



Joint Health Overview Scrutiny Committee (JHOSC)

26th September 2018



A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England





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Background

OHSEL was first established in 2013 by local health commissioners, to promote and develop more integrated, out-of-hospital and preventative care. Since 2015, and the creation of STPs, OHSEL now includes representatives from NHS trusts, local councils and other stakeholders, working in partnership to ensure a sustainable future for NHS services in south east London.

OHSEL represents a range of complex projects at different stages in their development. Our plans are the result of several years of discussion between patients, members of the public, doctors, nurses and other clinicians from different settings, council representatives, local and national commissioners and many others.

In 2018, the focus of the STP continues to be on how we can make services sustainable for the people of south east London, delivering high quality patient care with the best possible outcomes in ways that are affordable. To achieve this we are focusing on three key areas:

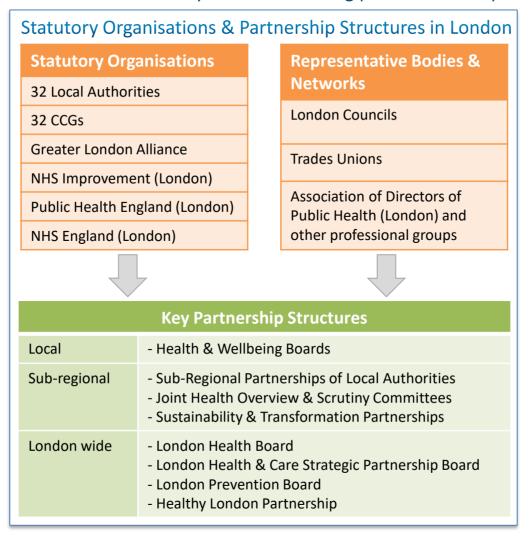
- 1. Integrated care systems, especially focusing on coordinated work at borough level and maximising the opportunities for community based care. These borough (or place based) systems are characterised by close working between CCGs, primary and community care and local authorities with involvement of local acute service providers.
- 2. **'End to end pathway work'**, which continues to be the focus of our clinical leadership groups. These pathways work from prevention and self-care through primary, community, acute and tertiary services and bring together physical and mental health. We know that evidence based, well-managed pathways lead to better patient outcomes and cost effective care.
- 3. **Provider collaboration** work, which includes productivity work in areas such as procurement, but is also increasingly looking at clinical collaboration to support fragile services and networked services for cancer, orthopaedics and pathology.





Introduction

This is a basic pack aimed at new JHOSC members who may have no previous experience in working with health partners. It is presented as briefing material ahead of the scrutiny committee taking place on 26th September 2018.



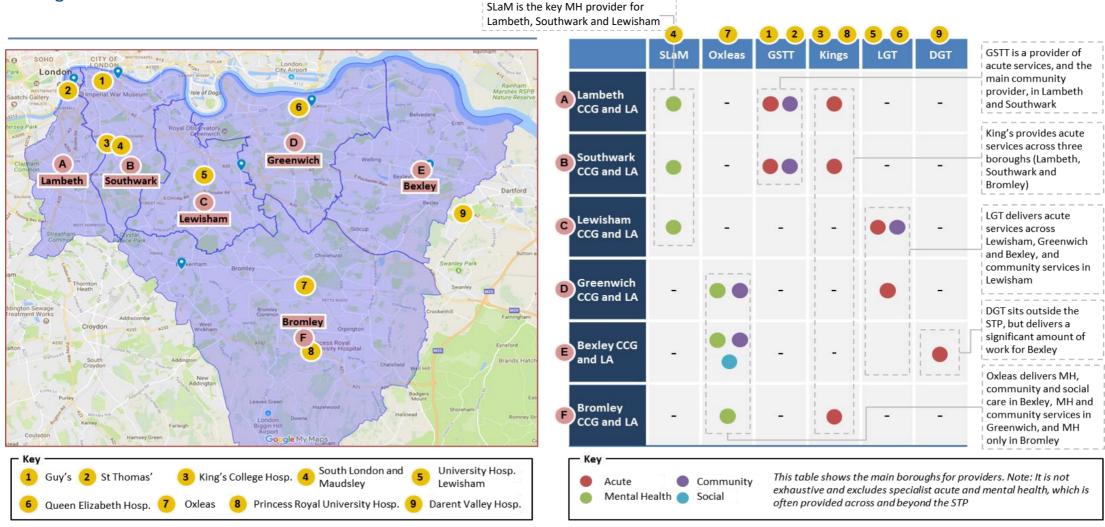
Our Healthier South East London

NHS

Sustainability and Transformation Partnership

SEL STP Map

South East London is a complicated system, with a diverse population served by many different and overlapping organisations.

