Our Healthier South East London
Improving health and care together

NHS

Bromley Health & Wellbeing Board

Update - summary pack

Our Healthier South East London – summary report January 2015

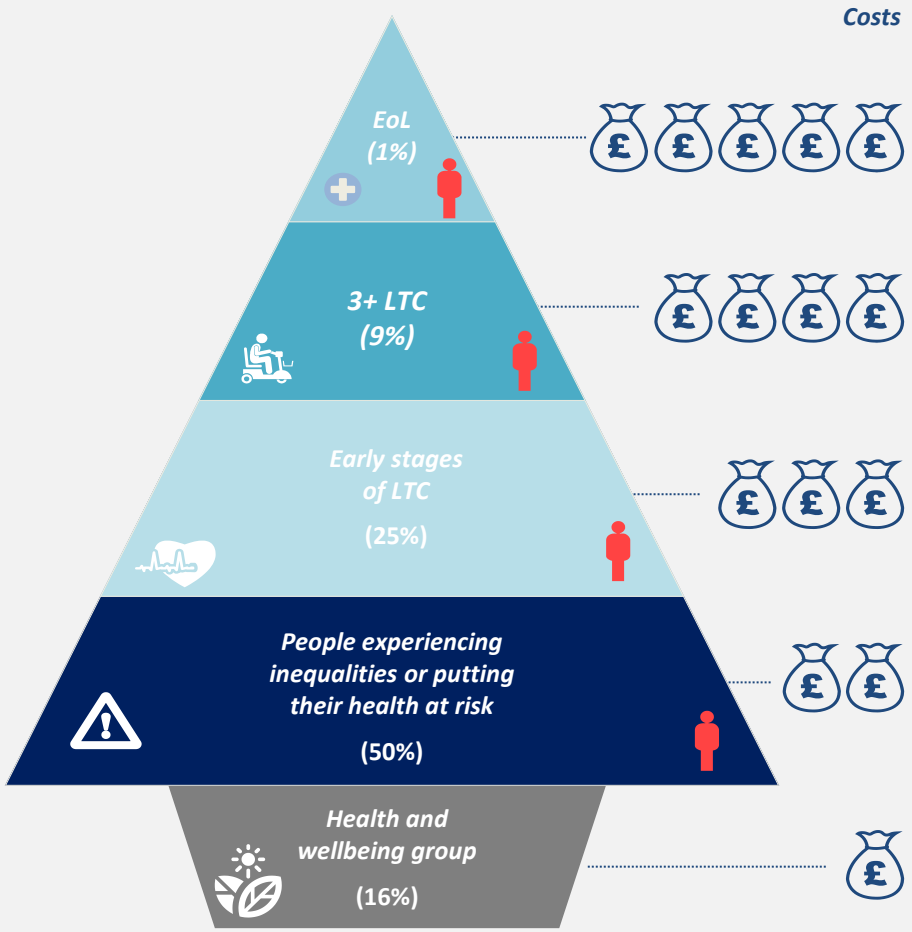
- A draft strategy for south east London was presented to the Health & Wellbeing Board in July 2014 and submitted to NHS England
- Significant work since then has been undertaken to develop the strategy further through the Clinical Leadership Groups, Clinical Executive Group, Partnership Group, Clinical Commissioning Board, which include colleagues
- There has been extended Public and Patient Voice (PPV) input to these key groups and the Patient and Public Partnership Group is now very active. A number of wider engagement events have also taken place, feedback from which has been used throughout the development of the strategy
- This paper is a six month summary of all this activity and includes updates on the detailed work carried out by each of the 6 CLGs to date as well as the significant areas where progress has been made:
  - Population segmentation
  - Local Care Networks
  - Whole System Model
  - Forward planning

Our Healthier South East London: population segmentation

- The population of South East London has been segmented to show: people living healthy lives; those at risk of developing a long term condition (LTC); and those who are living with LTC.

- Local Care Networks will support people to live healthier lives and reduce the risk to people exposed to risk factors either by birth or behaviour. For people with a long term condition, LCNs will take a rehabilitative/ reablement approach enabling people to manage their own health positively and to prevent deterioration wherever possible. For those people with complex LTC or who are in the last year of life, support will be available to enable them to lead as full and active life as possible.

