Our Healthier South East London Joint Health Overview & Scrutiny Committee

Monday 1 February 2016
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Rebecca Lury – Chair
Councillor Judith Ellis – Vice Chair
Councillor Rezina Chowdhury
Councillor Ross Downing
Councillor Jacqui Dyer
Councillor Judith Ellis
Councillor Hannah Gray
Councillor Alan Hall
Councillor James Hunt
Councillor Averil Lekau
Councillor Rebecca Lury
Councillor Matthew Morrow
Councillor John Muldoon
Councillor Bill Williams

Reserves

Councillor Paul Fleming
Councillor Jasmine Ali

INFORMATION FOR MEMBERS OF THE PUBLIC

Please report to the reception desk on your arrival and you will be directed to the meeting room, which will be on the ground floor of the building.

Contact: Julie Timbrell on 020 7525 0514 or email: Julie.timbrell@southwark.gov.uk

---

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 21 January 2016

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Monday 1 February 2016
7.00 pm
Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at the meeting.	
4.	**DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING**	
5.	**TERMS OF REFERENCE** The committee will agree the Terms of Reference – a draft is enclosed, along with a briefing paper summarising the exercise of the health scrutiny function and governance arrangements for the Our Healthier South East London (OHSEL) Joint Health Overview and Scrutiny Committee (JHOSC). Enclosed are: - Draft Terms of Reference - Governance briefing paper	1 - 9

Item No.	Title	Page No.

6. OUR HEALTHIER SOUTH EAST LONDON PROGRAMME 10 - 47

The Our Healthier South East London briefing presentation enclosed will be presented by:

- Mark Easton, Programme Director OHSEL
- Dr Jonty Heaversedge, Clinical Chair, NHS Southwark Clinical Commissioning Group
- Annabel Burn, Chief Officer, NHS Greenwich Clinical Commissioning Group

The following are also enclosed:

- Our Healthier South East London: workstream and consultation briefing
- A glossary of terms used by Our Healthier South East London

7. WORKPLAN

The committee will discuss the work programme

8. PART B - CLOSED BUSINESS

9. DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

10. EXCLUSION OF PRESS AND PUBLIC

The following motion should be moved, seconded and approved if the committee wishes to exclude the press and public to deal with reports revealing exempt information:

"That the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 1-7, Access to information Procedure rules of the Constitution."

Date: 21 January 2016

Appendix 1

DRAFT

Joint Health Overview and Scrutiny Committee

"Our Healthier South East London"

(Proposals for a five year commissioning strategy developed by 6 CCGs which aims to improve health, reduce health inequalities and ensure all health services in South East London meet safety and quality standards consistently and are sustainable in the longer term)

TERMS OF REFERENCE

The Joint Health Overview and Scrutiny Committee is constituted in accordance with the Local Authority Public Health, Health & Wellbeing Boards and Health Scrutiny Regulations 2013 (the "Regulations") and Department of Health Guidance to respond to substantial reconfiguration proposals covering more than one Council area from the Our Healthier South East London programme ("OHSEL"). OHSEL is a proposal devised by the 6 CCGs covering the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. It proposes a five year commissioning strategy for the areas covered by the 6 London Boroughs represented on this joint overview and scrutiny committee. The CCGs state that the programme is developed to improve health, reduce health inequalities and ensure all health services in South East London meet safety and quality standards consistently and are sustainable in the longer term.

The Joint Committee's terms of reference are:

1. To undertake all the functions of a statutory Joint Health Overview and Scrutiny Committee in accordance with the Regulations and Department of Health Guidance. This includes, but is not limited to the following:-

   (a) To consider and respond to the proposals from the OHSEL for the reconfiguration of Health Services in South East London.

   (b) To scrutinise any consultation process conducted by the 6 CCGs in relation to OHSEL, but not to replicate any consultation process.

   (c) This does not include the power to make any decision to make a referral to the Secretary of State in relation to the proposals from the CCGs for Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. However, any individual borough may make a specific delegation to the JHOSC in relation to their own power to make such a referral on their behalf.

Membership

Membership of the Committee will be two named Members from each of the following local authorities:-

London Borough of Bexley;
London Borough of Bromley;
London Borough of Greenwich;
London Borough of Lambeth;
London Borough of Lewisham;
London Borough of Southwark.

Members must not be an Executive Member.

PROCEDURES

Chair and Vice-Chair

1. The Committee will appoint a Chair and Vice-Chair at its first meeting. The Chair and Vice-Chair should be members of different participating authorities.

Substitutions

2. Substitutes may attend Committee meetings in lieu of nominated members. Continuity of attendance throughout the review is strongly encouraged however.

3. It will be the responsibility of individual committee members and their local authorities to arrange substitutions and to ensure that the lead authority is informed of any changes prior to the meeting.

4. Where a substitute is attending the meeting, it will be the responsibility of the nominated member to brief them in advance of the meeting

Quorum

5. The quorum of the meeting of the Joint Committee will be 4 members, each of whom should be from a different participating authority.

Voting

6. It is hoped that the Committee will be able to reach their decisions by consensus. However, in the event that a vote is required each member present will have one vote. In the event of there being an equality of votes, the Chair of the meeting will have the casting vote.

7. On completion of the scrutiny review by the Joint Committee, it shall produce a single final report, reflecting the views of all the local authorities involved.

Meetings

8. Meetings of the Joint Committee will normally be held in public and will take place at venues within South East London. The normal access to information provisions applying to meetings of the Overview and Scrutiny committees will apply. However, there may be occasions on which the Joint Committee may need to make visits outside of the formal Committee meeting setting.

9. Meetings shall last for up to two hours from the time the meeting is due to commence. The Joint Committee may resolve, by a simple majority, before the expiry of 2 hours from the start of the meeting to continue the meeting for a maximum further period of up to 30 minutes.

Local Overview and Scrutiny Committees

10. The Joint Committee will encourage its Members to inform their local overview and scrutiny committees of the work of the Joint Committee and any proposals contained within the OHSEL programme.

11. The Joint Committee will invite its Members to represent to the Joint Committee the views of their local overview and scrutiny committees on the OHSEL programme and the Joint Committee's work.

Communication

12. The Joint Committee will establish clear lines of communication between the NHS, participating local authorities and itself. All formal correspondence between the Committee, local authorities and the NHS on this matter will be administered by *(named officer/borough to be determined)* or *(other)* until such officer is appointed.

Representations

13. The Joint Committee will identify and invite witnesses to address the committee and may wish to undertake consultation with a range of stakeholders. However as a general principle the committee will not consider any written or verbal submissions from individual members of the public. It will however pass written submissions on to the OHSEL programme carrying out the consultation.

Support

14. Administrative and research support will be provided by the scrutiny teams of the 6 boroughs working together.

Assumptions

15. The Joint Committee will be based on the following assumptions:-

    (a) That the Joint Health Scrutiny Committee is constituted to respond to the work of the OHSEL Programme including any proposals it puts

forward and any consultation it may carry out, as well as comment on the public and patient involvement activity in which the NHS has engaged in relation to this matter.

(b) That the OHSEL Programme will permit the Joint Health Scrutiny Committee access to the outcome of any public consultation phase prior to the formulation and submission of the Joint Committee's response to such public consultations.

Joint Health Overview and Scrutiny Committee

"Our Healthier South East London"

Briefing paper summarising the exercise of the health scrutiny function and governance arrangements for the Joint Health Overview and Scrutiny Committee

1 February 2016

---

1. Introduction

1.1. The arrangements for the scrutiny of local health services by local authorities are set out in the **Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013** ("the Regulations").

1.2. The Regulations confer the function of scrutinising local health services onto local authorities. They may discharge this function through their own overview and scrutiny committee ("OSC"), or in some circumstances the OSC of another local authority. The Regulations also provide for the discharge of health scrutiny functions by a joint OSC comprising two or more authorities (see section 3, below).

2. Powers of review and scrutiny

General power

2.1. The Regulations empower a local authority to **"review and scrutinise any matter relating to the planning, provision and operation of the health service in its area"**.

2.2. When reviewing or scrutinising a particular matter a local authority must invite comments from interested parties and to take into account information from the Local Healthwatch organisation or Local Healthwatch contractor. A local authority may also receive referrals of matters for review and scrutiny by a Local Healthwatch organisation, and in that event it must acknowledge the referral and keep the referrer informed of any action taken. These requirements aside, the procedure for review and scrutiny is a matter for a local authority to decide.

2.3. Where a local authority has reviewed and scrutinised a matter, it may make reports and recommendations to "a responsible person".[1] Such reports must follow a format set out in the Regulations. Where a local authority

[1] "Responsible person" refers to both "relevant NHS bodies" (meaning the NHS Commissioning Board, Clinical Commissioning Groups and the NHS trusts) and "relevant health service" providers" (meaning health service providers besides NHS trusts undertaking "relevant services")

arranges for the scrutiny function to be discharged through a joint OSC, the joint OSC may also make reports and recommendations to the appointing local authorities.

Consultation by responsible persons and making a written report to the Secretary of State

2.4. When a "responsible person" has under consideration **"any proposal for the substantial development of the health service"** or a **"substantial variation"** of a service, they must consult the local authority to whose area the proposal relates. They must also provide the dates they intend to make the decision and the deadline for comments.

What is a "substantial development or variation"? This term is not defined in the Regulations. Guidance from CfPS[2] suggests that authorities and NHS bodies should develop local agreements or sets of criteria about what might be regarded as 'substantial' in the local context.

2.5. The duty does not arise where:

- a "responsible person" is satisfied the decision has to be taken without consultation because of a risk to the safety or welfare of patients or staff.[3] In such a case the responsible person must notify the local authority and give reasons.

- There is a proposal to establish or dissolve an NHS Trust or CCG, or to vary the constitution of either, unless this proposal itself amounts to a "substantial development or variation".

- The proposals arise from a trust special administrator's report or draft report, or recommendations from a health special administrator in relation to a company subject to a health special administration order.

2.6. A local authority is empowered to comment (and make recommendations to the responsible person) on the proposal within the timescale laid down by the responsible person.