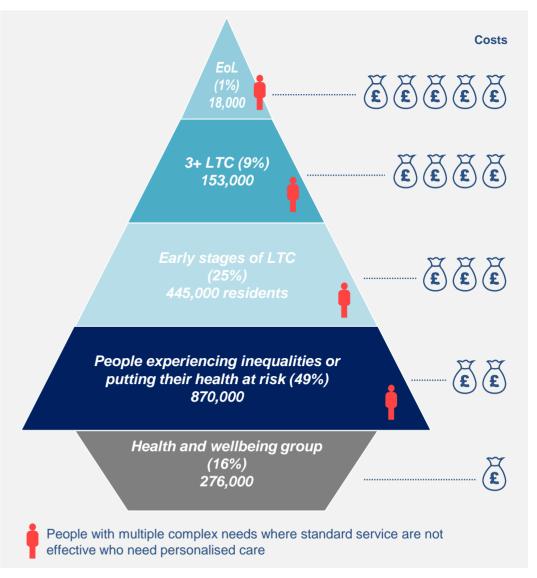






The case for change (2016)

- Locally, we face many of the challenges that are experienced nationally. The three gaps that are identified in the 5YFV are found in SE London.
- The quality of care that patients receive too often depends on when and where they access services, resulting in variable outcomes and patient experience.
- In order to prevent these challenges from getting worse, it is imperative we ensure our population is enabled to stay well.
- However, we face a number of challenges to the prevention agenda, such as workforce recruitment and retention, and significant financial pressures across the health and care system.
- The model (right) segments our population into groups depending on their condition and level of risk.



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Sustainability and Transformation Partnership



STP plan on a page (2016)

Our challenges

Jurfive priorities and are

The impact of our

Demand for health and care services is increasing.

There is unacceptable variation in care, quality and outcomes across SEL.

Our system is fragmented resulting in duplication and confusion.

The cost of delivering health and care services is increasing.

Developing consistent and high quality community based care (CBC), primary care development and prevention

Improve quality and reducingvariationacross both physical and mental health

Reducing cost through provider collaboration

3

Developing sustainable specialised services

- · Promoting self-care and prevention
- Improved access and coordination of care
- Sustainable primary care
- Co-operative structures across parts of the system
- · Financial investment by the system
- Contracting and whole population budgets

- · Integration of mental health
- · Reduce pressure on and simplify A&E
- · Implementation of standards, policies and auidelines
- Collaborate to improve quality and efficiency through consolidation (e.g. Elective Orthopaedics)
- Standardise care across pathways

 Standardise and consolidate non-clinical support services

- · Optimise workforce
- · Capitalise on collective buving power
- Consolidate clinical support services
- · Capitalise on collective estate

- · Joint commissioning and delivery models
- · Strategic plan for South London
- London Specialised Commissioning Planning Board
- Managing demand across boundaries
- Mental health collaboration

Changing how we work together to deliver the transformation required

- Effective joint governance able to address difficult issues
- Incorporation of whole commissioning spend including specialist
- Sustainable workforce strategy
- Collective estates strategy and management
- New models of collaboration and delivery

- Reduction in A&E attends and non-elective admissions
- Reduced length of stay
- Reduced re-admissions
- Early identification and intervention
- Delivery of care in alternative settings (Net savings c.£119m)

Cross-organisation productivity savings from joint working, consolidation and improved efficiency.