- The services available will be proactive, accessible and coordinated; with a flexible, holistic approach to ensure every contact counts; whilst still encouraging self-reliance. This will be delivered to geographically coherent populations, at scale..



Local Care Networks are the foundation of the whole system model providing person centred services to populations

Strong confident communities

Self care

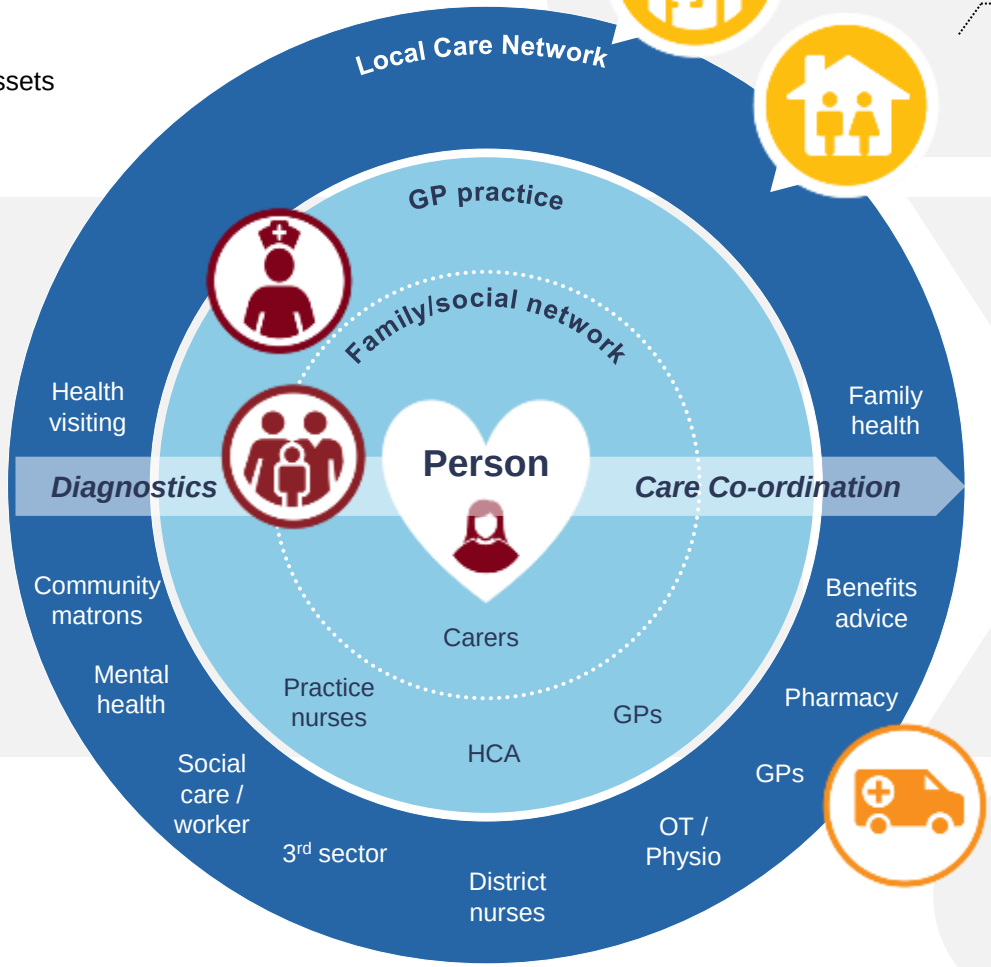
Proactive, Accessible , Coordinated, Continuous Care

- Health coaching
- Self management tool kits
- Social prescribing
- Optimising neighbourhood assets

Population needs and ***budget***

Managed care

- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes



Specialist input *shared between LCNs:*

Pulled into care delivery from outside the network: Virtual clinics | Specialist nurses | Consultants | Geriatricians | End of Life expertise | Specialist rehab

Wider community infrastructure:

Police | fire service | schools | Housing

Affordable high quality outcomes

Urgent and emergency

Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care

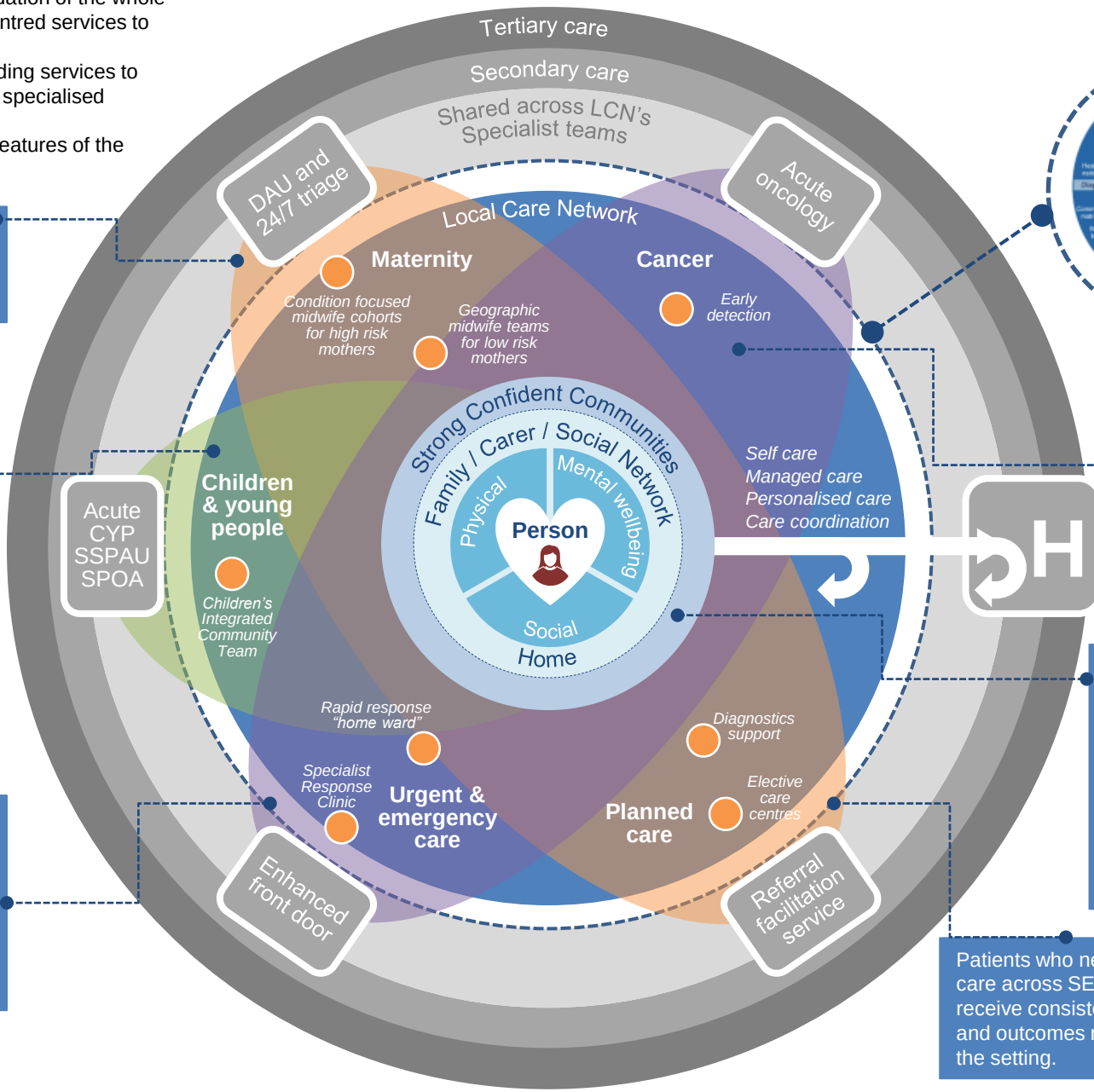
This is Our Healthier South East London health and care whole system model

- This is our integrated system model.
- Local Care Networks are the foundation of the whole system model providing person centred services to populations
- The petals are the pathways providing services to cohorts of people and drawing on specialised services
- The orange circles represent key features of the model

Mums-to-be will receive a personalised service, continuity of care and a range of birthing options