2.7. If there is a disagreement between a local authority and the "responsible person" in relation to a recommendation made by a local authority, the responsible person must notify the local authority and both must take such

[2] *Substantial variations and developments of health services: a guide (*CfPS, December 2005) www.cfps.org.uk/domains/cfps.org.uk/local/media/uploads/33.pdf

[3] Guidance issued by the Department of Health gives the example of a decision to close a ward immediately because of a viral outbreak

steps as are reasonably practicable to try to reach an agreement. If the local authority has not made a recommendation, but is considering writing to the Secretary of State (see below), it must notify the "responsible person" if they are exercising this power or the date by which it proposes to exercise this power.

2.8. On receiving a consultation, a local authority may make a written report to the Secretary of State if it

- is not satisfied that the consultation on the proposal has been adequate,
- is not satisfied that the reasons for the lack of consultation in an urgent case are adequate, or
- considers that the proposal would not be in the interests of the health service in its area.

2.9. A report to the Secretary of State must contain information prescribed by the Regulations, including an explanation of the proposal under consideration and the basis (reasons and evidence as appropriate) of the report.

2.10. However, a local authority cannot make a written report in a case where there is a disagreement between the authority and the "responsible person" in relation to a recommendation made by the local authority (see 2.8 above) unless:

- In a case where recommendations have been made, steps towards reaching an agreement have been taken, but an agreement has not been reached within a reasonable period of time or the responsible person has not taken any steps to reach an agreement within a reasonable period of time; or
- In a case where the local authority has not made a recommendation, but is considering writing to the Secretary of State, the local authority has notified the responsible person they are exercising this power or the date by which it proposes to exercise this power.

2.11. On receiving a report, the Secretary of State may make a decision on any report challenging the adequacy of the consultation, or give directions to the NHS Board (who may in turn give directions to a CCG) in relation to a submission that that the proposal would not be in the interests of the health service. "Directions" may include a requirement to consult, determine the matter in a particular way or to take steps (or not take steps) in relation to the matter.

Provision of and obtaining information

2.12. To enable a local authority to carry out any of its scrutiny functions, a "responsible person" must provide such information about the planning, provision and operation of health services as may be reasonably required. This does not apply to confidential information or other information whose disclosure is prohibited by law, or to any information in a trust special administrator's report or recommendations from a health special administrator.

2.13. A local authority may require a member or employee of a responsible person to attend before it to answer such questions as appear to it necessary to carry out any of its scrutiny functions.

3. Joint arrangements

3.1. The exercise of a local authority's scrutiny functions as described above is subject to any joint arrangements in place.

3.2. A local authority **may** arrange the discharge of any of its scrutiny functions by a joint committee, on such terms and conditions as the authorities involved may consider appropriate.

3.3. However, in a case where a "responsible person" consults more than one local authority on a substantial development or variation (see 2.4ff), those local authorities **must** appoint a joint overview and scrutiny committee for the purposes of that consultation. In such a case, only that committee will be able to comment, seek information and question members or employees of the "responsible person".

3.4. The Regulations also enable the Secretary of State to direct a local authority to make arrangements for the discharge of scrutiny function by an overview and scrutiny committee or a joint committee and to comply with these requirements.

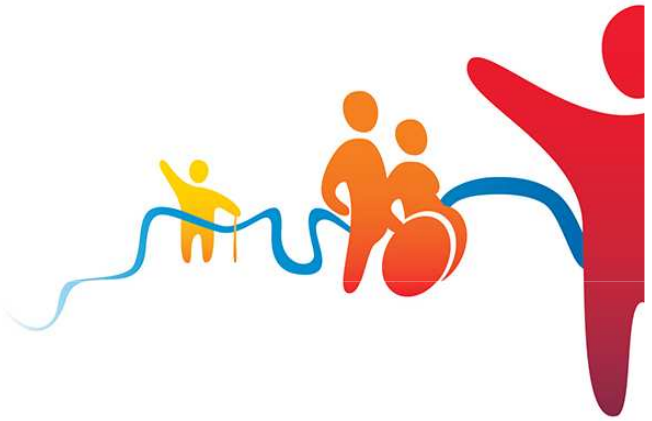
3.5. However arrangements are made for the joint exercise of scrutiny functions, whether by a joint committee at the discretion of the participating authorities or in discharge of the duty to appoint a joint overview and scrutiny committee to respond to a joint consultation, the Regulations appear to leave open the possibility that the power to make a referral to the Secretary of State (see 2.8ff) can be reserved to individual local authorities. But if the arrangements are made in a way that reserve the power to make a written report to the joint committee, then the local authorities cannot then exercise that power themselves.

3.6. If joint arrangements are in place but the exercise of the power to make a written report is exercisable by individual authorities, it will need to be borne in mind that the Regulations prescribe what a written report has to contain. If a local authority thinks consultation on a proposal for a substantial development has been inadequate or has inadequate reasons, it needs to explain what steps it has taken to try to reach agreement on these matters with the responsible body. An individual authority will in preparing its written report therefore have to give an account of steps taken by the joint committee outside of its own control. Also, in a case where a local authority has had to appoint a joint overview and scrutiny committee, it is only that committee which can comment on the proposal, seek information and question members or employees of the “responsible person”.

Our Healthier South East London
Improving health and care together

NHS

Joint Health Overview and Scrutiny Committee (JHOSC)



1 February 2016

Agenda Item 6

Introduction

- Our Healthier South East London is a five year commissioning strategy that aims to improve health, reduce health inequalities and ensure all health services in south east London meet safety and quality standards consistently and are sustainable in the longer term
- The programme is founded on a partnership approach with health and care providers, commissioners, Healthwatch, voluntary and community sector and patients and carers
- We have grouped our work into the following six areas with **Mental Health** being embedded across all workstreams

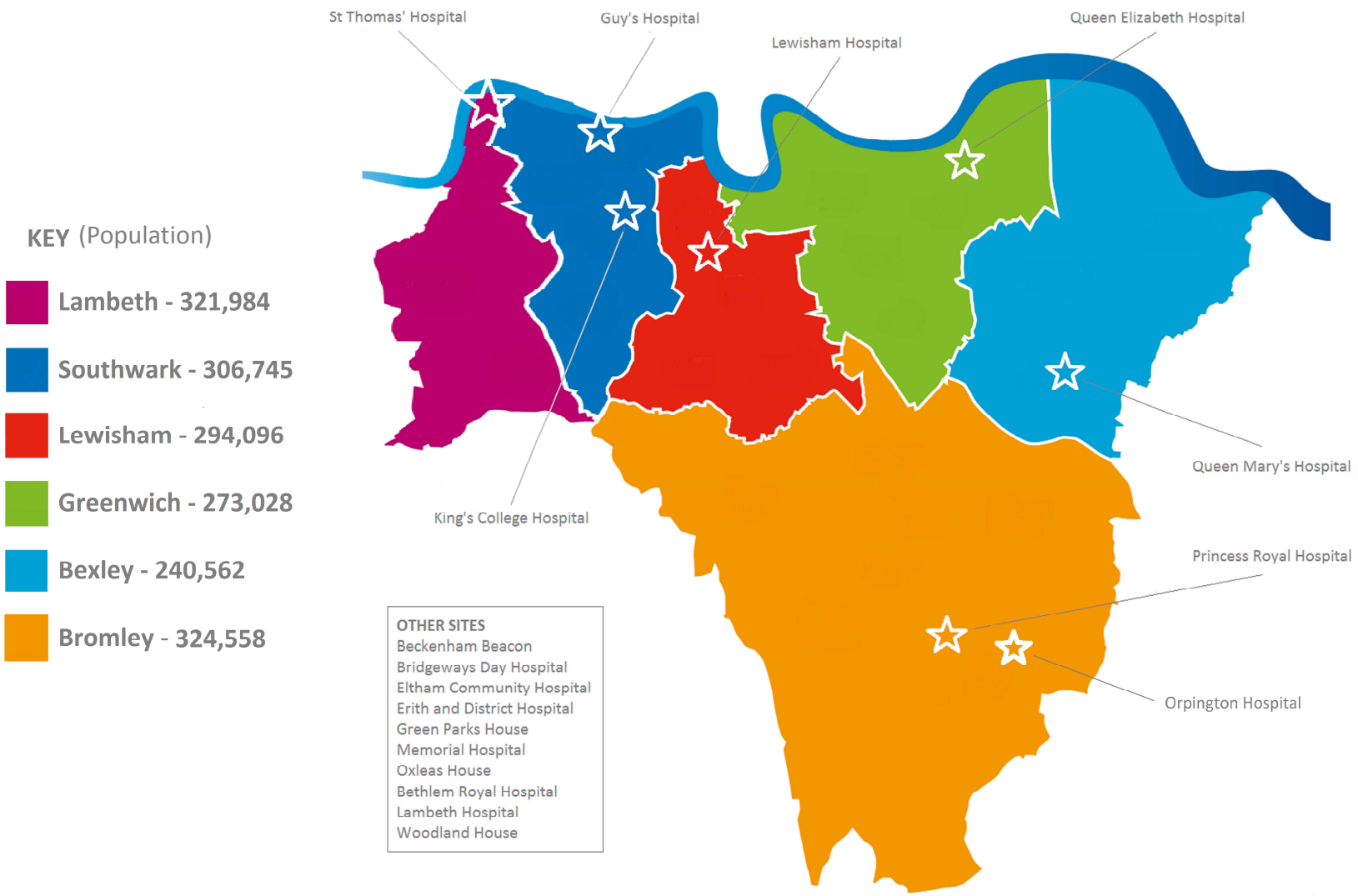
1. Community Based Care
2. Planned Care
3. Urgent and Emergency Care
4. Maternity
5. Children and Young People
6. Cancer

You asked us to cover the following areas:

- How things are now / the impact of our strategy
- How Mental Health is embedded in our proposals
- Financial implications of the new models of care
- Timelines for proposed changes (see Appendix A)

