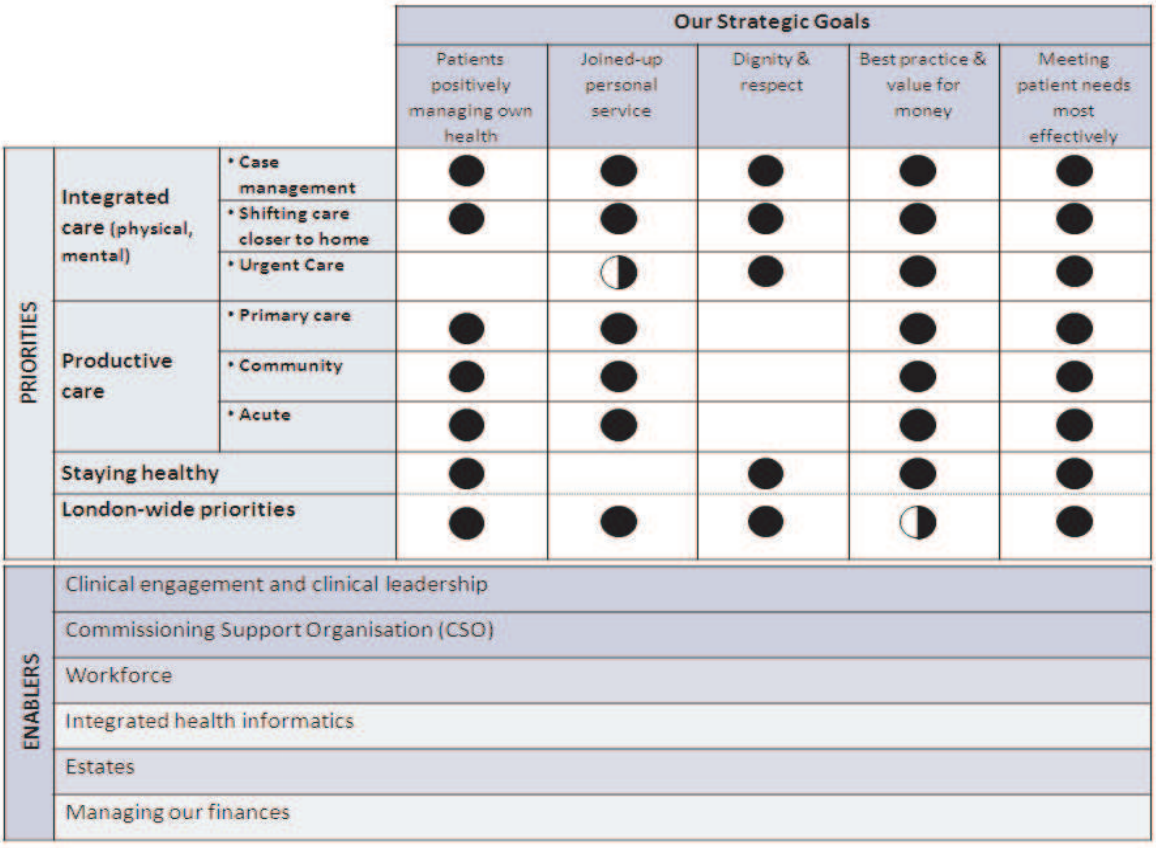
The case for change in Section 5 above demonstrates that a significant step change in performance of the SEL health system will be required to realise the vision and strategic goals of the cluster, our clinical leaders and borough partners, as described in Section 4.

This section describes how, working together, we intend to make that step change to achieve our vision and strategic goals.

As illustrated in Figure 3, our plan is to deliver our vision and strategic goals through the pursuit of four priorities:

i. Integrated care
ii. Productive care
iii. Staying Healthy
iv. London-wide programmes

Figure 3: Mapping priorities and strategic programmes to vision



A strategic change programme has been established for each priority, and each strategic change programme contains a set of initiatives, or opportunities, enacted at borough, cross-borough, cluster or pan-London level. Together with a set of enablers, described in section 7, this constitutes our delivery agenda.

In the following we pages we present a consolidated view for each priority of:

- Rationale why we have selected the area as a priority
- Principles the principles we see informing the approach to improving performance and, where relevant, the design of new care models across the South East London health economy
- Opportunities the opportunities, or initiatives, which are being, or will be, pursued to improve performance, delivering new care models as appropriate; showing progress to-date and planned investment/disinvestment and expected benefits

6.1 Our strategic programmes and the key role of primary care

Our approach to implementation and delivery monitoring is described in Section 8. In doing so we are conscious that high quality primary care underpins the successful delivery of all of our plans for out of hospital care and primary and community services transformation, being the foundation of each care pathway (e.g. safe care, right care, end of life care, urgent and emergency care, long term conditions) and our vision for integrated care networks. Our ambition is to achieve continuous improvements in quality, productivity, patient experience and health outcomes of primary care and produce a legacy for our Pathfinders to build upon.

To drive efficiency and productivity improvements we have completed reviews of PMS contracts in four boroughs and will commence PMS reviews in Lambeth and Southwark with the aim of commissioning services to match the identified health needs of the population through a core offering to be delivered by each practice.

There is a strong need for greater transparency of performance information. Using the London-wide List Maintenance policy, we will ensure that all practices have accurate and validated registered lists. This will enable monitoring of practices' actual performance regarding, for example, immunisation levels, screening coverage and prevalence levels of long term conditions. This information will feed into the pan-London dashboard for quality outcomes and contract compliance that we will utilise to support improved performance in 2012/13.

We will continuously monitor contract performance and quality of services delivered. The performance framework reviews on infection control, health and safety, business continuity,

child protection, employment checks and clinical governance domains. We have a track record of, and will continue to, proactively managing instances of poor performance in south east London, including the issue of breach and remedial notices as required. Opportunities are being taken on retirement of practitioners to review the current provision and to agree new arrangements such as list dispersal.

We will roll out EMIS Web (a GP practice information system) to 138 practices across Lambeth, Southwark, Lewisham and Greenwich which will allow the delivery of the electronic transfer of patient records between GP practices, the uploading of the summary care record and the next iteration of the electronic prescription service (EPS2). EPS2 will allow patients to nominate their pharmacy for prescription pickup and assist practices in reducing repeat prescription workload.

Unplanned care in SEL London is provided through a complex network of services, including primary and secondary care services. We have an opportunity to build upon existing services and developments to ensure quality and value for money. Through our priorities (see section 6) we aim to:

- Understand the current issues regarding the delivery of unplanned care both in and out of hours
- Understand what is driving demand
- Review how services are commissioned and develop best practice consistent approaches to support future contractual arrangements, where appropriate
- Understand future changes and their impact, including but not exclusive to the implementation of 111
- Map potential duplication in provision of unscheduled care services within and across boroughs and make recommendations for cost effective commissioning of services to future CCGs and the NHS National Commissioning Board.

6.2 Opportunities delivered through four strategic programmes

Integrated Care

Rationale
• Integrated care enables improved individualised care to people with long term conditions and to frequent users of services by addressing their specific care needs using a case managed approach • By undertaking population risk stratification to predict need we can respond to provide evidence-based care on a proactive and planned basis for the individual. • We will develop greater integration between primary, community, acute hospital and social care in order to improve clinical outcomes, care planning and patient satisfaction through seamless patient and care pathways • We see integrated care systems as key to unlocking significant improvements in patient experience and satisfaction. The quality of care will rise. Patients will experience better healthcare as close as possible to their home and be better equipped to self-manage their conditions. • Integrated care, in areas such as diabetes and the care of the elderly, offer significant improvements to clinical outcomes and efficiency.