(Net saving c. £232m)

- Increased collaboration
- Reduced duplication
- · Management of flow

(Need to address £190m)

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability





Working with JHOSC

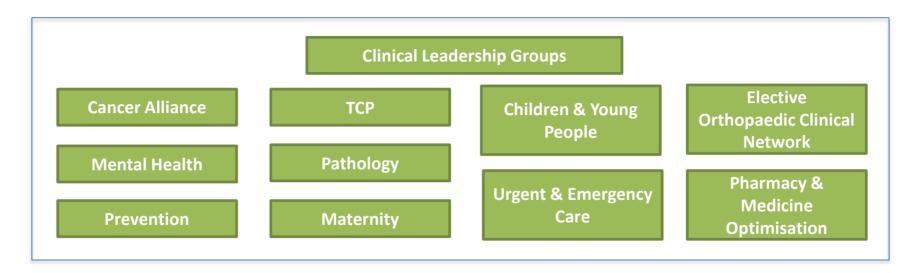
These are examples of some of the programmes that have been scrutinised by the JHOSC over the last few years:

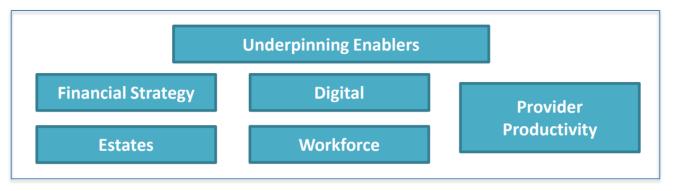
- Looking at proposals for orthopaedic surgery (2016)
- Kings' College Hospital Financial position (2018)
- Urgent and Emergency care (2017)
- Mental Health (2017)





OHSEL Programme Structure









Cancer

The SEL Cancer Alliance is one of the clinical programmes of work to support the transformation of care across South East London.

Priorities include:

- Preventing people from getting cancer.
- Screening for cancer.
- Treating patients who have been diagnosed with cancer in a timely way. Performance is measured through the '62 day cancer performance' targets.
- Living well with and beyond cancer.
- End of life (palliative) care.

Recent achievements include:

- Working closely with NHS Improvement's Intensive support team on reducing waiting times.
- Development of a one-stop gynaecology clinic at the Queen Elizabeth Hospital.
- Expansion of clinic for patients with worrying symptoms that do not fit a specific pathway across SE London.

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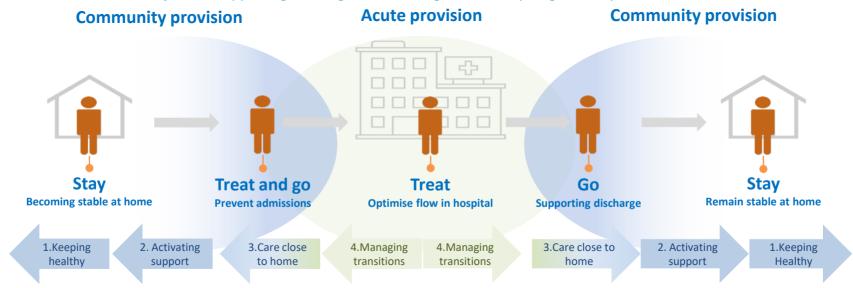
Community Based Care (CBC)

The STP Community based care programme is one of the Clinical Leadership Groups established to support the transformation of care across South East London.

Community based care delivered by Local Care Networks (LCN) is the foundation of our whole system model. There is no standard south east Londoner for us to model our service on. As such, we have built our LCNs around geographically coherent and self-identifying communities, supported by scaled up general practice using natural boundaries within boroughs.

The programme sets out how quality primary and community care will be consistently provided by Local Care Networks (LCNs) supporting local populations. LCNs will involve primary, community and social care colleagues working together and drawing on others from across the local health system to provide proactive patient centred care. Services respond to the varied needs and characteristics of our local communities and support the development of services that our patients and communities said mattered most to them:

- 1. "Keeping healthy and preventing illness and managing my condition" Promote prevention, self-care, and self-management close to home.
- 2. "Activating support from my family, carers and community" Build strong and confident communities and involved, informed patients and carers.
- 3. "Receiving great quality whole person care close to home" Bring primary care and community services together providing a wider range of care close to home.
- **4.** "Easy transitions in and out of hospital" Supporting discharge and reducing unnecessary length of stay.







Children & Young People

The CYP programme aims to bring commissioners, providers and parents and children together to define, design and deliver a transformation programme of work across all services for children and young people. The programme responds to a number of policy initiatives including the Five Year Forward View, Future in Mind, SEND reforms, Children's Continuing Care and also emerging policy and best practice.

It aims to deliver improvements in access, outcomes and experience of a range of CYP services.

CYP Mental Health Programme aims to deliver:

- Intensive Treatment Programme (ITP) refresh for young people.
- Prevention and early diagnosis of mental health problems in children and young people.
- Improving and increasing access to specialist treatment when needed.