Our Healthier South East London
Improving health and care together

NHS



A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Engagement

- We have completed a phase of 'early engagement' – involving more than 1,700 people
- Patient voices and Healthwatch have been supported to be equals in the design of new models of care alongside clinicians, care professionals and commissioners
- Equalities Analyses have been undertaken and this has been fed into the development of new models of care as well as informing priorities for further engagement
- Engagement activity has been reviewed by our Stakeholder Reference Group including how options for potential consultation are selected
- A series of 'You Said We Did' publications have been published and shared with participants in the programme so far
- Our engagement approach is being externally assured by independent consultation experts 'The Consultation Institute'

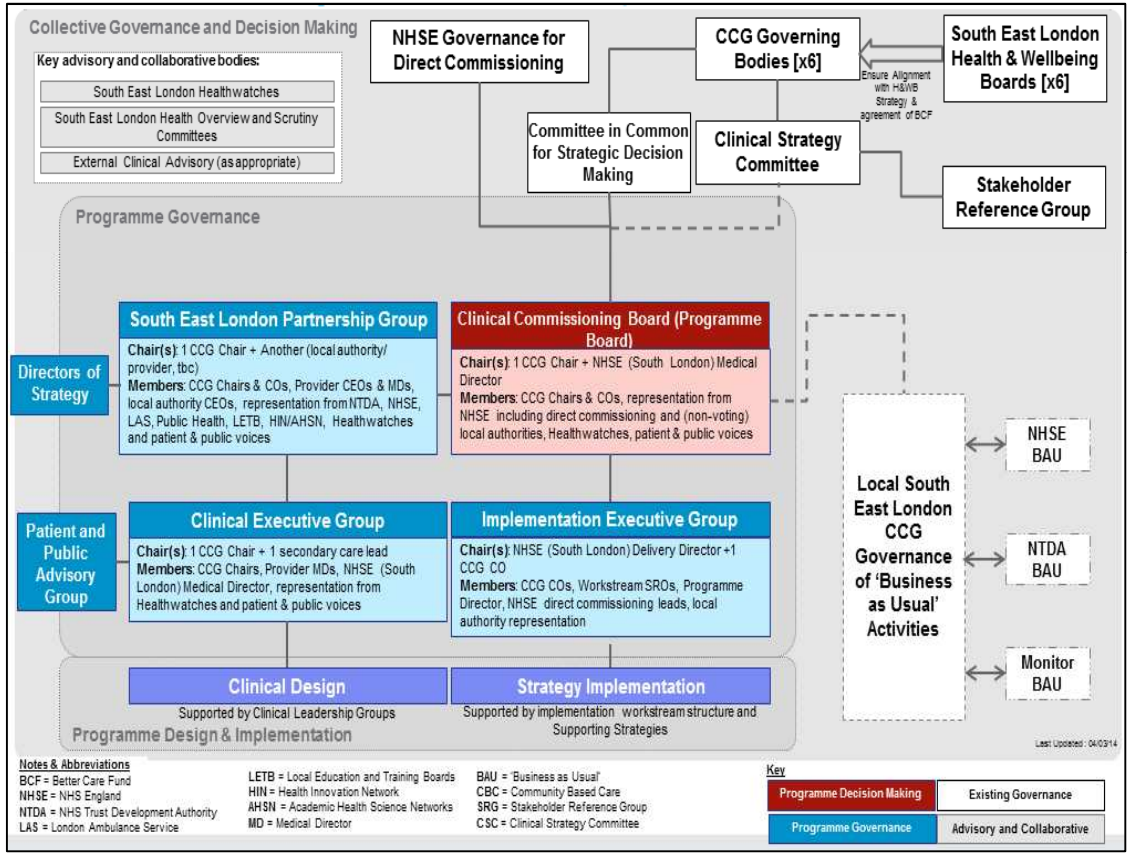
Briefing materials provided to JHOSC members

As part of supporting the establishment of your Joint Health Overview and Scrutiny Committee we have provided:

- A briefing pack
- A briefing session for scrutiny chairs – Monday 16th November 2015 (and 1:1 meeting for Bexley)
- Copies of key programme materials including:
  - Issues Paper - http://www.ourhealthiersel.nhs.uk/Downloads/Help%20us%20improve%20your%20local%20NHS_V12.pdf
  - Emerging Models' and further thinking - http://www.ourhealthiersel.nhs.uk/Downloads/Help%20us%20improve%20your%20local%20NHS%20-%20emerging%20models.pdf

Decision making process

- A 'Committee in Common' (CiC) is being established for the six CCGs to take decisions related to the OHSEL programme
- The CiC brings together local decisions on the OHSEL programme that have been made by CCGs
- NHS England will assure any proposal for potential consultation, incorporating a review of our approach to the 'four reconfiguration tests'



1 Cancer

How things are now

- 43% of cancers are caused by lifestyle factors, so are potentially preventable
- There is poorer access to treatment for some people, especially for older patients
- Poor patient outcomes are driven by late diagnosis and poor access to treatment
- There are rising numbers of patients living with and beyond cancer. 200,000 Londoners now, forecast to be 400,000 by 2020
- Nationally, our cancer outcomes are among the worst in Europe
- There is a lack of personalised care
- Patients don't always have the information they need and, crucially, the support to understand it
- Limited choice for end of life care and lack of support for carers

Impact of '*Our Healthier South East London*'

- Consistent achievement of cancer waiting times across south east London with a focus on reducing long waits
- Earlier diagnosis of cancer by increasing patient screening, including fast track into diagnostics for serious but unspecific cancer symptoms
- **Acute oncology services,** of a high standard supported by connected IT systems across providers
- **Two new cancer centres** – providing world class services more locally from Guy's and Queen Mary's Hospital
- **Education and training packages for Local Care Networks**:
  - Better support for cancer detection skills in General Practice with rapid access to diagnostics
  - Better coordination of care, supporting self management and rehabilitation, providing more personalised care, through risk stratification for the consequences of living with and beyond cancer and its treatment

2 Maternity

How things are now

- The birth rate has risen considerably over the last few years and although this increase is now slowing, there are increasing numbers of women with more complicated health and social care needs who require more support.
- Women are not making themselves known earlier enough in their pregnancy.
- There are capacity issues across the region; women can be diverted away from their hospital of choice
- Service users are broadly satisfied but improvements are needed in some areas; e.g. Post natal care
- A key challenge is the recruitment and retention of the highly skilled workforce we need.
- Providers are not meeting all of the London Quality Standards

Impact of '*Our Healthier South East London*'

- Women can expect to receive:
  - Timely access to community based antenatal and postnatal maternity services which are closely linked with other community based health, social and voluntary sector services all supporting pregnancy, childbirth and new parenthood.
  - Midwifery-led continuity of maternity care as standard.
  - Support from clinically expert and highly-skilled multidisciplinary teams delivering high quality, kind, safe and effective services.
  - Hospital based medically-led intervention when necessary.
  - Support to have a normal birth, in the right location for them, with the least intervention as possible.
- Providers will have plans in place to achieve the London Quality Standards

3 Community Based Care (CBC)

How things are now

- Patients and carers tell us that care is not joined up between different services
- Some groups of patients and carers experience barriers to accessing some services
- Some people would like greater control of their own care
- It can be difficult getting a GP appointment, so patients and carers access Urgent and Emergency care
- Patients do not always understand where to get help or how the system works
- We already have many first class community-based services across south east London, with CCGs looking to increase their number and quality. All boroughs are working on integrated care programmes for people with Long Term Conditions (some examples below):
- **Greenwich**: The national "Pioneer Project" builds upon existing integrated care systems for older people and people with physical disabilities
- **Lewisham:** A population based programme which integrates primary, community, social car services and, following a successful bid to run a local pilot, mental health services The aim of this project is to create a single service to help avoid hospital admissions.
- **Bexley:** Case management approach to identify patients with complex needs, in combination with integrated care services for older people across health and social care

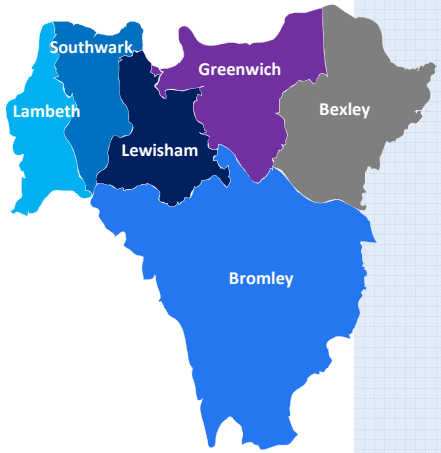
Impact of *'Our Healthier South East London'*

- A map of Local Care Networks is provided in **Appendix B**
- Greater focus on preventing avoidable admissions
- Stronger focus on health and wellbeing
- More coordination of care in the community
- GP and other community services to be available 8.00am-8.00pm
- Improved access to specialist care outside of hospital
- Employ more care navigators to Improve communication with patients so they know where to go for help
- Community based services should better support patients when they are discharged from other parts of the health system
- People will be supported to live independently and know what to do when things go wrong
- New (or improved) Local Care Networks, bringing together general practice, primary, community (physical and mental health), social care and voluntary sector colleagues to provide holistic patient centred care in each area.
- All Local Care Networks will share a number of core elements, with an additional set of locally determined initiatives, specific to the population of the Local Care Network.

3 The CBC Target Model – as adopted by all CCGs

Integrated Single System Leadership and Management

Serving geographically coherent populations of between 50,000 – 150,000



'The Core' (as a minimum all LCNs should encompass)

- Leadership team
- All general practices working at scale (federated with integrated IT system (s) and leadership)
- All community pharmacy
- Voluntary and community sector
- Community nursing for adults & children
- Social care
- Community Mental Health Teams
- Community therapy
- Community based diagnostics
- Patient and carer engagement groups

Working with…

- Strong and confident communities
- Accessible 'hot' clinics for acute cancer and urgent and emergency care. These are fast outpatient appointments and diagnostic clinics without an inpatient stay
- Specialist opinion (not face to face) and clear specialist service pathways
  Pathways to Multi Disciplinary Teams for rehabilitation and on-going management of long term conditions
- Integrated 111, London Ambulance and Out of Hours system (interface with UCCs co-located with ED model)
- Housing, education and other council services
- Community based midwifery teams
- Private and voluntary sector e.g. care homes and domiciliary care
- Cancer services
- Children's integrated community team and short stay units
- Rapid response services
- Carers
- And there will be others..