Principles
We see the core components of integrated care systems across south east London as: • Maintaining robust patient registers • Patient risk stratification to focus on patients at risk of developing illness • Common clinical protocols applied along patient pathways by all providers • Defined care packages, tailored to the needs of each individual • Care that is proactively planned, co-ordinated and delivered • A multi-disciplinary team approach across health and social care • Case conferences for patients with complex needs • Continuous review of performance of and by multi-disciplinary teams with peer support. Integrated care systems will reduce hospital based care and increase care in home and closer to home settings. This will require • A different and mobile workforce. • New and better payment mechanisms to ensure that money flows to care providers appropriately. With our partners, we will build the right incentives to ensure that happens to close hospital capacity where necessary. • Improved community health facilities. We are developing a number of new purpose-built buildings in Greenwich and Lambeth to deliver integrated care in community settings. We are also progressing strategic solutions for services at

Orpington Hospital and for future services on the Queen Mary's Hospital site

High quality primary care underpins our plans for Integrated Care systems. We believe that integrated care will deliver better care closer to home. We are developing and testing different models of models of integrated care. We are working with KHP and social services in Lambeth and Southwark to develop integrated care models focusing on the care of the elderly, long term conditions and urgent care. In Lewisham, and also across Bexley, Bromley and Greenwich, we are exploring opportunities to integrate primary, community, acute and social care.

Offender Health: HMP Brixton, HMP Belmarsh and HMP and YOI Isis are located in south east London. A fourth prison is due to open in 2012. We aim, *"to give prisoners access to the same quality and range of Healthcare services as the general public receives from the National Health Service".*

Prisoners disproportionately come from disadvantaged socio-economic groups, with more physical and more mental and social health problems than the general population, and more frequently high risk behaviours. We are modelling our prison health services along an integrated approach involving joined up primary and secondary care, within the prison establishment where possible.

Opportunities

Opportunity	Impact	Mile-stone	KPI
Integrated care – case management			
LTC Case Management and Admissions Avoidance ***SEL-wide***	Including COPD, MSK, Dermatology, Diabetes • Reduction in admissions and high cost attendances (pre HRG4) • Improved quality of care for patients	*On-going*	• *Reduced emergency admissions* • *# patients actively case managed.* • *Reduced referrals to 2° care* • *Reduction in 2° care OP appointments* • *Shorter waiting times / reduction in total waiting list*

Opportunity	Impact	Mile-stone	KPI
End of life care *Greenwich, Lambeth, Southwark*	*Work with local Hospices and Marie Curie to implement the integrated EOLC model of care, incl. evaluation of the model, tendering, and implementation of best practice pathways.*	*On-going*	• *Increased number able to die at home* • *Improved patient experience* • *Reduced emergency admissions*
Integrated care – shifting care closer to home			
Pathway redesign *SEL-wide*	Redesign of pathways including: Cardiology, Anticoagulation, Palliative Care, Minor oral surgery, Oxygen Management, Neuro Rehab, Gynaecology	*03/12*	• *Reduction in OP referrals (from GPs)* • *Reduction in emergency admissions* • *% shift of activity to community settings*
Referral management *SEL-wide*	*Changes to reduce the number of inappropriate GP initiated referrals to OP, shifting activity from acute setting to community. Reduce variation in GP referrals*	*04/12 For 1st outpatient appointments*	• *Shift of OP activity to community* • *1st OP attendances (from GP)* • *1st OP attendances (consultants)* • *Follow-up attendances* • *Emergency admissions for LTC* • *Patient experience*
Primary Eye care Assessment and Referral Service (PEARS) *Bexley, Bromley, Greenwich*	*Skills of optometrists used to prioritise and manage patients presenting with the majority of minor eye conditions. This enables as many patients as possible to be seen quickly and in a local primary care setting, avoiding secondary referrals*	*04/12*	• *LES Claim forms* • *Acute OP activity reduction*
Intermediate care *Bromley, Greenwich, Lambeth, Southwark*	*Redesigning the intermediate care model to rebalance bed provision and community rehabilitation.*	*10/12*	• *Reduction in excess bed days* • *Reduction in delayed discharges* • *Reduction in cancelled ops* • *Reduction in length of stay*
Minor Oral Surgery *Bexley, Bromley,*	*Shift to primary care of procedures currently undertaken in a secondary care but suitable to be undertaken in primary care*	*04/12*	• *Reduction in secondary care activity* • *Reduced referrals*

Opportunity	Impact	Mile-stone	KPI
Greenwich			
Elderly care *Bexley, Greenwich, Lambeth, Southwark*	Redesigned care pathway for older people: • Integrated primary and secondary care • Risk Stratification Modelling (part of ProMISE - management of frail & elderly patients) • Redesign of the QMS campus • Integration with Mental Health services	*04/13* *10/12* *To be advised*	• *Reduced length of stay* • *Reduced numbers of readmissions*
Develop Primary Care and expand Mental Health IAPT *SEL-wide*	Implement SEL Mental Health case for change focusing on • Support for those with LTC and MH • Primary care services • IAPT • Crisis services	*Ongoing* *10/12* *9/12* *10/12*	• *Reduce emergency admissions* • *Improved experience of service users and carers* • *Reduction in acute / forensic and residential care beds* • *Improved patient experience*
Redesign CAMHs *Greenwich, Southwark*	*Working in partnership with Local Authority colleagues redesign of CAMHS services*	*03/13*	• *Awaiting further detail*
Integrated care – urgent care			
Integrated provision of urgent care and OOH	• *Retendering of existing multiple providers* • *Achieve seamless provision at lower cost* • *Whole system model, redesign undertaken collaboratively with neighbouring CCGs.*	*12/11*	• *Reduce A&E attendances* • *Reduce emergency admissions*
Expand UCCs	• *Redesign front end of A&E to reduce unnecessary admissions*	*On-going*	• *Reduce A&E attendances* • *Reduce emergency admissions*
Enabling Integration of Community, Primary, Mental Health and Acute Care			
Eltham Community Hospital *Greenwich*	*Offers opportunity to integrate Primary, Community and Acute services networked with local GP surgeries*	*04/12*	• *Reduction in referrals to 2° care*
QMS campus *Bexley*	*Design a health campus focus on elderly care, integrated primary and secondary services*	*04/13*	• *Reduced length of stay* • *Reduced numbers of admissions*
Orpington *Bromley*	*Strategic opportunity to integrate Primary, Community and Acute services. Plans under development therefore no delivery milestone as yet*	*TBA*	• *Reduction in referrals to 2° care* • *Shift of activity into home and community settings*
Dulwich *Southwark*	*Strategic opportunity to integrate Primary, Community and Acute services. Plans under*	*TBA*	• *Reduction in referrals to 2° care*

Opportunity	Impact	Mile-stone	KPI
	development therefore no delivery milestone as yet		• *Shift of activity into home and community settings*
Heart of East Greenwich Centre *Greenwich*	*Strategic opportunity to integrate Primary, Community and Acute services. Plans under development therefore no delivery milestone as yet*	*TBA*	• *Reduced referrals to 2° care* • *Shift of activity into home and community settings*
Kidbrooke *Greenwich*	*Strategic opportunity to integrate Primary, Community and Acute services for the Urban village development replacing the Ferrier estate. Plans under development therefore no delivery milestone as yet*	*TBA*	• *Reduction in referrals to 2° care* • *Shift of activity into home and community settings*

Productive Care

Rationale

- We believe that patients should be treated in hospital where necessary and at home or closer to home where possible. The majority of patients are best cared for in the community, providing better access to care closer to home and avoiding unnecessary visits to hospitals for routine care.
- Patients with long term conditions such as COPD and diabetes particularly benefit from a more localised model for routine healthcare. A more localised model of care closer to home also enables patients and carers to take greater control over their care and self-management of their conditions.
- Currently, south east London has a high level of emergency hospital admissions which could be managed in primary and community care, particularly for patients with diabetes and respiratory illnesses.
- Primary care services need to achieve greater economies of scale to ensure better access for patients, for example improving access to urgent care services through GP-led networks, particularly out of hours.
- Primary care services can also support moving care out of hospital to more cost effective settings closer to home, for example day-case surgery, diagnostics and outpatient services.
- Localising routine medical services with primary care would enable patients to access a wider range of services closer to home, 'under one roof' and would enable providers to offer more convenient services such as better out of hours access.

