

South East London NHS Commissioning Strategy
Update for Health & Wellbeing Board– July 2014

Introduction

Bromley Clinical Commissioning Group (CCG) and its five partner CCGs in south east London (Bexley, Greenwich, Lambeth, Lewisham and Southwark) are working with commissioning leads from NHS England and in close partnership with local authorities, hospitals, community health services, mental health services, patients, carers and local people on a five year strategy to improve health and health services across south east London.

The strategy focuses on the most important health issues for people in the region, as identified in the south east London Case for Change. The Case for Change has been developed by local clinicians, public health and social care colleagues and has been tested more widely with local people and other stakeholders. It is based on local needs and aspirations and builds on work at borough level, whilst taking into account national and London-wide policies.

The strategy addresses issues which need collective action or where there is added value in CCGs working together across south east London. It builds on local plans, including Health and Wellbeing Strategies, and draws on Joint Strategic Needs Assessments, and existing best practice. Bromley's (and the other boroughs') Joint Strategic Needs Assessment, commissioning plans and Health and Wellbeing Strategies will continue to be produced to identify borough-specific issues and challenges and the plans to address them and they will continue to shape the South East London Commissioning Strategy.

The strategy also meets the requirement of NHS England that every CCG should have a five year strategy. The current version of the strategy (published on Bromley CCGs website) has been submitted to NHS England for review, in accordance with a national deadline. It is very much a work in progress and the next stage of its development is described later in this paper.

Programme Vision

The problem we are trying to solve:

Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well.

The longer we leave these problems, the worse they will get. We all need to change what we do and how we do it.

Our collective vision for south east London:

In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

How is the strategy being developed?

The overall shaping of the strategy is undertaken by the programme's Partnership Group. Membership includes the CCG chairs and chief officers; NHS provider chief executives and medical directors; local authority chief executives; NHS England representatives; Healthwatch representatives; and local patient and public voices. It is chaired by a CCG clinical chair. Health and Wellbeing Boards have been briefed on the strategy as it has been developing and have reviewed and commented on the Case for Change. As work on the strategy has continued over the period of local elections and annual general meetings, it will be brought back in its current form to Health and Wellbeing Boards for discussion to inform the next stage of development.

The programme board for the strategy is the Clinical Commissioning Board.

Membership of this is:

- the clinical chairs and chief officers from each of the CCGs
- representation from NHS England
- representation from local authority chief executives
- Healthwatch and local patient and public voices

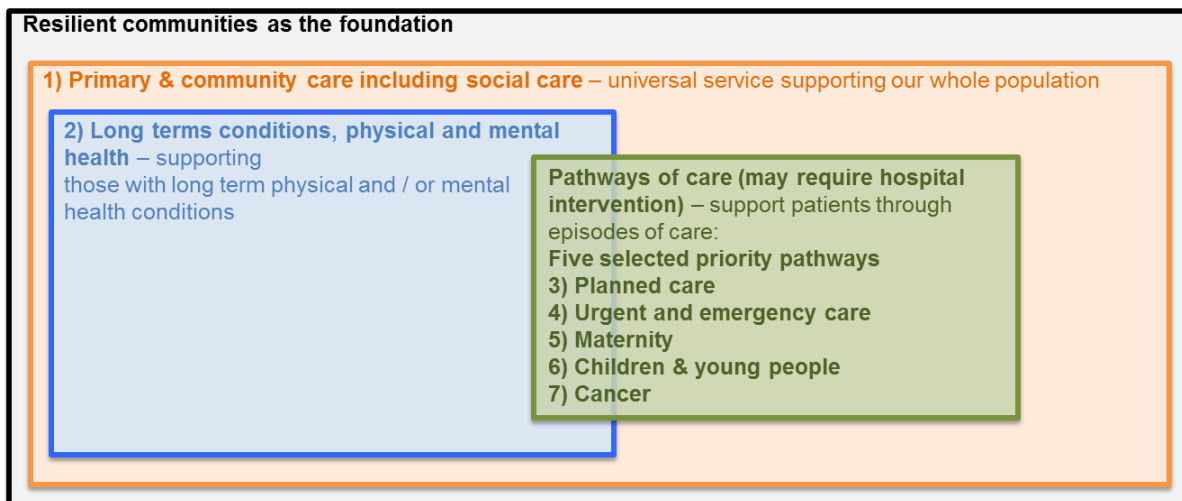
The Clinical Commissioning Board reports to the Clinical Strategy Committee of Bromley and its five partner CCGs, which in turn reports to each of the CCGs' Governing Bodies. Any decisions about investment and/or changes which may impact on services are taken by Bromley CCG's Governing Body and those of the other five CCGs.

The details of the strategy are being developed by the Clinical Executive Group (CEG), and the Clinical Leadership Groups (CLGs). These are groups of local clinicians, commissioners, social care leads and other experts, Healthwatch representatives and patient and public voices from each of the boroughs. They are working together on seven key areas:

- Primary and Community Care
- Long Term Conditions – Physical and Mental Health
- Urgent and Emergency Care
- Maternity
- Children and Young People
- Cancer
- Planned Care

The emerging model

Emerging thinking from the CLGs, the CEG and the Partnership Group has informed a system-level model of an integrated care system (below), delivered through the seven strategic interventions set out in the previous section.