High Impact Schemes

- Supporting people to manage their own health (Asset Mapping, Social Prescribing, education, community champions etc.)
- Prevention – Obesity, Alcohol and Smoking
- Improved Core general practice access plus - 8-8
- Enhanced call and recall – improves screening and early identification and management of LTCs
- Reduction in gap between recorded and expected prevalence in LTC
- Supporting vulnerable people in the community including those in care homes and domiciliary care
- Reduction in variation (level up) primary care management of LTCs
- Reablement – Admissions avoidance and effective discharge
- MDT configuration – main LTC groups (incl. MH) and Frail elderly
- End of Life Care
- Medicines Management

Integrated Pathways of care

4 Urgent and Emergency Care

How things are now

- South east London has a slowly increasing older population; frail elderly residents live alone and are often isolated. This can result in patients presenting at A&E and/or requiring ambulance services even if their presenting medical condition can be managed at home if the necessary support was in place in the community
- To reduce ED waits, allow patients to be re-directed immediately, and be seen and treated through rapid, expert early assessment. Also provide consistency of stream for paediatric patients
- Not all Urgent and Emergency Care is compliant with London Quality Standards
- Not all Urgent Care facilities are compliant with the national specifications (e.g. opening hours / staffing / provision of diagnostics)

Impact of *'Our Healthier South East London'*

- We want to be able to manage the A&E demand without increasing the number of A&Es we have
- Be able to stream patients consistently and manage the frail elderly population better
- Broadly achieving the London Quality Standards in all areas:
  - Acute medicine
  - Emergency general surgery
  - Emergency departments
  - Critical care
  - Fractured neck of femur
- All Urgent Care facilities will be compliant in line with the national specification - meaning that patients can be assured that there is consistency of service and quality whichever Urgent Care service they access

5 Children and Young People

How things are now

- Children and young people (C&YP) represent about 25% south east London's population and we have a higher proportion of younger people, especially those aged 0-9 years.
- Compared to elsewhere in the country, C&YP across the Capital suffer from poorer health across a number of areas from higher levels of mortality and serious illness, poorer mental health, variability in outcomes from common diseases such as asthma, and significant public health issues such as obesity.
- Our young people and their carers find that care is not joined up and that it can be hard to navigate through the different services
- Families cite difficulty in accessing GP appointments so emergency department are the default choice
- Families also tell us that they require more flexibility as to when their child can be seen; too few appointments are available after school
- 1 in 10 C&YP aged 5 - 16 suffer from a diagnosable mental health disorder – and this number is growing. However, there are known capacity constraints within parts of south east London both in terms of Children and Adolescent Mental Health services (CAMHS) and in the number of paediatric trained nurses

Impact of '*Our Healthier South East London*'

- Local Care Networks will look after the needs of the majority of our children.
- Practice staff, especially GPs will become more skilled at dealing with C&YP and have access to specialist advice and support; for instance, help lines managed by consultant paediatricians
- Local pharmacists will play a greater role in the care of our C&YP
- C&YP and their families will become better informed about where to go for help and support
- For those with more complex needs:
    - Services will be more joined up and easier to navigate
    - There will be greater integration of care; *I won't have to tell my story over and over again*
    - Specialist paediatric nurses (e.g. asthma) will work across borough boundaries
    - Mental health support will be increased and all staff will have the knowledge to look for warning signs
    - There will be more care in the community, including acute care; our C&YP shouldn't go to hospital unless absolutely necessary
    - Short stay paediatric assessment units will make sure that those who do seek emergency care can be discharged as quickly as possible
    - Providers will work towards achievement of the London Quality Standards

6 Planned Care

How things are now

- There are differences in patient outcomes and experiences, depending on where and when they access care
- The time between your first appointment to having a diagnostic test, to receiving your test results could be quicker, meaning earlier diagnosis and better patient outcomes
- Patients should be better informed about what will happen throughout their treatment, empowering them to have more control and choice over their care
- Early supported discharge and a stronger focus on rehabilitation could help patients return home sooner
- Different services use different IT systems that are not always compatible. This leads to unnecessary duplication of paperwork and diagnostic tests
- The Briggs Report (March 2015) states that the population is living longer and by 2030 over 15.3 million of the population in the UK will be over the age of 65 years. as a consequence, we will see an ever increasing demand on our health resources which are already stretched. Orthopaedic referrals from GPs to secondary care providers are increasing by 7-8% per annum
- Variation in practice is unsustainable and needs addressing urgently.

Impact of *'Our Healthier South East London'*

- All patients across south east London will receive the same quality and outcomes, regardless of where they are treated
- **Elective Care Centres – SEE NEXT SLIDE**
- **Pathway review -** Develop high level, best practice standards across a number of specialties in Planned Care, meaning quality and efficiency improvements can be achieved. This work will be aligned with that of the national **Briggs team.**
- **Trust efficiency savings -** Targets have been agreed with Providers for efficiency savings, as part of normal KPIs in the following key areas:
  - Reducing number of follow-ups
  - Excess Bed Days
  - Inpatient to day case
  - Day case to outpatient

6 Planned Care

Elective Orthopaedic Centres

The consolidation of orthopaedic inpatient elective care centre across south east London potential helps us address the following issues:

- Ever rising demand and limited capacity
- variation in the quality of care and clinical outcomes for patients
- Minimises negative risk and error, thus improving patient safety
- Reduces waiting times for procedures
- Consistent achievement of estimated date of discharge and reduced average length of stay
- Reduced cancellation rates
- Reduction in procurement costs
- Sees a reduction in post-operative complications

The consolidated approach reflects the recommendations made through the “Briggs” report – “Getting it right first time”

Consolidation could potentially be achieved at one or two centres and may give us the opportunity to bring together specialist as well as routine work.

This proposal is being worked up into a business case and option appraisal, and depending on where we get to, we need to talk to you about the necessity of formal public consultation.

Our Healthier South East London
Improving health and care together

NHS

How Mental Health is embedded

- OHSEL strategy takes a holistic approach – mental health integrated throughout Whole System Model and recognised in our Clinical Leadership Groups
- Mental health is incorporated into other clinical workstreams– borough-based CCGs are responsible for mental health commissioning and strategy

Mental Health in the Clinical Models:

Urgent & Emergency Care

- Front door streaming
- Better symptom recognition
- Parallel working of Psychiatric Liaison Nurse within ED
- One hour referral to MH nurse

Cancer

- Support throughout treatment phase
- Support post treatment (patient and carer) – IAPT
- Review outcomes and learn from the London Cancer Alliance

Children & Young People

- Build parenting and peer support in the community
- Enable young people to talk about physical and mental health
- School based support to enhance emotional resilience of children

Community Based Care

- Enhance primary care mental health services
- Increase provision for early intervention
- Improve support for people with long-term conditions
- Upscale of services to assist people with dementia

Maternity

- LCNs promote physical and mental wellbeing before conception
- Named midwife
- Identify those at high risk before 10 weeks
- Improve access to support for women and babies

Planned Care

- Mental health support will be included in Elective Care Centres Pathway Reviews
- Review the use of mental wellbeing questionnaires with musculoskeletal patients

A pa[illegible]ley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Our Healthier South East London
Improving health and care together

NHS

The affordability challenge

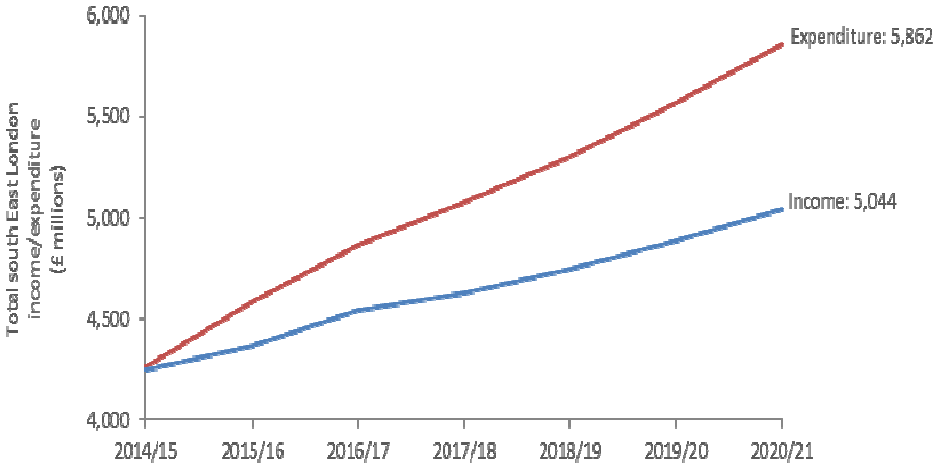
If we continue to provide services as they are provided today they will become increasingly unaffordable.

NHS funding increases broadly in line with inflation each year, and now the NHS has been allocated an additional £8.4 billion in funding by 2020/21 as a result of the Comprehensive Spending Review.

However, the overall costs of providing care are rising much faster than funding:

- Firstly, populations are growing and life expectancies are increasing – therefore requiring the NHS to treat more people with more complex conditions than ever before.
- Secondly, the cost of providing healthcare (e.g. on pay and pensions for the NHS workforce, drugs and devices, capital costs etc.) often grows faster than the inflation measure used in calculating NHS funding.