Principles

We will drive the health system to be more productive across primary and hospital and community based secondary care settings. Our approach includes:

- Clinically led re/designed clinical pathways
- Using integrated care models to unlock innovation across care settings
- Common protocols with acute providers where possible
- Care closer to home where possible; hospital where necessary
- Right care, right place, right time philosophy

- Improving access to services
- Transforming primary care services
- Use of contractual levers to drive productivity
- Review of Personal Medical Service contracts
- Use of systematic patient and user feedback
- Evidence based practice
- Developing new workforce
- Making good quality referrals
- Expanding diagnostics for primary care
- Avoiding unnecessary treatments and appointments
- Co-ordinating patient journeys
- Creating the right incentives for providers
- Driving up standards in primary care and reducing variation in performance

Opportunities

Opportunity	Impact	Mile-stone	KPI
Productive care – Primary & Community			
Improve access to primary care service ***SEL wide***	*Improved access* – Open 12 hours a day 7 days a week *Developing the scope and capacity of primary care to manage care more effectively in the community.*	*On-going*	• *Reduces A&E attendances* • *Increased numbers registered on GP lists*
PMS Reviews ***Lambeth & Southwark***	*Improved efficiency and productivity of Primary Care services through review of the PMS contract*	*from 12/11*	• *Reduced expenditure on Primary Care*
Prescribing in Primary Care ***SEL wide***	*Deliver cost effective prescribing within budget, reduce variation between practices in prescribing spend, improve quality of prescribing.*	*On-going*	• *Prescribing budget - monthly forecasts* • *Prescribing dashboard - quarterly update of QIPP areas* • *BCBV prescribing indicators* • *National benchmark of prescribing QIPP indicators*
Alternative care pathways and delivery protocols ***SEL wide***	Extension of alternative care pathways and redesign delivery protocols so that A&E is not default destination.	*04/12*	• *Reduce A&E attendances* • *Shift of activity from acute to community*

Opportunity	Impact	Mile-stone	KPI
Community Services integration ***Lambeth, Lewisham***	Improved efficiency and productivity of community services to ensure more people can be managed in the community.	*On-going*	• *Practice based community nursing caseloads* • *Patient facing contact time* • *Emergency admissions* • *Readmissions* • *Admissions into long term care*
Productive care – Acute			
Treatment Access Policy ***SEL wide***	*Demand management and decommissioning of POLCE. Ensure adherence to South East London Treatment Access Policy for SEL patients by GPs and trusts*	*On-going*	• *Day case and admitted HRGs for procedures under the policy*
OP follow up appointments ***SEL wide***	*Change in thresholds for outpatient follow up activity, in contracts negotiated by cluster acute contracting team*	*On-going*	• *OP FU ratios*
Medicines management initiatives ***SEL wide***	• *Prescribing enteral feeds, Patient Drug Waste and Direct Supply Dressing* • *Shared formulary with SLHT, GST, KCH and LHNT for high cost drugs/high risk conditions, new anti-coagulation drugs, challenging PbR excluded drugs, management of the RAG list of drugs*	*04/12* *On-going*	• *Awaiting update*
Emergency admissions ***SEL wide***	*Improved cost effectiveness of care and movement of people into planned steams of care.* • *Lambeth and Southwark: review Virtual Ward pilot and commission extension if evidence of impact; work with KHP to improve admitted emergency pathways and further alternatives to admission based on integrated care pilot* • *All: develop single point of access for community based service via 111; re-commission EoL care*	*To be advised*	• *Reduce numbers of emergency admissions and readmissions* • *Reduce A&E attendance* • *Increase the number of people supported to die at home* • *Reduced conversion of A&E attendances to admissions* • *Admissions into long term care* • *Readmissions*
Acute KPIs and thresholds ***SEL wide***	*Opportunities to generate savings and improve quality by encouraging acute providers to achieve benchmarks and KPIs*	*02/12*	• *Relating to thresholds*
Contract challenge ***SEL wide***	*Clinical and technical contract challenge Awaiting further detail*	*On-going*	• *Awaiting further detail*

Staying Healthy

Rationale

- The main causes of premature death are common across south east London. We believe that by creating opportunities for people to choose and maintain healthy lifestyles we will make major contributions to increasing life expectancy, reducing health inequalities, reducing hospital admissions and preventing and delaying the development of long term conditions.
- Smoking is a leading risk factor for the top causes of premature death for our population (CVD, some cancers, respiratory diseases) . Smoking contributes to other conditions such as osteoporosis, cataracts, childhood infections and digestive disorders
- Physical inactivity is a leading risk factor for the main causes of premature death for our population (CVD, cancers, and respiratory diseases. Childhood obesity rates are high in south east London
- Babies who are not breastfed are much more likely to develop illnesses such as gastroenteritis and respiratory infections requiring hospitalisation as children. In later life they are more likely to develop high blood pressure and cholesterol levels and associated illness.
- Mothers who do not breastfeed have increased risk of breast and ovarian cancers and may find it difficult to return to pregnancy weight
- Too many people die of alcohol related problems in south east London. Alcohol-related problems place a major burden on health services in primary care, A&E, acute and specialist services and also across wider societal areas of crime, accidents, domestic violence and unemployment.

Principles

We will:

- *Employ strategies aimed at the whole population as well as focusing on specific local patient groups*
- *Maximise the Olympics legacy to promote sport and physical exercise*
- *Use tailored social marketing programmes to target to specific groups for specific health and lifestyle issues (e.g. male smokers)*
- *Continue workforce development programmes for example to support and signpost smokers into stop smoking services*
- *Step up communication programmes with patients*
- *Expand services in community settings and workplaces*
- *Further develop partnerships with professional and leisure sports clubs*

Opportunities

Opportunity	Impact	Mile-stone	KPI
Tackling Obesity, Diet and Physical Activity	*Reduce the level of obesity in adults and children reducing the impact on heart, diabetes etc.*	*On-going*	*Reduction in number of school age obese children*
Smoking	• *A range of community/primary-care based services to support smokers give up* • *Estimated to have significant impact on cost of smoking-related illness* • *Encourage stop smoking services for patients diagnosed with COPD*	*On-going*	*Smoking cessation numbers*
NHS Health Checks	*Introduction of a systematic approach to prevention in primary care which will include NHS health checks plus (assessing risk of CVD, diabetes, renal disease and the PLUS element identifying those at risk of each of the remaining JSNA priorities: respiratory disease; cancers (screening compliance); depression; falls (over 65 yrs).*	*On-going*	*Number of patients receiving health checks*
Implement fall prevention programme	*Identify those patients most at risk and develop resource and protocols to reduce likelihood of falls, including sight tests, home safety checks and exercise programmes*		*Numbers on prevention programmes*
Tuberculosis	In conjunction with London-wide TB programme: • Performance management of uptake of neonatal BCG vaccinations to ensure London boroughs with TB rates >40 cases per 100k achieve a min. 70% uptake by age 4 months.	On-going	• *Deduced rates of TB* • *Improved screening* • *70% uptake in infants by age 4 months.*
Cancer	In conjunction with London-wide Cancer programme: • *Smoking cessation* • *Reducing alcohol misuse* • *Screening*	04/12	• *Improved survival rates* • *Reduced smoking prevalence* • *Increased screening uptake rates* • *Increased rates of early diagnosis*

London-wide Priorities

Rationale

- Our strategy reflects that we need to adopt different strategies for different populations and some services better tackled at populations larger than south east London, due to for example the rarity of condition, specialism and complexity of care or the scalability of solutions to common issues.
- Evidence suggests that centralising the most specialist services so that specialist teams treat higher numbers of patients and develop their skills would improve clinical outcomes and reduce lengths of stay in hospital. For example, complex arterial surgery, e.g. abdominal aortic aneurysm (AAA) repair, has also been shown to produce better outcomes when performed by specialist vascular surgeons
- *Healthcare practice and technologies change rapidly. Increasingly care can and is being provided at home and closer to home settings, which reduce hospital income. Strategic solutions are required to ensure that hospital services remain viable or are replaced by high quality alternatives.*
- NHS south east London, together with other London PCTs, is driving a series of patient care pathway service redesign programmes to improve the quality, efficiency and productivity of commissioned services.