Special Educational Needs and Disability (SEND) and Complex Needs:

Detailed work has taken place to improve the care that children receive to make it more coordinated and consistent. Examples include:

Neuro Developmental Treatment pathway, Autism, ADHD

Long Term Conditions and Urgent & Emergency Care

- Improving the health of children with Asthma to reduce the impact on their day to day lives.
- Improving the experience of children accessing Urgent Care services.

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Maternity

The Local Maternity System is a non-statutory partnership of providers, commissioners and service users (through each local borough's Maternity Voice Partnership's (MVP's)) working across the STP.

The maternity programme's strategy, direction of travel and focus areas arise from the recommendations of the Better Births National Maternity Review.

Our Better Births Plan was developed earlier this year and covers the following areas:

- Personalised care
- Multi-professional working
- Continuity of carer
- Improving safety
- Better postnatal and perinatal mental health care.

The main deliverables of this plan are to improve choice and personalisation of maternity services so that:

- All women have a personalised care plan.
- All women are able to make choices regarding their maternity care.
- Continuity of carer for most women.
- More women able to give birth in midwifery led settings.

The plan also aims to improve the safety of maternity care through:

- Reducing the rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020 and 50% by 2030.
- Ensuring that services are learning from incidents and that this learning is shared.





Mental Health

The STP Mental Health workstream is one of the clinical programmes of work to support the transformation of care across south east London. The programme's delivery priorities and objectives are in line with the 5 Year Forward View in order to meet the rising demand for mental health services.

The programme also provides a governance framework for collective monitoring and reporting of performance against the standards.

The 5 areas of focus for 18/19 are as follows:

- Developing the Mental Health workforce to deliver 5 Year Forward View targets.
- Supporting CCGs and Providers in reducing inappropriate Out of Area Placement (OAPS) and strengthening crisis pathways.
- Working with employment support providers to submit bids for funding to increase the number of Individual Placement Support (IPS) services within south east London.
- Children's and Young People's Mental Health (CYP MH) Increasing service capacity and capability to enable more young people to have access to services.
- Support commissioners and providers to deliver the Increased Access to Psychological Therapies (IAPT) and Long term condition model to achieve IAPT 5 Year Forward View standards.





Urgent & Emergency Care Programme

There is a growing demand for urgent and emergency care services, but we know that some of the people who access these services could be seen in other settings, such as by a GP. We also know that sometimes it can be hard to understand which of these services should be used, which often means that patients spend a long time waiting in an A&E department when they could have been cared for elsewhere more quickly.

In the south east London urgent and emergency care programme we are working towards:

- Joining up the south east London services.
- Directing patients to the right settings and professionals for their care needs. An example of this work is through transforming NHS 111 into an Integrated Urgent Care service.
- Looking at how we can enhance care in other settings. For example changing our urgent care centres into urgent treatment centres.
- Supporting the winter planning process. This involves bringing the health and care system together to prepare for the winter season and to review performance and learning once the season has finished in order to build on opportunities for improvement.





Pathology Programme

Provider Trusts and Clinical Commissioning Groups in South East London have been working together to develop a network for delivering pathology services. All providers will have to be part of a pathology network in the future.

The Pathology programme board was formed in September 2017 and is informed by a number of working groups including clinical input from pathology clinical leads and pathology service users and a workforce group that will engage with directly employed pathology staff.

To create the network model, the programme has launched a procurement process and issued a tender notice (in August 2018) to look for a pathology provider or providers who are able to provide services that meet our clinical needs, make the best use of the latest technology and are both safe, efficient and fit for the future. Most of our local providers are part of the procurement process already. Lewisham & Greenwich Trust will make a decision about joining later this month.