Expenditure in south east London is growing at a much faster rate than funding:

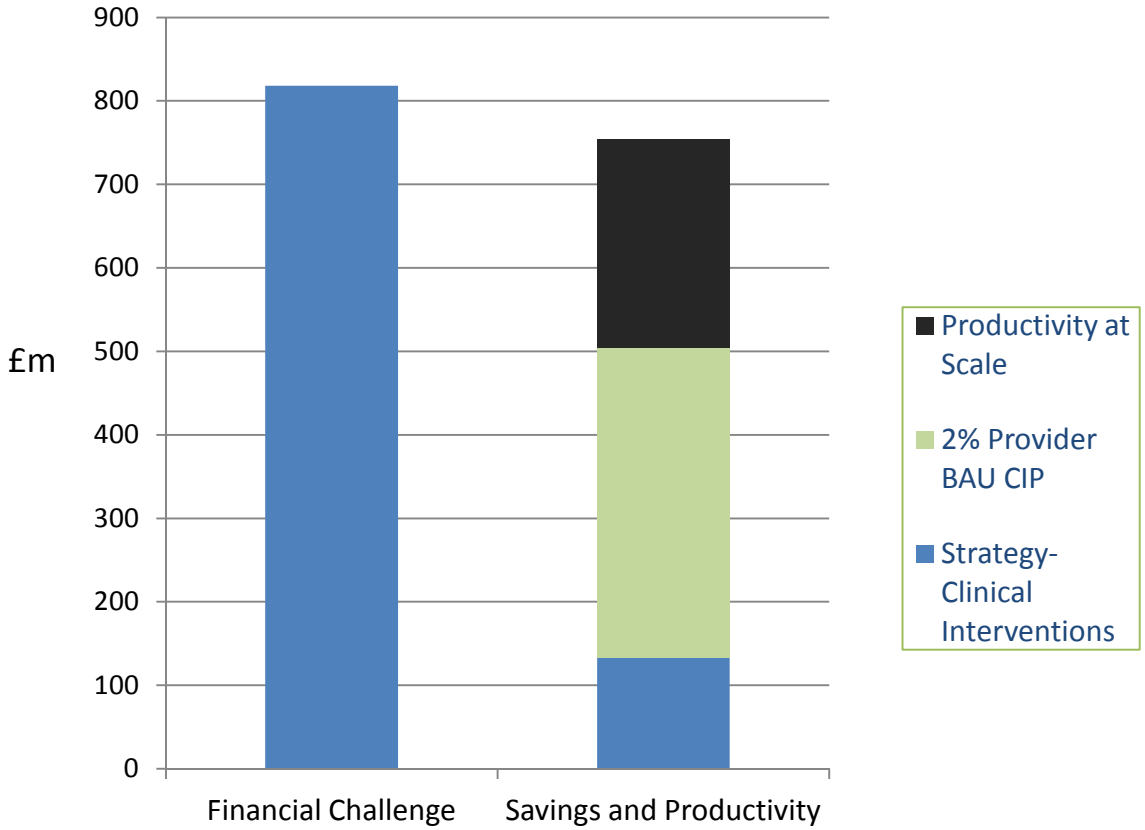


In south east London, we have forecast that by 2020/21, if we continue providing services as they are today, the cost of providing healthcare will outgrow funding and other income by **£818 million**.

Our Healthier South East London
Improving health and care together

NHS England

We close the financial gap in three ways



- "Productivity at Scale" is the name we give to the work we are doing with providers to centralist back office, procurement and HR services and reduce costs
- All providers need to save 2% of their budget year on year as part of business as usual
- The strategy helps us contain costs while maintaining or improving quality

Appendices

- A Timelines for the six clinical areas
- B Local Care Networks map
- C Current planned care service provision

A Cancer

Timeline

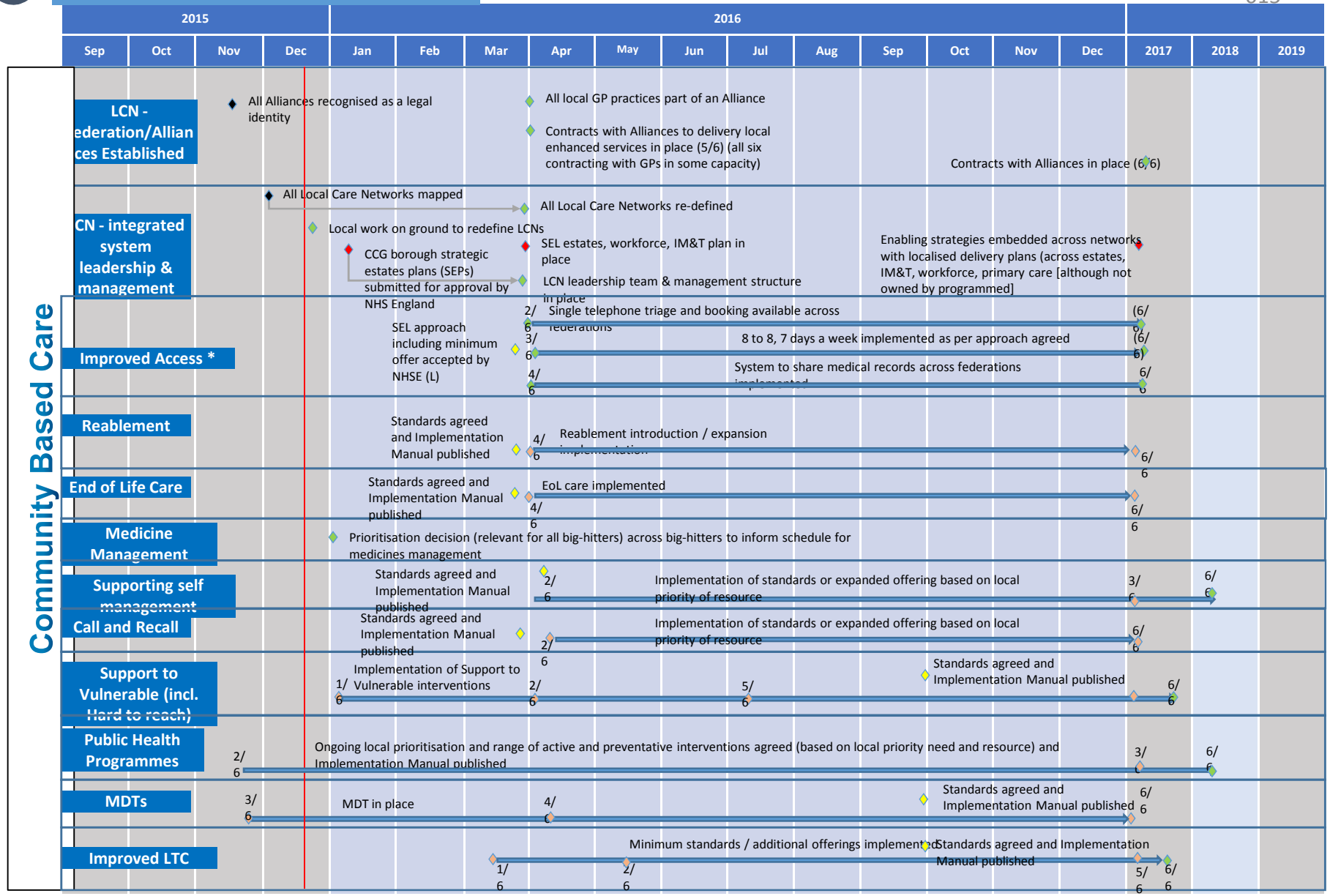
	2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Education and training package for LCNs	- Business case - Training package scoping, delivery approach and procurement case finalised		- Rolled out/implemented	- Commissioning intentions 17/18 (if no funding required)			- Commissioning intentions 18/19 (if funding required)	
Acute oncology services			- Protocols and pathways agreed and costed	- Rolled out/Implemented				
Telephone advice line		- Business case	- Rolled out/Implemented					
Improved care coordination during treatment phases			- Model defined - Business case - Implementation plan agreed	- Include in commissioning intentions 17/18			- Rolled out/implemented	
Diagnostic centres: unspecific but serious symptom pathway		- Cost and capacity business case - Pilot agreed	- Pilot commences				- Review outcomes of pilot	- Include in commissioning intentions 18/19

A Maternity

Timeline

	2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Continuity of midwife led care	Begin to map current provision	Initial proposals and sign off	Inform commissioning intentions for 16/17 →	→	Delivery →	→	→	→
Recruitment and retention midwives	HoMs to review career pathway and consider mitigations	Initial proposals for providers and commissioners to consider. HEE/HESL to be involved →	→	→	Delivery →	→	→	→
Emergency pathway – London Quality Standards	Providers plans to achieve LQS agreed	Implementation →	→	→	→	→	→	→

A CBC Programme Plan



Milestone Legend

As Requirements

Design Implementation

Complete

Enablers

* .....Agreed

A Urgent and Emergency Care

Timeline

	15/16	2016/17				2017/18			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Achieving the London Quality Standards	Agree Network actions and provider recommendations	Delivery →	→	→	→	→	→	→	→
Front door streaming and specialist interface	Understand issues, solutions and benefits – front door streaming all ages	Agree Network actions and provider recommendations	Delivery →	→	→	→	→	→	→
		Review all ages Mental health interface - issues, solutions and benefits	Agree Network actions and provider recommendations	Delivery →	→	→	→	→	→
Meeting the facilities specification	Agree steering group and approach. Recommendations made to achieve the specification	Agree Network actions and provider recommendations	Delivery →	→	→	→	→	→	→
Network meetings		March Network Meeting (Approval)		July Network Meeting (Approval)	November Network Meeting (Approval)	March Network Meeting (Approval)		July Network Meeting (Approval)	November Network Meeting (Approval)

A Children and Young People

Timeline

	2016				2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrated Community based care – stage 1	Development of specification of service for C&YP with asthma	Development & sign off	Inform 16/17 commissioning intentions	Commissioner & provider planning	Delivery →	→	→	→
Integrated Community based care – stage 2		Development of specification of service for C&YP with other complex conditions (eg diabetes)	Sign off Inform 16/17 commissioning intentions	Commissioner & provider planning	Delivery →	→	→	→
Emergency pathway – London Quality Standards	Providers plans to achieve LQS agreed	Delivery →	→	→	→	→	→	→
Emergency pathway – short stay paediatric assessment units	Evaluation methodology agreed	Evaluation process begins →	→	Evaluation completed Outcomes inform commissioning intentions	Delivery →	→	→	→