Principles

We will work in partnership with the London Specialised Commissioning Group, clinical networks, other PCT clusters and other stakeholders to build and deliver strategic solutions to London wide issues and to develop more effective clinical interfaces between tertiary, secondary and primary care services. The programmes set out below will impact on 2012/13 contracts*:*

- Better hospitals: We aim to improve hospital productivity, develop a programme approach to raising quality & safety standards; develop strategic approaches to service reconfigurations where required and to develop a London model for future health campuses.
- Stronger specialist care: We will implement agreed best practice pathways for: cancer, stroke, trauma & cardio-vascular services.

We will implement agreed models of care for cancer and tertiary paediatrics. The move to commissioning cancer on the basis of patient pathways and contracting through the Integrated Cancer Systems (ICS) and not individual organisations requires Commissioners to work together to commission the ICS, for common pathway specifications and common metrics.

We will build best practice expectations into our contracts with providers of specialised services along whole patient pathways: Prevention, Awareness, Screening, Genetic risk, Access and Presentation, Diagnostics, Treatment, Follow up, Living with illness, End of life care.

Opportunities (All being implemented SEL-wide)

Opportunity	Impact	Mile-stone	KPI
Cancer	• Implementation of agreed model of care and best practice pathways • Implementation of NHS Institute for Innovation: transforming inpatient cancer care programme	04/12	• Improved survival rates • Reduced smoking prevalence • Reduced waiting times • Reduced follow ups • Increased rates of early diagnosis • Increased screening uptake rates
Stroke and Cardiovascular	Implementation of cardiovascular model of care and agreed pathways for stroke and cardiovascular services	03/12	• Improved survival rates • Reduced numbers of follow up appointments • Improved patient experience • Faster access to imaging
Tertiary paediatrics	Implementation of agreed model of care for tertiary paediatric services & complex paediatric surgery: • Implementation of agreed best practice pathways • Decommissioning from some sites and ending of services in networks that are clinically determined as being unsafe or severely isolated	*TBA*	• TBA
Adult emergency services:	Commissioning standards for AES applied to local providers' acute medicine and emergency general surgery services	On-going	• Awaiting details
Building better hospitals and hospital services	Service reconfigurations where needed and development of London model for health campuses, to deliver improved hospital productivity and quality and safety, and deliver strategic solutions for financially challenged NHS providers	On-going	• Awaiting details
Modernising Pathology Services	• Shift towards commissioning direct access services based on a London wide acceptable price range and currency • Procurement of services from Providers which meet the 'Modernising Pathology Services in London' approved turnaround times for both direct access and acute services.	02/12	• Services should meet standards for recommended turnaround times
Tuberculosis	• Pan-London protocols agreed for the use of directly observed therapy and cohort	On-going	• Deduced rates of TB • Improved screening

Opportunity	Impact	Mile-stone	KPI
	review • All Providers expected to adhere to these protocols and use risk assessment tool available through London TB Register, to identify patients at risk of non-compliance with treatment • *TB prevention opportunities included under Staying Healthy programme*		• 70% uptake in infants by age 4 months.
Maternity Services	Continued local improvement programmes to: • Improve the quality and safety of maternity services minimum clinical standards • Use key indicators from the maternity dashboard to improve clinical standards, particularly on reducing PP haemorrhage, 3rd degree tear and mortality rates. • Deliver direct access/self referral for patients • Ensure transparent capacity planning to enable choice for caesarian section.	On-going	• Reduced rates of C sections • Improved patient experience • Achievement of staffing levels for midwives in line with Birthrate Plus • Reduced antenatal day admissions
Implementation of 111	• Single point of access for all non urgent unscheduled care services including GP in and out of hours, community health, walk in centres, Urgent Care Centres, A&E Departments, pharmacy	11/12	• Reduced A&E conversion rates

7. Enablers

Our work around clinical engagement and leadership, commissioning support, workforce, integrated health informatics, incentives and contractual levers, better use of estate, financial management and CSP delivery monitoring, which will support delivery.

7.1 Clinical engagement and leadership

Clinical engagement is excellent throughout the cluster, with every Pathfinder having their own local mechanisms in place to engage with practices to support the delivery of the local QIPP strategy.

Within each Borough, elections have been held to appoint a Pathfinder Chair and a number of clinical executives, these leaders will be key to the achievement of authorisation as CCGs in the coming year and beyond.

Each Pathfinder has their own learning and organisational development programme which is supported by external consortia of specialist providers who are providing a tailored programme to meet their individual local needs in their journey to becoming authorised by April 2013. All Pathfinders play a key role in leading the local development of their local strategies and in consultation with their Health and Well-Being Boards and local LINks.

Clinical leadership is key to the success of driving forward this plan over the next three years. The clinical leaders are together developing health economy ways of working with providers to ensure coordination in designing and implementing integrated ways of working.

NHS SEL fully supports the proposals for co-production and testing of Local Professional Networks to strengthen clinical input for primary care commissioning across the NHS National Commissioning Board built around each profession (pharmacy, dental and ophthalmic).

7.2 The Commissioning Support Organisation (CSO)

NHS South East London has been working with Pathfinders to develop a CSO for south London which will enable future CCGs to retain local skills and functions for them to operate within the £25 per head running cost allowance by purchasing a selection of services at scale. The South London CSO will be a fundamentally different organisation to the current PCT clusters and will require an organisational development programme to move to a customer-orientated organisation, with improved quality and responsiveness. A commercial outlook will also be key to its success with a decision made in 2012 on the future CSO organisational shape to take effect by 2015/16.

The core service offering being developed must further strengthen the enablers described in this section.

7.3 Workforce

It is not strategies, hospitals or surgeries that deliver healthcare to patients, it is people – doctors, nurses and the myriad of other staff groups, and workforce accounts for about 65% of healthcare costs. For South East London's vision – that more people In South East London will stay healthy, and every patient will experience joined-up healthcare which meets their needs in the most effective way – to be realised, a reshaping of the workforce will be fundamental. The challenge will be to develop the right skills and capacity in the workforce to undertake an extended range of services across different mix of care settings, working in a more integrated way and continuing to maintain safety and quality standards.

To achieve this, our workforce agenda is threefold:

1. Establish workforce indicators and assurance for clinical quality and safety

   In the current climate whilst productivity is important, ensuring patient safety and care quality must be paramount. Research has shown that reviewing a number of workforce indicators gives an organization a "health check", and a direct link to clinical quality and safety. Research also shows the better engaged and motivated the workforce, the better productivity and discretionary effort will be offered.

   Workforce assurance indicators will therefore be incorporated as part of each organisation's performance metrics across South East London, ensuring balances are achieved between control and freedom to act, staff engagement and productivity, and patient safety.

2. Facilitate a strategic shift in skills and capacity

   NHS SEL's role will be to oversee and influence the overall shape of the future workforce as a whole system, with particular focus on general practice, integrated care, and specialist services. We will do this by:

   - raising awareness of the impact, implications and opportunities workforce can have on commissioner service intentions
   - co-ordinating workforce plans across the cluster promoting collaboration across organisations
   - identifying and trialling innovative solutions to workforce challenges and share learning.

   Transformation will focus on different styles of working and skill-mix to achieve integration and better end to end care. In particular, our plan is to move many aspects of care such as management of long term conditions, increased prevention and screening, and some mental health management to general practice.