South east London CCGs and NHS England are working together to develop an integrated care system, delivered through the seven strategic interventions set out above. In this system integrated services will have:

- Involved and informed patients and carers
- Engaged and supportive communities
- Adaptable and capable staff

Underpinned by the characteristics of our integrated system:

- Build resilient communities
- Promote health and wellbeing
- Provide accessible & easy to navigate services
- Join up services from different agencies & disciplines
- Deliver early diagnosis & intervention
- Raise the quality of services to the same high standard
- Support people to manage their own health & wellbeing
- Achieve improved outcomes for all residents

1) Primary and Community care

Primary and community care (defined in its broadest sense) will be provided at scale by 24 Local Care Networks supporting local populations. This will be a universal service covering the whole population ‘cradle to grave’. The changes to primary care will focus on four high impact areas:

- Access
- Proactive care
- Coordinated care
- Continuity of care

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2) Long term conditions, physical and mental health

Those with long term physical and / or mental health conditions will be supported with segmentation into three categories:

- a) People with a stable / well managed long term condition – who need support from primary care with some occasional input from community and hospital services
- b) People with complex long term conditions – requiring on-going support from co-ordinated health and social care
- c) People with multiple complex needs where standard services are not effective – requiring personally designed support from multiple agencies including voluntary sector

Local care networks will play a lead role at all stages and there will be a consistent focus on reablement; not just the prevention of deterioration, but returning people to better health.

3-7) Priority pathways

Priority pathways support patients through episodes of care, often including hospital care. These pathways have been prioritised based on our Case for Change and strategic context, feedback from our stakeholders and partners, including Health and Well-being Boards. Local Care Networks will be engaged as patients access these pathways, as will the wider health and social care teams where people have on-going long term conditions.

EMERGING CONTENT – SUBJECT TO FURTHER REVISION / DEVELOPMENT	3. Planned care including the following key features:	<ul style="list-style-type: none"> • Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and ‘one-stop-shops’ where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; speciality focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
	4. Urgent & emergency care including the following key features:	<ul style="list-style-type: none"> • Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to ‘do and discharge’ • Services meeting London Quality Standards
	5. Maternity including the following key features:	<ul style="list-style-type: none"> • Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multiples; birth centres for low risk primips • Continuity of care through a ‘midwifery led’ model with improved/extended consultant cover • Assessing for women’s toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
	6. Children including the following key features:	<ul style="list-style-type: none"> • Collective focus on the child including, ‘every contact counts’ • Improved Access – ‘no wrong door’ • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
	7. Cancer including the following key features:	<ul style="list-style-type: none"> • Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

Supporting Strategies

Clinical Leadership Groups and the Partnership Group have identified a number of cross-cutting supporting strategies to enable the delivery of interventions defined through the groups. Initially, five priority strategies will be developed. Other supporting strategies (for example, access to public transport) will be mobilised to support subsequent phases.

- IT and Information – to drive a consistent and accessible approach to IT and information across all providers
- Workforce – to develop a new workforce model that meets the needs of an increasingly community-based model of prevention and care
- Commissioning models – to develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system
- Communications and engagement – to support all aspects of the programme
- Estates – to support Local Care Networks promoting co-location of staff and services where appropriate; and ensure all estate is fit for the 21st century

Implementation work already underway

We understand the urgency to improve services and significant work is already underway to deliver parts of the strategy during years 1 - 2. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the strategy, and we have begun the process of evaluation and continuous improvement for these services.

Some examples of significant work already being implemented include:

- Development of wider primary care, provided at scale
- Developing a modern model of integrated care
- Improving and enhancing local urgent and emergency care
- Transforming specialised services
- Building resilient communities
- Partnership working across south east London
- Promoting public health role and prevention

Current Position and Next Steps

A strategy document was submitted to NHS England for review on 20 June 2014. This document was discussed in public at Bromley CCG's Governing Body on 12

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June, prior to submission. This submission is an early national milestone in the long-term development of the strategy.

From July 2014, considerable further work will be undertaken, including testing the models, reviewing the evidence to support them and modelling the impact of proposed interventions. Local and wider engagement will be taking place as part of this within Bromley and across south east London. There will be more opportunities for local people to become directly involved, and the strategy will be formally presented to each Health and Wellbeing Board for input and to shape it further.

Feedback from all the engagement and involvement will continue to inform development of the strategy.

If the strategy, as it develops further, results in proposals which would constitute significant service change; these would be the subject of formal consultation. The current thinking is that if any formal consultation is needed, it would be in the second half of 2015.

In the meantime, borough-level Joint Strategic Needs Assessments, the CCGs' commissioning plans and Health and Wellbeing strategies will continue to be produced locally to identify borough-specific issues and challenges and the plans to address them, which will in turn inform the further development of the strategy.