Our Healthier South East London
Improving health and care together

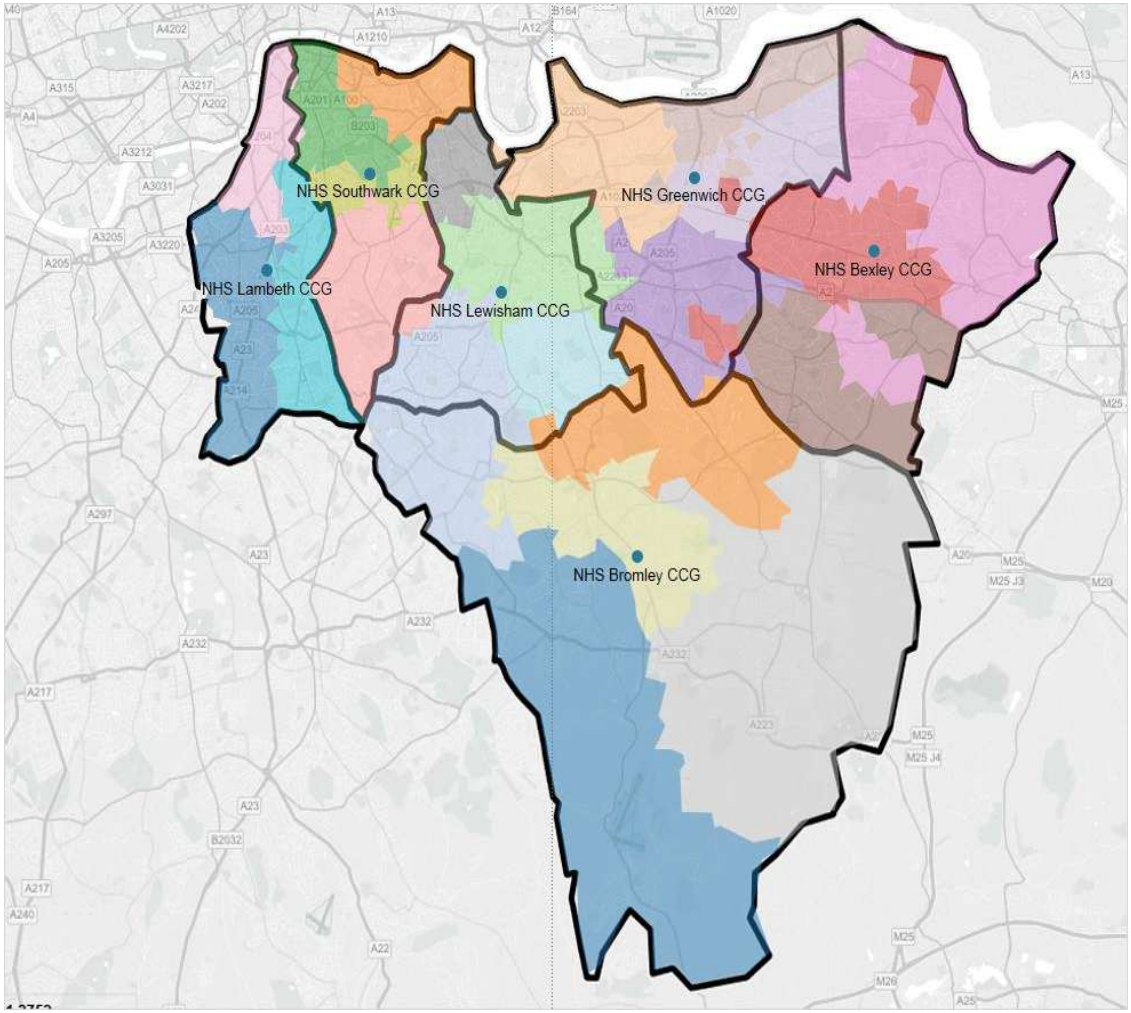
NHS

A Planned Care

Timeline

		2016				2017			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Diagnostics	TOHETI	- Programme perspective on impact shared with CCGs – testing outcomes so far		- Indicative costs to implement in SEL -Business case for roll-out - CCGs to build into commissioning intentions			-End of TOHETI programme - Model rolled out (if pilot successful)		
	Enhanced Network Solution for pathology								
Elective orthopaedic Centres		-Pre-consultation Business Case / Strategic Outline Case finalised	- NHSE assurance complete - Public Consultation (if required) Launched	- Public Consultation (if required) Concluded - Outline Business Case agreed					
Pathway review		-Confirm format and scope for pathway reviews - Working Group confirmed - Pathway review 1 commences							
Trust level efficiency savings		- Agreed in to Contracts	- Agreed KPI 2016/2017 - Provider delivery		-Progress update				

B South east London: areas served by Local Care Networks



Clocktower	Bexley
Frognal	
North Bexley	
Addington Road Team	Bromley
Beckenham Beacon Team	
Orpington Hub Team	
Princes Plain Team	
The Willows Team	
Blackheath & Charlton	Greenwich
Eltham	
Excel	
Network	
North Lambeth	Lambeth
South East Lambeth	
South West Lambeth	
Central Lewisham	Lewisham
North Lewisham	
South East Lewisham	
South West Lewisham	
Bermondsey & Rotherhithe	Southwark
Borough & Walworth	
Dulwich	
Peckham & Camberwell	

A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

C Planned Care – current service provision

Guy's and St Thomas'	**Guy's**: Outpatients, full range of elective inpatient and day surgery. Spinal surgery. Complex primary and revision joint surgery. Patients with significant co-morbidities. **St Thomas'**: Outpatients, trauma (support to A&E), non-elective spinal surgery, full range of paediatric orthopaedics
King's College Hospital	**Denmark Hill**: Outpatients, trauma, spinal trauma and neurosurgery, paediatric orthopaedic surgery, some high acuity elective if patients not suitable for Orpington **Princess Royal**: Outpatients, elective inpatient and day surgery, joint revisions and complex primary joint surgery, trauma (support to A&E), **Orpington**: Outpatients, low risk elective inpatients and day cases
Lewisham and Greenwich Trust	**Lewisham**: Outpatients, elective inpatient, including high acuity patients, and day case surgery, trauma (support to A&E). Complex primary and revision joint surgery. Patients with significant co-morbidities. **Queen Elizabeth**: Outpatients, elective inpatient and day case surgery, trauma (support to A&E). Complex primary. Patients with significant co-morbidities.
Dartford and Gravesham Trust	**Darent Valley**: Outpatients, elective inpatient and day case surgery, trauma (support to A&E) **Queen Mary's, Sidcup**: Outpatients

Our Healthier South East London: workstream briefing for JOSC

Our Healthier South East London has six clinical workstreams: community-based care, planned care, urgent and emergency care, maternity, children and young people and cancer. Mental health is a cross-cutting issue which is being considered as part of each of the six workstreams.

Each workstream has developed a proposed model of care and these are set out in our publication *Help us improve your local NHS: Emerging models and further thinking* (attached).

This briefing sets out our current view on what areas of the programme may or may not amount to significant service change. In summary, while we believe that the overall impact of the proposed interventions are likely to be transformative, there is little need for significant change to individual services; the most significant changes are to orthopaedic services.

Community-based care

Better care outside hospital is central to our strategy and our proposed 'whole system model'. We are developing 'local care networks' made up of primary, community and social care colleagues working together and drawing on others from across health, wider community services like housing and schools, and the voluntary sector. Local care networks will be delivered at borough level, but with an over-arching set of principles.

These developments are already underway and we believe they will deliver major improvements both clinically and financially. We believe they are non-contentious and do not require public consultation.

Planned care

The proposed model of care suggests the development of one of more elective care centres for planned orthopaedic surgery. As this would involve centralising some elective care in one or two locations, we believe this may lead to significant service change. This centralisation is unlikely to cover day case work or outpatients. Our current timescale is for public consultation in summer 2016.

Urgent and emergency care

Our work to date suggests that investment in community and primary care services will help us avoid a further increase in A&E activity and hospital admissions, but will not significantly reduce it. We therefore expect that we will need to retain all of our

existing A&Es. It follows that we do not expect to consult on a proposed A&E reconfiguration.

Our strategy is for all standalone urgent care centres (those not on the same site as emergency departments) to have the same standards and provide consistent services. We are awaiting guidance on the application of national standards on urgent care which will support this. It is possible that local CCGs may want to make changes to local urgent care centres. This may require consultation, but at local borough level rather than across south east London. Any proposals to change local facilities will be brought forward at local level by CCGs.

Maternity

As with A&Es, our work to date suggests that we will continue to need all of our existing maternity units and that public consultation will not therefore be required. We are awaiting the outcome of the Cumberlege Review of maternity services before confirming this.

The focus of the model is on ensuring women have access to safe, personalised and positive experience if pregnancy, including better pre-pregnancy, antenatal and post-natal support (including mental health support where needed).

Children and young people

The model of care requires each hospital to have in place a short-stay paediatric assessment unit. As our hospitals all have these already, albeit to varying models, there will be a focus on ensuring that they meet the required outcomes. As we are not proposing closing any units, we do not believe there is a need for public consultation.

Our aim is to focus on prevention – keeping children and young people mentally and physically well – with more care taking place in community settings and high quality care in hospital for those who need it.

Cancer

We want to improve patient outcomes by putting measures in place to support earlier detection and diagnosis and increased screening. Two new cancer centres are being developed (at Guy's Hospital and Queen Mary's Hospital Sidcup).

Should any public consultation be required, we would set the proposed options in the context of the wider strategy, so that local people are aware of the whole strategy as well as the most significant changes being proposed.

Jargon Buster

A glossary of terms for Our Healthier South East London (the south east London commissioning strategy programme)

All industries, sciences and services have developed their own "jargon", or internal language which facilitates easy communication between those working in them. The NHS is no exception. While we try as hard as possible to keep our documents jargon free, sometimes we will use words, phrases and abbreviations which are not immediately clear to everyone reading it. This current list of jargon, abbreviations and acronyms explains what is meant in documents that we write. In some cases the same word or acronym has two or more uses, which are also explained below.