   It is important the primary care workforce has the capacity and capability to take on extended roles, to teach patients to become self-carers, and to deliver care the local population the needs, in a safe and qualitative manner. This will be done through projects such as a practice staff skills audit (leading to a better understanding of

education and development requirements), practice nurse leadership courses, and *Making the Move* (an initiative supporting secondary care nurses to move into general practice); these are already being developed and implemented. This improved profile for the primary care workforce will be an important legacy for NHS SEL.

3. Develop leadership talent – both clinical and managerial

As delivery of healthcare evolves, so health leadership must evolve and reflect it. Future leaders will focus on leading whole health systems, partnerships and collaboration, and need development accordingly, supported by the National Leadership Academy.

NHS South East London is participating in a London-wide scheme which uses a transparent, systematic approach to recognising top talent. Senior managers identified through this as having leadership potential will be eligible to join regional and national talent programmes. SEL recognises the need for the leadership of clinical networks and the contribution they bring to the local and regional levels.

7.4 Integrated health informatics

We know that our clinical commissioners will need high quality integrated health informatics to support and track delivery of our CSP. It is also clear that our current informatics capability is inadequate for these purposes, and our objective is therefore to revolutionise the informatics available to commissioners and the health system. As a first step, the cluster will undertake an evaluation of informatics needs and current provision, with the aspiration to use the planning South London CSO as the vehicle for future service provision if this can meet requirements.

Based on current knowledge, we envisage the establishment of a commercial-standard business intelligence function, with the ability to collect and analyse data from different care settings and to delivery standard and bespoke reports to a variety of commissioners at different levels, thereby enabling effective monitoring and decision-making. This would involve the creation of a single customer-focused informatics team and the development of a pan-South London data warehouse, containing data from primary, community, social and secondary care – for physical and mental health. The data warehouse will adhere to agreed service levels in terms of performance, availability, resilience, business continuity, disaster recovery and security.

While commissioning support is our primary focus, there are two further aspects of informatics we will need to support and influence:

- Proactive management of individual patients' healthcare

  A number of boroughs in South East London are implementing a population health management and patient risk stratification solution, which will enable GP practices to identify patients at risk of hospital admission and ensure they are taking steps to prevent it. The information available will help GPs to take accountability for their patients' whole experience of NHS care. NHS SEL will facilitate active learning and

sharing between the early borough adopters and those which have not yet progressed a population health management informatics solution.

- Enabling of joined-up care, through electronic scheduling and shared patient records

  Whilst ownership of clinical and booking systems rests with providers, the availability of the right informatics is, from NHS SEL's perspective, crucial to the implementation of its vision of joined up care and its priorities around integrated care. By maintaining delivery focus on outcomes, the cluster will ensure local solutions are pragmatic and business-led.

7.5 Estates

Buildings are key enablers to the delivery of high quality health services, and in particular for us to deliver our ambition for expanding integrated care and care out of hospital services. We have a portfolio of 138 properties; 72 leasehold and 66 freehold. Whilst there are some high quality buildings in the portfolio, many older properties need significant new investment or replacement. Backlog maintenance has been estimated at £8-10m and a capital programme of £7.244m is anticipated in 2011/12 of which £2.625m comprises grant to assist the transfer of properties used by Learning Disability services.

We also have scope for disinvestment in some properties. With careful planning, up to 10% of the older stock could be released, creating more scope for future investment in the remaining properties. Key new developments include plans in Lambeth for Ackerman Road and Norwood Hall, in Greenwich for Eltham Community Hospital and the Heart of East Greenwich Health Centre, in Southwark the strategy for the Dulwich Hospital site and in Bromley the disposal of Bassetts House

We are not only interested in estates that we own or operate. In Bromley we are working with partners to transform services currently provided from the Orpington Hospital site. We want to revitalise health services for Orpington patients and end the uncertainty about the future of the hospital site. In Bexley, we are at the early stages of planning a community healthcare campus model to support elderly and integrated care. We are exploring options that involve Queen Mary's Hospital. Both of these developments are being clinically led to meet identified needs and the estate solutions will be designed to meet the care models. We are conscious that the sites are owned by a significantly financially challenged NHS Trust, South London Healthcare Trust, that will be seeking value for money solutions to match its estate with the future capacity required to meet the needs of patients. Our strategy to expand integrated approaches to healthcare in community settings will reduce the requirement for hospital capacity (e.g. beds).

In line with Department of Health guidelines, we will develop plans to offer to transfer approximately 30% of our health centres to a small number of NHS community service providers, where they are the majority occupier. This will require disaggregation of the contracts and leases transfers. Other premises will remain under the management of NHS SEL pending further guidance from the Department of Health.

The General Practice estate is important, in particular as we aim to deliver more services in community settings. In south east London there are 268 practices. A challenge over the coming year will be to understand the investment required in that estate to ensure that it is both fit for purpose and can comply with the new requirements anticipated with the Care Quality Commission registration in April 2013.

Our estate includes 11 administrative buildings of varying sizes and quality, located across the six south east London boroughs. We have indentified scope to reduce and rationalise our administrative buildings. We anticipate that there will be a number of disposals in 2012/13 that will result in more efficient use of office premises to support our emerging CCGs. An early priority will be to secure a strategic solution to ensure that any retained administrative premises are fit for purpose, provide value for money and enable commissioning support staff to be accessible to and readily support the new CCGs or the National Commissioning Board.

7.6 Managing our finances

Financial balance is a statutory requirement for our six PCTs. Delivery of the PCTs' planned financial positions is a core priority. The Cluster and Pathfinders play a vital leadership role in this. The financial position is reviewed regularly by local Pathfinders, the Cluster Joint Board and the Board's Performance, Finance and QIPP Committee. Quarterly Joint Cluster and BSU QIPP stocktake meetings provide executive assurance of financial and service performance including QIPP delivery and review progress against the achievement of full authorisation. Internal and external audit review the PCTs' financial management, reporting and controls.

The achievement of in-year and underlying financial balance is supported by the delivery of Recovery Plans. These plans are kept under Board review as part of the agreed overall financial reporting arrangements. Savings proposals are developed through a process of budget challenge across all areas of activity, which includes an approach of targeting a stretch 150% of savings required in order ensure delivery of 100% of targeted savings.

Organisational change and the associated period of transition bring significant changes in the responsibilities of individual staff members, different reporting lines and changes in key personnel and represents an organisational risk. The Cluster and BSU finance teams is working with senior staff to ensure changes to the budgetary framework are quickly embedded, including:

- Revised budgetary framework
- Refreshed budgetary delegation to budget holders
- Refreshed authorised signatory lists
- Enhanced reporting arrangements
- Budget holder guidance and training

We actively pursue debtor management to ensure all income due to the PCTs is recovered. Our processes ensure that creditors are paid efficiently and on time within the Better Payment Practice Code. Outstanding creditor balances are, wherever possible, minimised.

8. Impact on the System

The projected outcomes of our strategy in terms of activity and finance, together with its potential implications on key providers of NHS SEL, the associated risks and planned mitigations

8.1 Impact on patients and public

The Equality Delivery System (EDS) is a new tool with a new nine-step approach to equality and human rights has been developed for the NHS. The aim is to improve transparency, engagement and performance on equality and human rights across all aspects of NHS activity. The intention is that as far as possible the equality responsibilities of an organisation should be part of routine business, whether strategic development, business planning, commissioning or service provision, (i.e. all).

In the SEL Cluster, we have been working with the equality leads from the six BSUs and from the local Provider Trusts in conjunction with the Cluster Corporate Equalities Group, to ensure that our EDS implementation plan meets its objectives. On 14 November 2011, the SEL Cluster held an Equality Delivery System launch event to explain the system, roles and expectations to stakeholders. Local interested parties who attended included LINks, staff, GP Pathfinders, clincial leads, local authorities, voluntary organisations and union representatives.