SEL Elective Orthopaedic Clinical Network

- Osteoarthritis is a condition that affects a person's joints hips, knees, ankles, shoulders and elbows causing pain and stiffness reducing a person's quality of life through reduced mobility, ability to care for oneself e.g. washing and dressing and inability to carry out usual home, work, social or community activities. Pain and discomfort experienced through this condition can increase a person's anxiety and depression.
- It most commonly occurs in weight-bearing joints (a person's hip or knee) during middle to late adulthood (50-84) years. In South East London Arthritis Research UK estimates that 1 in 5 people aged 50-84 suffer mild knee osteoarthritis and 1 in 8 people aged 50-84 suffer mild hip osteoarthritis.
- For the most severe osteoarthritis surgery is required to replace a damaged and painful joint with a prosthetic. In 2017/18 1,444 SE London patients received replacement knees and 1,184 patients received replacement hips.
- SE London Providers (Guy's & St Thomas' NHS Foundation Trust, King's College London NHS Foundation Trust and Lewisham & Greenwich NHS Trust) have formed a clinical network to deliver improvements in the quality of patient care and outcomes for this care pathway, as well as working to deliver these services as efficiently and sustainably as possible. This network comprises patients, surgeons, nurses, managers and all staff involved in the care pathway. We aim to recruit 2 more patient and 1 carer representative into the network.
- The network has co-produced an optimal care pathway for delivery of planned hip and knee replacement surgery and is now working to develop service improvements which bring the current services in line with the optimal pathway.





Digital Enabler Programme

The STP digital programme is one of the enabling streams of work to support the transformation of care across South East London.

The aims include:

- Improving information sharing for health and care professionals to support effective and timely decisions for individuals in their care.
- Ensuring that information is shared safely, securely and appropriately.
- Developing IT infrastructure to support more flexible working for health and care teams.
- Supporting use of technology to improve access to health and care services, advice and guidance and individual care records.
- Encouraging innovation, appropriate use of technology, and adoption of national initiatives to improve services and/or reduce costs.

The programme is overseen by a Digital Board which has citizen, clinicians and technology representation from each health and social care sector. This is supported by a small team based at the STP, including part time secondments of a Clinical Chief Information Officer and a Chief Information Officer.

The STP has used national awards of Estates and Technology Transformation Funding (ETTF) to support the work programme to date. An allocation of NHS national digital monies (of circa £13 million over the next three years) is currently being confirmed.

Recent developments include the delivery of a real-time shared care record (Virtual Care Record); an information sharing framework; scanning of GP held records, piloting of patient apps and development of a digital strategy and supporting workplan for the STP.

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Estates Enabler Programme

Overview of STP:

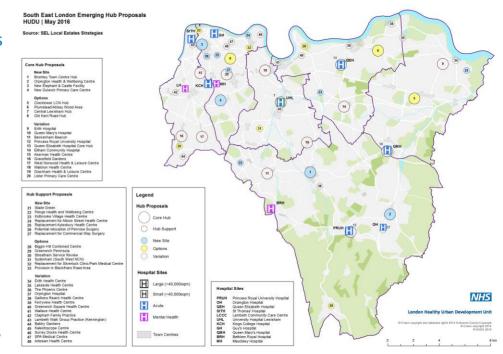
- focused on delivering transformational change through new care models targeted at both meeting the growing health and care demands of the population more effectively whilst achieving long-term financial sustainability across the SEL health and care landscape.
- Future will provide place based care through care networks/hubs
- 8 acute sites ranging from poor quality to newer PFI buildings.

Overview of emerging STP healthcare models:

- Delivery of transformational change through the development / implementation new models of care
- Delivery of high quality, accessible, integrated care closer to home
- Delivery of solutions to reduce improve quality and reduce variation
- A focus on prevention & long-term improvements in health and wellbeing
- Delivery of solutions to achieve long term financial sustainability across the SEL health economy

Priority Programmes & Projects:

- Utilisation Programme to increase average utilisation to 85%
- Delivery of disposal pipeline
- Delivery of local hub property across the area from both existing estate and new development
- Reduce non clinical use on acute/clinical sites
- Implement agile/smart working across all organisations
- Working with Councils to maximise social regeneration benefits



Key policy workstreams:

- Five year Forward View
- GP Forward View
- Carter report
- Naylor review
- London Devolution
- London Housing Strategy
- One Public Estate





Workforce Enabler Programme

This programme focuses on:

- Recruiting and retaining a skilled workforce.
- Skills development with local colleges and universities.
- Workforce productivity, such as working remotely without the need to return to base.
- Resilient workforce with training programmes supported by Health Education England.
- Adaptable workforce able to respond to changing technology and patient needs, for example online consultations.
- Representative of the communities that it serves, by encouraging diversity in the workforce and employment of local people.
- Healthy Workforce, for example by offering well-being courses at work.