We hope that this list is useful. If there are any other words or phrases which are unclear on our website or in any of our published documents, please let us know. Contact SELStrategy@nhs.net

The list is alphabetic, as being the easiest way to access any subject.

111: a 24 hours a day 7 days a week contact number (free of charge from landlines and mobiles) which can provide medical advice and help when it is not a 999 emergency situation.

999: the 24/7 number to call for real emergencies. Callers will be asked what service is required (Fire, ambulance or police) and will be sent send appropriate help. In SEL, LAS emergency vehicles are staffed by paramedics able to assess and give emergency treatment. Attendance of an LAS vehicle and crew is not a guarantee of being taken to A&E.

A&E (Accident & Emergency): a hospital service which provides care for emergency, life threatening and critical conditions for patients of all ages, twenty-four hours a day, seven days a week. This is also known as ED – Emergency Department. It is common for paediatric (children) emergencies to be managed in a separate area of the departments

Acute care: short-term treatment, usually provided in hospital.

Acute trust: an NHS Hospital Trust or Foundation Trust providing and/ or managing hospitals. Some acute trusts also provide community services, such as Guy's and St Thomas' NHS Foundation Trust.

Admission (to a hospital): needing (at least) an overnight stay in hospital, either for an emergency or following a planned procedure.

ALOS (Average Length of Stay – also sometimes LOS, Length of Stay): is an average of the length of time a patient stays in a hospital when admitted. Collection of this data is essential to service planners and audit.

Asthma –Chronic lung disorders with a variety of causes but all characterised by reversibility of small airway obstruction. Not to be confused with COPD (See below)

'At scale' provision: Existing or proposed services which are or can potentially be provided across a greater population or geographical area (larger scale). Usually used in the context of the whole of south east London or across more than one borough. In primary care, this term is also used to mean a service provided at a much larger scale than found in current GP practices e.g. serving populations of 50,000 or more

Blue Light Case; patients transported to hospital A&E by emergency ambulance in response to a 999 call or GP request

CAMHS: Child and Adolescent Mental Health Services

Care Pathway: the care and treatment a patient receives from start to finish for a particular illness or condition, usually across several parts of the health service and often including social care. Care pathways as planned for a condition can ensure full seamless integration of all the necessary services.

Carer/informal carer: a person who looks after or supports someone else due to illness or disability. This can be an unpaid, **informal carer**, who may be family members, including children and young people, who live with the person they care for; or family, friends or neighbours who live elsewhere. C**arer** is also used to describe paid staff working in care homes and/or supporting people at home, particularly staff who do not have professional qualifications

Case for Change: sets out the reasons why current health and integrated services need to change if SEL is to improve health, reduce health inequalities and deliver health and integrated care services which are of consistently high quality within the money available.

CCB (Clinical Commissioning Board): the key decision making body for the five year strategy, which brings together commissioners from CCGs, NHS England and Local Authorities. It also includes patient, public and Healthwatch representation.

CCG (Clinical Commissioning Groups): Statutory Organisations which plan and fund (commission) most local health services. These replaced primary care trusts (PCTs) in April 2013. CCGs are led by GPs and other clinicians. All GP practices in a CCG area are members. Each CCG in south east London covers one borough. CCGs do not commission or fund GP contracts (See NHS England)

CEG (Clinical Executive Group): This brings together clinical leaders (medical and nursing directors from NHS providers, clinical chairs from CCGs) and patient, public and Healthwatch representation. It provides the clinical leadership for the strategy programme as a whole; provides challenge and assurance to the individual clinical leadership groups; and manages interdependencies across groups.

CEPN (Community Education Provider Networks): Local CCG-led group of providers including social services, co-ordinating and prioritising a more network-based approach to designing and delivering health education and training.

CHD (Coronary Heart Disease): the narrowing or blockage of the coronary arteries, the major blood vessels around the heart. (See also CVD)

CIP (Cost Improvement Plan): plans to meet the cost savings targets by NHS organisations.

Clinical Leadership Groups (CLGs): clinically-led working groups consisting of senior experts drawn from across commissioners, providers of NHS services, social care and public health, as well as patient, public and Healthwatch representation.

CNS: Clinical Nurse Specialist – a nurse who specialises and has a high level of qualifications and experience in a specific area. (In medical texts CNS can mean Central Nervous System. However in our documents we are unlikely ever to use the abbreviation in this context.)

Collective action: Work that we can do across the six boroughs – this is either because we can do it more efficiently and effectively together, or because the changes being looked at will affect more than one borough

Commissioning: The planning, buying (procurement) and contract management of health and health care services. This can be for a local community a specific population or a specific condition. This can be done at National NHS, Local NHS or CCG levels..

Community Based Care: covers a range of community based services which can range from district nursing, health visiting, foot health, sexual and reproductive health and specialist nursing services.

Contacts / NHS contacts / every contact counts: A contact occurs every time a patient or a member of the public sees, talks to, or otherwise makes contact with a health professional. ‘Every contact counts’ refers to making these meetings and conversations as meaningful as possible in helping patients keep healthy and/or manage their health. There is a specific, structured programme to improve the effectiveness of our contacts in addressing a range of health issues (used in Yorkshire and Humber) which we are considering as part of developing the strategy.

Continuing Healthcare: CCG-funded packages of care given to those meeting set criteria.

Co-production: Co-production is an approach to ensuring that effective and long-term partnership is at the heart of services. It aims to bring together, in an equal relationship, professionals, users, communities and any other relevant individuals to jointly design and deliver services.

COPD (Chronic Obstructive Pulmonary Disease): The name for a collection of lung diseases including chronic bronchitis and emphysema. Characterised by irreversible airways and lung damage. (see Asthma)

CSU (Commissioning Support Unit): An organisation providing back-office support (such as IT, HR, contract management and communications) to CCGs.

CQC (Care Quality Commission): An organisation funded by the Government to inspect all hospitals, care homes and care services in England to make sure they are meeting government standards and to share their findings with the public.

CQUINs (Commissioning for Quality and Innovation): A contractual mechanism that allows commissioners to pay providers for completing activities that directly relate to improving the quality of care received by patients.

CVD (Cardiovascular Disease): Also known as heart disease, this refers to diseases that affect the heart or blood vessels. (CVS). Hypertension (high blood pressure) is the most common form.

CVS (Cardiovascular system) the heart, arteries capillaries and veins

Day case or day surgery: patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day.

Deficit: the net financial position of an organisation where expenditure (outgoings) is greater than income. (opposite: Surplus)

ECG (Electrocardiogram): a test of the electrical activity of the heart.

Elective centre: a hospital or a distinct part of a hospital which provides elective (planned) care, separated from urgent and emergency care.

Elective surgery: planned / non-emergency surgery (i.e. not immediately necessary to save life). This is usually carried out in a hospital either as a day case or an inpatient. Minor surgery may be carried out in a range of approved settings

Emergency admission: a patient who is admitted to hospital on the same day due to urgent need (also known as urgent admission and unplanned care).

End of Life Care – dignified care of the dying planned as far as possible to include the patient's wishes as to where they are cared for.

Every contact counts: every time a patient or a member of the public sees, talks to, or otherwise makes contact with a health professional every effort is given to making these meetings and conversations as meaningful as possible in helping patients keep healthy and/or manage their health. There is a specific, structured programme to improve the effectiveness of our contacts in addressing a range of health issues (used in Yorkshire and Humber) which we are considering as part of developing the strategy

Financial surplus: the net financial position of an organisation where income is greater than expenditure (outgoings) – so there is a surplus of money at year end.

Foundation Trust: a NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms, including around funding of and investment in services. They are regulated by Monitor – The independent regulator of NHS Foundation Trusts.

Friends & Family - the Friends and Family Test (FFT) is a simple question that patients are asked when they leave hospital about whether they would recommend the hospital to their friends or family. This gives hospitals a better understanding of the needs of their patients to help them continually improve services.

The test asks the following standardised question: "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?" Patients will use a descriptive six-point response scale to answer the question with the following response categories:
1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

This test will be extended to all GP services in late 2014.

General Practice – the medical specialty providing a range of health care services within the community. Now typically includes doctors and nurses, May include physiotherapists and other community services.

GP: General Practitioner (s), your local doctor (s). Usually practicing in groups)

GSTT: Guy's and St Thomas' NHS Foundation Trust, which runs Guy's and St Thomas' hospital and community services across Lambeth and Southwark.

Governing Body: Sets the direction of the CCG by developing plans and priorities for improving NHS services to ensure people in their borough get the best healthcare services possible; and ensures strong and effective leadership, management and accountability. Governing Body members are primarily GPs, together with as CCG executive staff and lay members.

Health and Wellbeing Strategies: jointly-agreed and locally-determined set of priorities for local partners (including CCGs and local Authorities) to use as basis of commissioning plans.

Healthwatch England: an independent organisation giving people a local voice about their health and social care services. It supports and co-ordinates the activity of all the Local Healthwatch. Each borough or CCG area typically has its own largely autonomous Healthwatch. It aims to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. They have a seat on health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when preparing local needs assessments and strategies such as the Joint Strategic Needs Assessment (JSNA).

Healthwatch: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Boroughs each have a Healthwatch. The six south east London Healthwatches have representation on all the CLGs and PPAG.

HESL: Health Education England – South London region. Health Education England (HEE) is responsible for the education, training and personal development of the workforce in the NHS, and recruiting for values; HESL is the organisation with responsibility for south London within the overall umbrella of HEE.

Home ward: a care pathway (system) in which professional care is delivered to patients in their own homes rather than on a ward in hospital, organising the care in a similar way to a ward. It is a cost effective system and avoids hospital admissions which can cause stress to elderly and vulnerable patients.