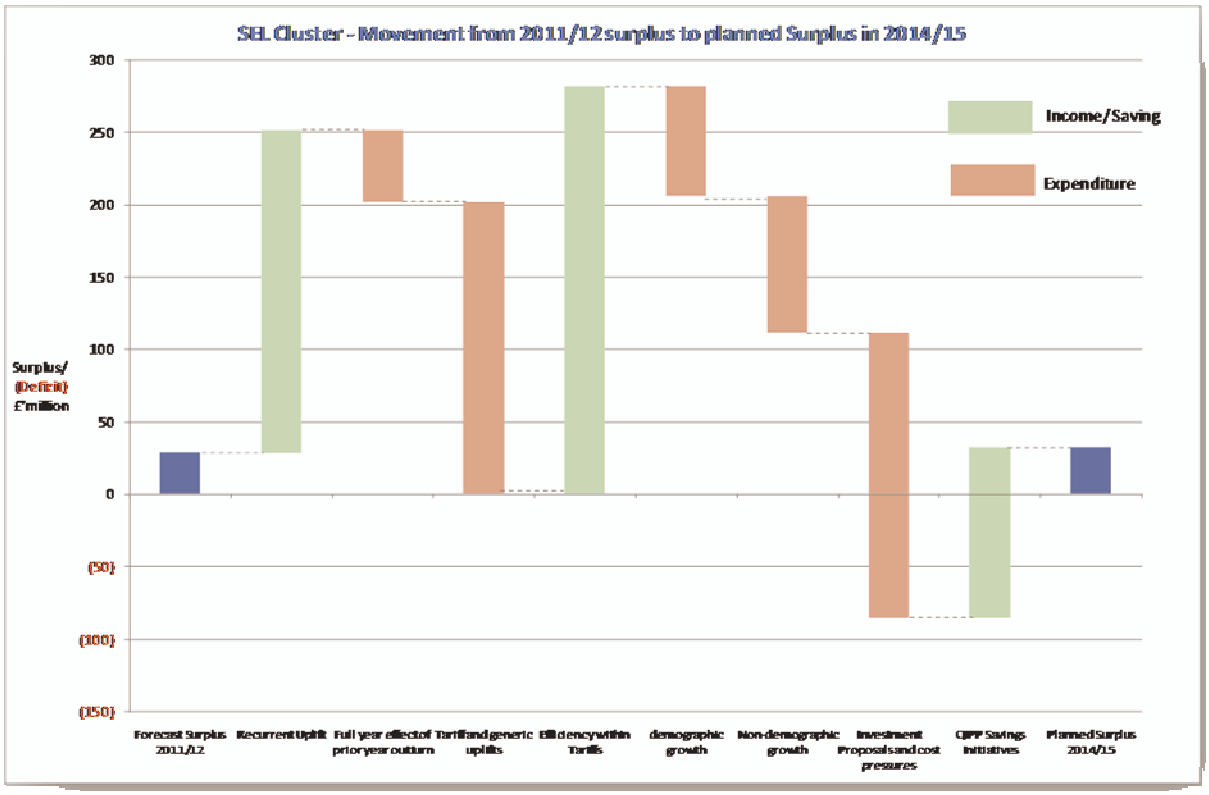
Work on reviewing the QIPP programme in the light of equalities is being pursued and we are in discussions with NHS London and the Department of Health regarding the potential of jointly working to implement the EDS framework in detail to two areas, unscheduled care and introduction of the 111 number.

Our strategy will transform primary and community services and provide care and support in home and community settings. Fewer patients will need to attend hospital services. Our integrated approach will be built around the needs of patients. Better joined up and personalised care will result in better patient experiences, fewer duplicated diagnostic tests and better co-ordination of contacts with health and social care professionals. We aim to develop a more structured approach to gaining feedback and experiences of patients and ensuring that our service plans are improved by building upon patient feedback.

8.2 Summary Income and Expenditure Plan

Financial Plans have been updated for each borough and for each the three years based on NHS London's planning guidance and locally developed investment and QIPP savings plans. Changes to income and expenditure, by PCT, is set out in the Appendices and also summarised in total for South East London below:

Figure 4: Change in Income and Expenditure 2012/13 – 2014/15



8.3 Impact of savings initiatives across care settings

Existing detailed QIPP savings plans have been reviewed by CCGs with support from Cluster teams. New QIPP schemes have been initiated and included in financial plans. In total QIPP savings schemes across 2012/13 – 2014/15 total £173.5m, however schemes have been RAG rated to deliver savings of £117.8m and it is this total that is assumed to be delivered within financial plans.

A summary of QIPP initiatives and their impact by expenditure area over 2012/13 to 2014/15 is set out below:

Table 4: QIPP Savings by Expenditure Area 2012/13 – 2014/15

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	Total SEL cluster
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Planned QIPP Savings Before Risk Rating							
Acute	24,170	14,173	25,146	18,441	20,682	16,562	119,174
Client Groups	1,744	147	6,062	11,417	3,300	3,961	26,631
Primary Care	1,250	3,612	3,037	4,207	1,650	4,869	18,624
Corporate	0	0	1,192	781	400	2,343	4,716
Other Budgets and Reserves	3,788	485	0	0	100	0	4,373
Total	**30,952**	**18,417**	**35,436**	**34,846**	**26,132**	**27,735**	**173,518**

Planned QIPP Savings After Risk Rating							
Acute	12,802	8,100	16,345	13,249	13,668	13,353	77,517
Client Groups	1,244	(23)	4,148	7,371	2,475	3,761	18,977
Primary Care	1,250	1,836	2,462	3,160	1,238	3,350	13,295
Corporate	0	0	1,192	391	200	2,003	3,786
Other Budgets and Reserves	3,788	364	0	0	75	0	4,227
Total	**19,084**	**10,276**	**24,147**	**24,171**	**17,656**	**22,468**	**117,801**

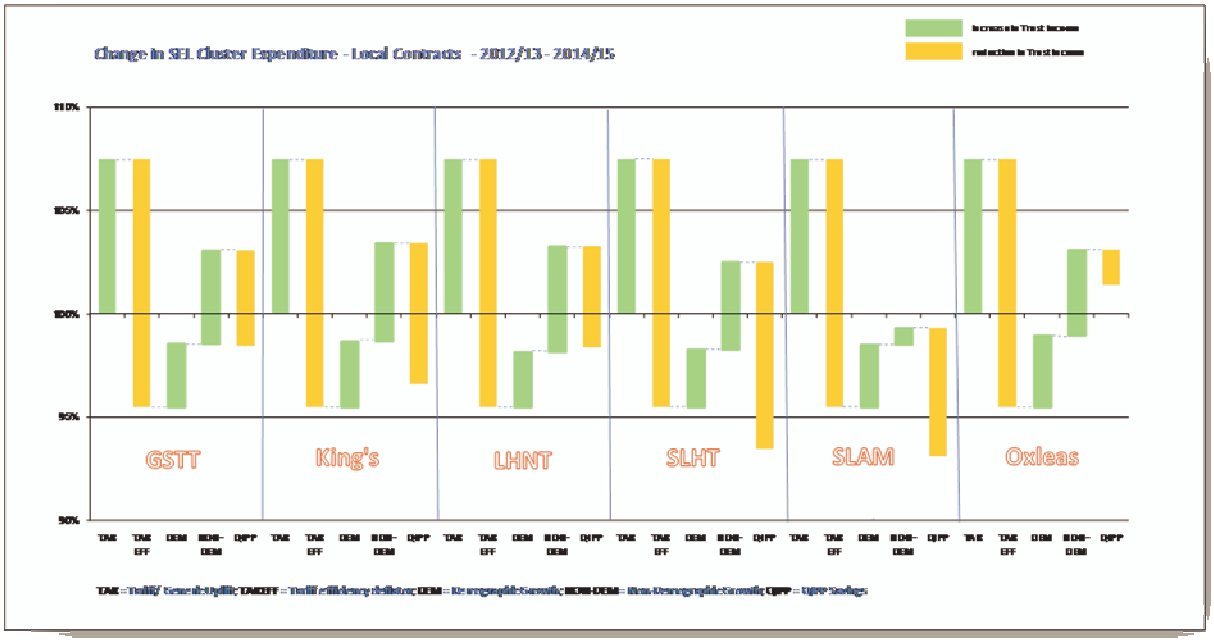
[**DN** – the following needs to be reworded in terms of strategic investment]

It should be noted that at this stage the Bexley QIPP programme includes unidentified QIPP of £3.488m in 2012/13, which will be required for the Care Trust to deliver a 1% surplus in 2012/13. This remains under review and discussions are ongoing around special assistance for the Care Trust including cluster-wide solutions to delivering financial balance over the medium term.