IEG (Implementation Executive Group): the executive group supporting the Clinical Commissioning Board (CCB), providing oversight to planning, implementation, benefits realisation and assurance. The IEG will also have a responsibility to make recommendations to the CCB on the optimal structure and scope of the programme

Implementation: putting into practice the plans and strategies that have been developed

Independent sector: a range of non-public sector organisations involved in service provision, including private, voluntary and charitable organisations

Inpatient: a patient who stays overnight in hospital, either following an emergency admission or a planned procedure.

Intervention: term for the point at which a medical, social care or other professional gets involved in a person's healthcare. Early intervention is when this happens before a person's health is severely affected. This term is also used as a general name for a medical or nursing procedure.

JSNA (Joint Strategic Needs Assessment): a document which analyses the health needs of a population to inform the commissioning of health, well-being and social care services. This document is updated annually.

KCH: King's College Hospital NHS Foundation Trust.

Keogh / Keogh requirements: Clinical standards set out by NHS England's Sir Bruce Keogh for seven day services across the NHS

KHP (King's Health Partners): one of five Academic Health Science Centres in England, made up of Guy's and St Thomas', Kings College Hospital, South London and the Maudsley (SLaM) and King's College London. It works to transfer research into practice, teaching and clinical practice to the benefit of patients.

LIS (Local Incentive Scheme): a process to encourage GPs to proactively look at specific health objectives for the local population. This has included long term conditions (such as COPD and diabetes), early cancer diagnosis and effective prescribing.

London Clinical Standards: These are the minimum standards of care that patients attending A&E / admitted as an emergency or using maternity services should expect to receive in every acute hospital in London. These standards are set out by NHS England and have been agreed by all CCGs. Although they are specific to London, they are consistent with, and sometimes build on, national standards.

LTC (Long Term Condition): a long term or chronic condition or illness that cannot be cured (but can be managed through medication and/ or therapy) and that people live with for a long time, such as diabetes, heart disease, dementia and asthma.

Mortality rate: a measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit of time. National and local mortality rates can be compared and are essential in determining local priorities for services.

Midwife led unit: a unit which specialises in delivering babies by midwives, without the intervention of a consultant obstetrician.

Minor surgery (Minor ops) -small surgical procedures which may be carried out in a range of approved settings

Multidisciplinary / multi-professional teams (MDTs): teams comprising different kinds of staff involved in patient care – this could include GPs, nurses, psychologists, occupational therapists, pharmacists, social care staff, hospital doctors and other specialists.

NHS England: This body oversees the day-to-day operation of the NHS from April 2013 as set out in the Health and Social Care Act 2012 and is responsible for

commissioning some local services, such as GPs, and all specialised services such as prisons, HIV. It also assures the performance of CCGs.

Obstetrics: the medical specialty that deals with care for women during pregnancy, childbirth and the postnatal period.

OoH (Out of Hours)**:** a term usually referring to services available between 6.30pm and 8.00am and sometimes also at weekends. This sometimes specifically refers to GP type services. **OoH** may also mean Out of Hospital

Partnership Group: This brings together a wide range of senior clinicians and managers from commissioners, including local authorities, providers of NHS services and advisory bodies and also includes patient and public voices representation. It is the key advisory group to the Clinical Commissioning Group.

PHB: Personal Health Budgets: A personal health budget is an amount of money to support an individuals' identified health and wellbeing needs, planned and agreed between them and their local NHS team. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

Personal health budgets work in a similar way to the personal budgets that many people are already using to manage and pay for their social care.

Planned Care: where a patient is referred for treatment and there is a pre-determined pathway of care.

PPAG (Patient and Public Advisory Group)**:** the collective forum for the strategy's patient and public voices (or patient, public and Healthwatch representation and reports to the Clinical Executive Group (CEG).

PPV: patient and public voices – people who are part of the strategy development to ensure that the experiences and values of patients and the public are included in all discussions

Primary care: Sometimes used to describe the services provided by GPs, NHS dentists, optometrists (opticians) and community pharmacists. This may also include other community health services

Primary Care Trust (PCT): NHS bodies that commissioned primary, community and secondary care from providers before April 2013.

Priority pathways: the five areas of focus for the strategy, in addition to primary and community care and long term conditions, agreed as priorities for joint working across south east London.

Proactive care: care that actively seeks to prevent ill health or a deterioration in health by intervening and working with people before they get ill . (also called preventive care)

QIPP (Quality, Innovation, Productivity and Prevention): an NHS-wide initiative to deliver more and better services and care with fewer resources. **RMS or RMBS: Referral management (Booking) Service:** Central referral system for agreed clinical pathways.

RTT - Referral to Treatment Time: standards included in the NHS Constitution that establish a patient's right to be treated within a specified time frame. These standards are The Referral to Treatment (RTT) operational standards are that 90 per cent of admitted (requiring at least overnight stay) and 95 percent of non-admitted (outpatient/day case) patients should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks.

Secondary care: More specialised care, usually after referral from GP (primary care). This can be provided in a hospital or in the community.

SEL: south east London

SELDOC – **S**outh **E**ast **L**ondon **Doc**tors – a co-operative organisation of member practices which provides Out of Hours Services across NHS Lambeth, Southwark and Lewisham CCGs, including telephone advice, GP consultations and home visits

SLaM: South London and Maudsley NHS Foundation Trust, providing a range of hospital and community mental health services.

SLIC (South London Integrated Care): a programme across Lambeth and Southwark looking at how to co-ordinate care for older people and people with long term conditions, so that people have a better experience of care and are supported to keep healthy and maintain independence. This involves a range of organisations working together including Lambeth and Southwark CCGs, GPs, Guy's and St Thomas' NHS Foundation Trust, King's College Hospital Foundation Trust, South London and Maudsley NHS Foundation Trust and Lambeth and Southwark Councils.

Social Care: a range of non-medical services arranged by local councils to help people in need of support due to illness, disability, old age or poverty. Social care services are available to everyone, regardless of background. However rules about eligibility apply.

Specialist hospital: a hospital which provides specialist care for complex conditions. There are none in south east London but patients might be referred to one – for instance, the Royal Marsden cancer hospital or Moorfields Eye Hospital.

Supporting strategies: Workstreams (programmes of work) that have been set up to support the overall aims of the strategy programme. They are: Information and IT; Communications and Engagement; Workforce; Commissioning models; and Estates.

System-wide: Across the whole of the health service or health and social care system, sometimes specifically in south east London

Tertiary care: very specialised care, usually provided in hospital, where a patient is referred by a secondary care provider. Tertiary care is supplied by Specialists to Specialists

TSA (Trust Special Administrator): Appointed by the Secretary of State in 2012 to make recommendations in relation to South London Healthcare NHS Trust, which was identified as not sustainable in its existing form.

UCC (Urgent Care Centre): a centre which provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening.

Unplanned Care: is care that is not planned or pre-booked with your GP or hospital.

Voluntary and Community Sector / Organisations: not-for-profit organisations set up to offer services to specific groups in society. These can be run and staffed by paid professionals as well as volunteers.

Walk in Centre: where unregistered patients may go if they need to see a GP or nurse without an appointment

Our Healthier South East London
Joint Health Overview & Scrutiny Committee
MUNICIPAL YEAR 2015-16
AGENDA DISTRIBUTION LIST (OPEN)
NOTE: Original held by Scrutiny Team; all amendments/queries to Julie Timbrell Tel: 020 7525 0514

Name	No of copies
Committee Members	
Councillor Rebecca Lury (Chair)	1
Councillor Judith Ellis (Vice Chair)	1
Councillor Rezina Chowdhury	1
Councillor Ross Downing	1
Councillor Jacqui Dyer	1
Councillor Hannah Gray	1
Councillor Alan Hall	1
Councillor James Hunt	1
Councillor Averil Lekau	1
Councillor Matthew Morrow	1
Councillor John Muldoon	1
Councillor Bill Williams	1
Our Healthier South East London	
Rory Hegarty, Communications & Engagement Director	1
Mark Easton, Programme Director	1
Oliver Lake, Partner - Transformation	1
Fiona Gaylor, Patient and Public Voice Project Manager	1
Health Partners	
Matthew Patrick, CEO, SLaM NHS Trust	1
Jo Kent, SLAM, Locality Manager, SLaM	1
Zoe Reed, Director of Organisation & Community, SLaM	1
Marian Ridley & & Jackie Parrott Guy's & St Thomas' NHS FT	1
Lord Kerslake, Chair, KCH Hospital NHS Trust	1
Julie Gifford, Prog. Manager External Partnerships, GSTT	1
Geraldine Malone, Guy's & St Thomas's	1
Jessica Bush, Head of Engagement and Patient Experience King's College Hospital KCH FT	1

Name	No of copies
Southwark Council & Southwark Clinical Commissioning Group Officers	
David Quirke-Thornton, Strategic Director of Children's & Adults Services	1
Andrew Bland, Chief Officer, Southwark CCG	1
Dr Ruth Wallis, Southwark Public Health Director	1
Shelley Burke, Southwark Head of Overview & Scrutiny	1
Sarah Feasey, Legal Services	1
Tom Crisp, Legal Services	1
Norman Coombe, Legal Services	1
Chris Page, Principal Cabinet Assistant	1
Niko Baar, Liberal Democrat Political Assistant	10
Julie Timbrell, Southwark scrutiny project manager , Scrutiny Team SPARES	
External	
Healthwatch Bexley	1
Healthwatch Bromley	1
Healthwatch Lewisham	1
Healthwatch Lambeth	1
Healthwatch Greenwich	1
Healthwatch Southwark	1

Electronic agenda (no hard copy)
Cllr Jasmine Ali, Southwark reserve members
Cllr Paul Fleming, Southwark reserve member
Rick Henderson, Independent Advocacy Service
Tom White, Southwark Pensioners' Action Group
Jay Strickland, Southwark Adult Social Care Director
Jin Lim , Southwark Public Health Assistant Director
Alain Lodge (Greenwich)
Louise Peek (Bexley)
Graham Walton (Bromley)
Simone vanElk (Lewisham)
Elaine Carter (Lambeth)

Total:50

Dated: January 2016