8.4 Provider Impact

An initial impact assessment of plans on local providers income from SEL is set out below with further detail by year in the Financial Appendix. This assessment will continue to be refined based on discussions and negotiations with providers, further detailed working up of QIPP implementation plans and taking into account detailed guidance for 2012/13 and beyond.

Figure 5: Change in Local Trust Income 2012/13 – 2014/15



9. Implementation

How opportunities that make up our four strategic programmes will be delivered and monitored and how we will address the risks associated with the Commissioning Strategy

9.1 Implementation plan

Figure 6: High level Implementation Roadmap

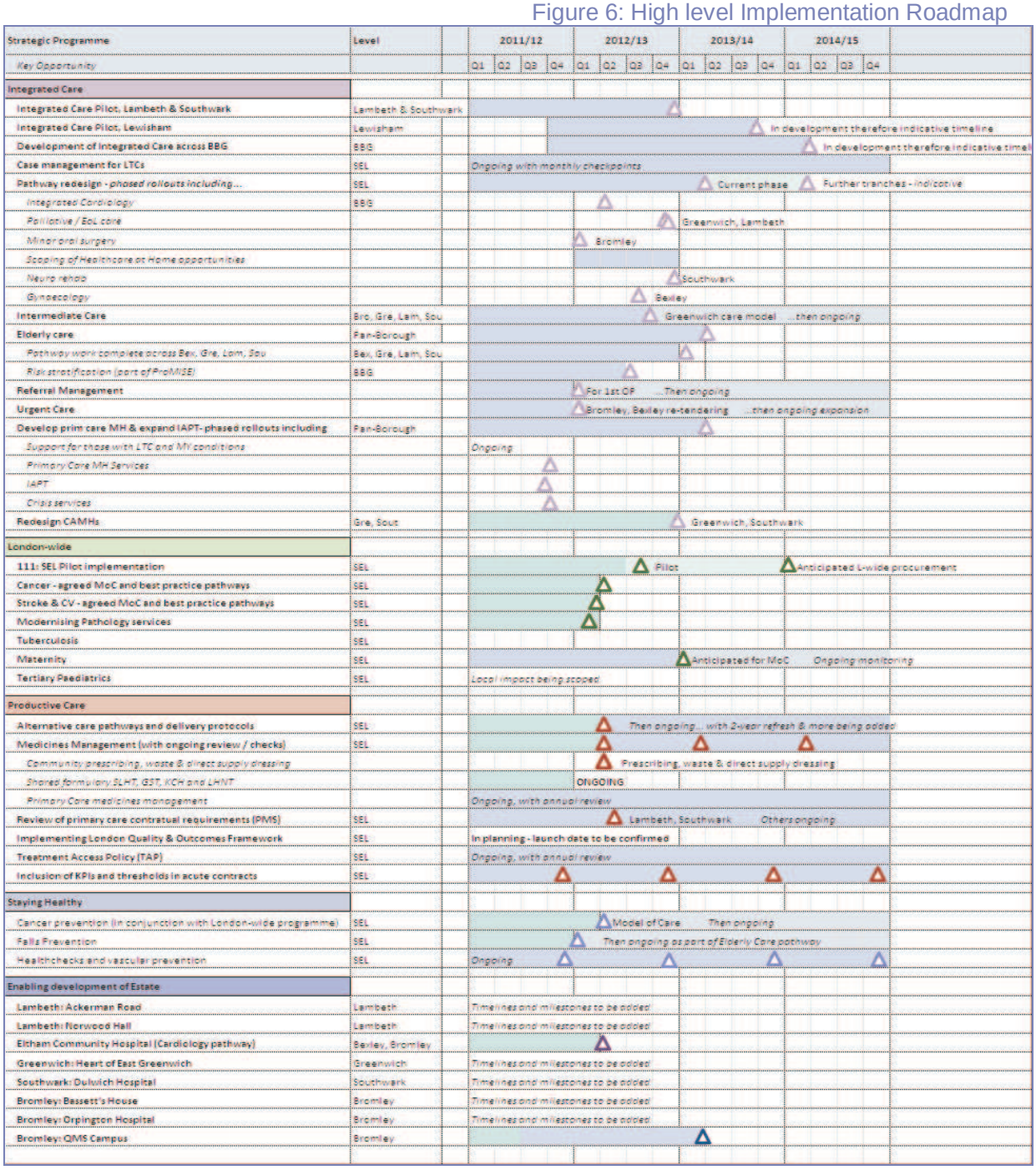


Figure 6 shows the high-level implementation roadmap for strategic priorities across SEL. This shows the delivery trajectory for our most critical opportunities (current and new) – detailed implementation plans for each of the four strategic programmes are under development and will be included in the February refresh of this strategy.

9.2 Delivering our strategy

Through our strategy, we will enable more people In South East London to stay healthy and mean that every patient will experience joined-up healthcare which meets their needs in the most effective way. It is also a crucial element of CCG authorisation and an effective transition to a reformed health system.

Our monitoring will be effective, issues will be promptly resolved, risks identified and managed and impediments to delivery will be removed at the earliest opportunity.

From a governance and management perspective, monitoring mechanisms must be established and maintained through a period of organisational transition. Our approach will be:

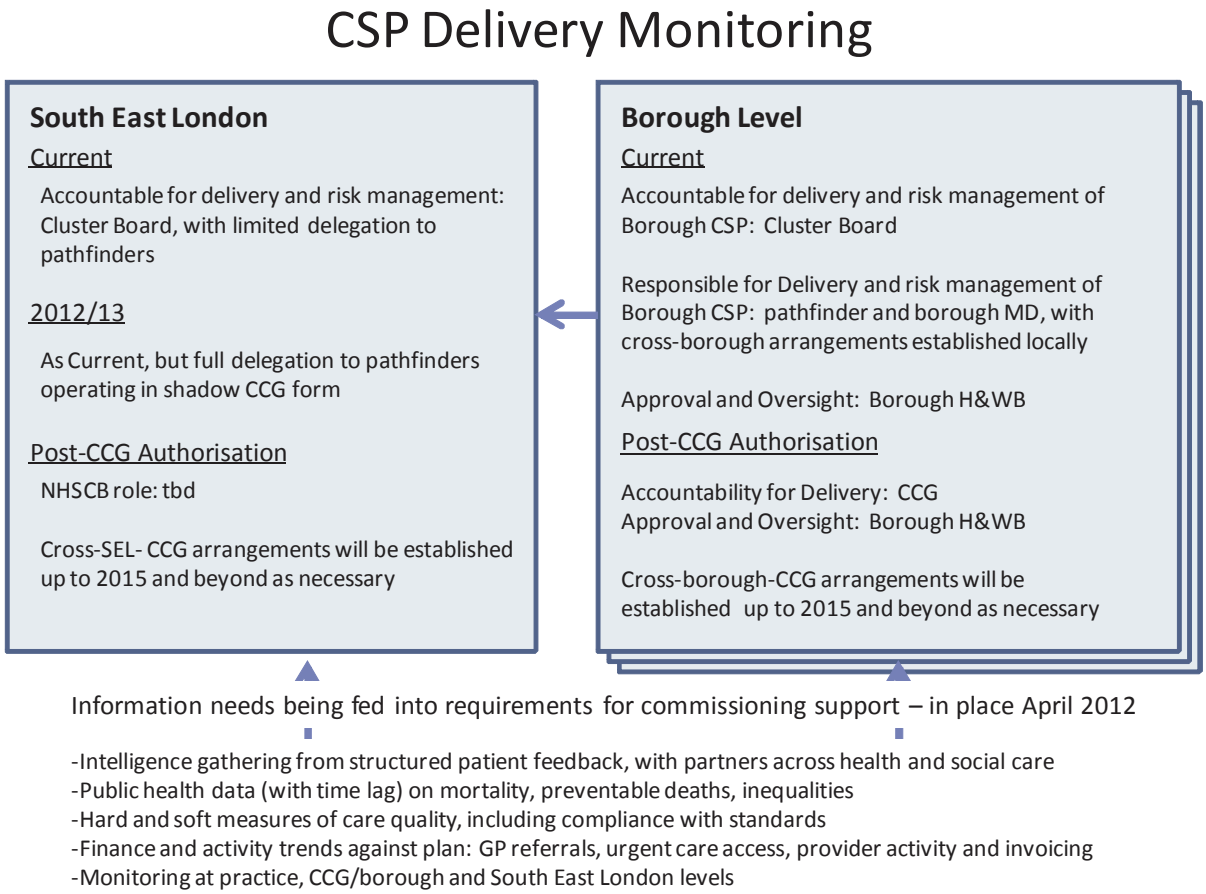
- Governance: establish clear arrangements for 2012/13, maintaining clear accountability and transparency at cluster level, whilst continuing the process of devolved responsibility to CCGs for a full shadow year in order to develop them for authorisation; design these arrangements so that they can migrate easily to the post-authorisation framework as this becomes clear

- Information: build CSP delivery monitoring information needs into the requirements for commissioning support, for which organisational arrangements will be in place by April 2012; the information collection, reporting and review mechanisms will be designed to give early warning of issues to be addressed. Of particular importance will be the development, with borough and provider partners, Links/Health Watch and patient participation group, of an integrated approach to the collection and review of patient feedback necessary to measure the achievement of our strategic goals

- Support and intervention: resources at cluster level will be organised to provide targeted support for the resolution of issues arising, whether with borough or cross-borough initiatives and performance or with wider threats to the delivery of the South East London strategic goals.

The figure below sets out our thinking on governance and information at this stage. Further work is planned to specify and put in place fully-functional arrangements by April 2012.

Figure 6: CSP Delivery Monitoring Framework



9.3 Risks and mitigations

This section provides a high-level analysis of the risks identified to the successful delivery of the CSP, together with mitigating actions.

Table 5: Strategic Risks and Mitigation

#	Risk	Mitigation
1.	There is a risk that attention on CSP delivery causes a loss of focus on operational performance and the quality and safety of services	SEL Cluster continues to manage the SEL All Risk Register.
2.	There is a risk that there will be insufficient clinical leadership to drive the strategy and sustain it to 2015 and beyond	See Clinical Leadership section
3.	There is a risk that the delivery of QIPP savings will slip, resulting in failure to meet CSP strategic goals around effectiveness and a lack of funding to invest in the change required for CSP delivery	QIPP planning aims to deliver 150% of the requirement Existing QIPP governance to track delivery

#	Risk	Mitigation
4.	There is a risk that the projected impact of CSP delivery, combined with their current position, will mean that NHS hospital trusts in SEL fail to achieve a viable position and are unable meet the requirements of Foundation Trust status	See detailed mitigation actions below in respect of South London Healthcare Trust and Lewisham Healthcare Trust
5.	There is a risk that the skillset and capacity of SEL workforce will not support the new models of care envisaged in the CSP as necessary to deliver our strategic goals	See Workforce section
6.	There is a risk that, on top of recent changes, further reorganisation and restructuring will diminish our organisation's ability to deliver: staff focus on delivery may suffer, skilled individuals may leave and organisational memory may be lost	Use delivery of this strategy as a rallying point. Continue to build ownership and develop capability and capacity at borough level Organise cluster resources to provide responsive and targeted support to cluster and borough level initiatives
7.	There is a risk that insufficient business intelligence will be available to enable cluster and borough leadership to monitor CSP delivery and make early interventions to remove barriers to the realisation of benefits	See Delivery Monitoring and Integrated Health Informatics sections

9.4 Foundation Trust pipeline

The Cluster contains a number of established Foundation Trusts in the form of acute providers GST and King's and mental health providers SLaM and Oxleas. Additionally the Cluster is heavily involved in supporting the Foundation Trust pipeline process for SLHT and Lewisham Healthcare:

South London Healthcare Trust

In considering the provider landscape south east London commissioners are live to the fact that South London Healthcare Trust [SLHT] is a highly financially challenged provider. It provides most of the general acute services for Bexley, Bromley and Greenwich patients and receives the majority of its patient income from south east London commissioners. There is consequently a high degree of

interdependency between the Trust's financial position and the financial health of the PCTs and future CCGs. The historical context is seen to be important here.

South East London commissioners have already led and successfully implemented a major reconfiguration of the acute services platform in outer south east London through the "A Picture of Health" (APOH) programme. 2011 saw the closure of an Accident and Emergency (A&E) department and maternity services on the Queen Mary's site in Bexley and consolidation of these services on the Queen Elizabeth site in Greenwich and the Princess Royal site in Bromley. Whilst many of the clinical benefits of this programme have been secured, including the mission critical improvement required in patient safety in A&E and in maternity services, the benefits have not resolved the financial problems of the Trust. We will need to take this into account in our strategic planning in order to secure the continuance of the core and essential services SLHT provides to our patients.

Our approach will include commissioner support for the work streams and milestones outlined in the Tripartite Framework agreement which sets out the journey that the Trust has committed to in respect of achieving Foundation Trust status and financial viability. A significant element of that work is internal productivity work to be undertaken within the Trust and the Challenged Trust Board has already supported a significant programme of work exploring the opportunities for such gains. Commissioners will therefore be working alongside other signatories to that agreement to understand the firm time line for delivery of improved cost control and productivity. In addition SE London Commissioners will be driving a clinically led process to design services that meet the identified needs of patients across primary, community and secondary care. Our overall strategy reduces the need for hospital capacity and increasingly delivers integrated care in community nad home settings. Our clinical commissioners will explore and agree the service model to be delivered for Bexley and work with the Trust to find solutions to the QMS campus proposals and for the future of the Orpington site.

We acknowledge that these are potential areas of cost reduction for the Trust as part of a required capacity reduction programme and as such the business cases for both of these areas and the services required within them must be sound, robust and affordable from both a commissioning perspective and a provider perspective. This is complex work and it is recognised that the business case development requires particular attention and priority. The commissioner view is that focus needs to promptly turn from income generation to capacity and associated cost reduction based on a needs led strategy in favour of a supply led strategy. The combination of financial and organisational issues for SLHT pose considerable risk to the delivery of the south east London commissioning strategy and the financial viability of Bexley, Bromley and Greenwich PCTs and the future CCGs.

Lewisham Healthcare

Lewisham Healthcare is a combined acute and community Trust with a strong track record of close partnership working with Local Commissioners. Our approach to supporting its ambition to become a Foundation Trust will be set within the context of the Tripartite Framework agreement which sets out the journey that the Trust has committed to in respect of achieving Foundation Trust status and associated financial viability. Commissioners will therefore be continuing with the significant raft of service redesign work streams already in train in Lewisham and which seek to maximise the benefits of an integrated Trust such as Lewisham healthcare.

Appendix A: CSP Summaries by Borough

Appendix B: Financial Case for Change and Delivery of Financial Balance

Please see separate attachments for Appendices.