Children and young people will be able to access more specialised services through children's integrated community teams

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services



Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer

Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

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Our Healthier South East London Whole System Outcomes (1/2)

Domain	Outcome/Impact	Example Indicator(s)	Metric/Target
Population Health	Preventing people from dying prematurely and supporting them to live longer and healthier lives	• Extended years of life • Potential years of life lost (PYLL) from causes considered amenable to healthcare for both adults and children & young people • Life expectancy at 75 for both males and females • Levels of confidence • Feeling empowered to make healthy decisions • Reduction in obesity • Reduction in alcohol misuse • Reduction in smoking • Reduction in emergency admissions	
	Reducing differences in life expectancy and healthy life expectancy between communities- starting with quality early childhood education and care	• Reduced gap in life expectancy at birth • Improvements in wider factors which affect health and wellbeing and health inequalities	
Quality of Life	Supporting people feel independent, in control of their health, and able to access personalised care to suit their needs	• Population reported outcome measures (not patient) • Living in my own home • Reduction in permanent admissions to residential and nursing care homes, per 100,000 population • Number supported to die at home if they wish	
	Provision of health and care that enables people to live a good quality of life with their long term condition	• Health-related quality of life for people with long-term conditions • Quality of extended years of life • Patient activation	

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Our Healthier South East London Whole System Outcomes (2/2)

Domain	Outcome/Impact	Example Indicator(s)	Metric/Target
Effectiveness of Care	Treatment that is effective, efficient and delivers the best results for patients including rapid reablement	• Reduction in the variation of service quality and clinical outcomes • 1 year survival rate for cancer • Care meets the best evidence-based standards (clinical protocols followed) • Reduction in emergency readmissions within 30 days of discharge from hospital • Sustainable provision of health and care	
	Delivering the right care, at right place, at the right time along the whole cycle of care	• Increased proportion of care delivered in the community • Reduced length of stay • Reduced A&E attendances and emergency admissions	
Quality of Care	Commitment to people having a positive experience of care	• Patient experience of primary care (GP services, GP OOH services, NHS dental services) • Patient experience of hospital care • Staff experience / satisfaction • Friends and family test • Overall satisfaction of people who use services with their care and support • Overall satisfaction of carers with social services • Patient Experience Headline score for Focus on Dignity and Respect Customer Service: • Waiting time • Convenience • Accessibility (carers) • Respect (care givers/experience) • Safe (measure) • There is appropriate care planning	
	Caring for people in a safe environment and protecting them from avoidable harm	• Reduced variation of care • Reduced avoided harm • Reduced late complications • Patient safety incidents reported • Safety incidents involving severe harm or death • Reduced hospital deaths attributable to problems in care	

Next steps

Next three months:

- Refinement of the whole system model and the models of care
- Modelling expected impacts for providers and commissioners
- Further development of the supporting strategies.
- Testing refreshed CCG Operating Plans against the strategy to ensure that there is consistency between the short and longer term plans
- Presenting the developing strategy to Health and Wellbeing Boards and other key meetings for review and input
- Further wide engagement

Summer 2015 – mid 2016

- Development of options & criteria to assess options for implementation
- Modelling to support option appraisal
- Business case development
- Consultation, if required.
- Continuing implementation of elements not requiring consultation, such as the development of the local care networks, community based care and improved clinical pathways

DRAFT – WORK IN PROGRESS

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Programme Plan

Phase 1 (January – May 2015)	Phase 2 (May – August 2015)	Phase 3 (September – November 2015)	Phase 4 (December 2015 – March 2016)	Phase 5 (April – June 2016)	Phase 6 (July 2016 - 2019)
Key Activities					
• Further refinement of the Whole System Model and the models of care, including testing with providers, partners and wider stakeholders • Modelling expected impacts for providers and commissioners • Further development of the supporting strategies • Clinical model implementation • Workshops– CO discussion on commissioner models , Provider and CLG	• Identification of potential for significant service change. • Developing criteria to assess options for implementation • Developing options • Option appraisal • Decisions on reference cases/preferred options • Modelling to support option appraisal and decision making • Further support to implementation: CBC and LCN • Continued work with partners to ensure ownership and wider engagement to test and develop	• Development of business cases. There will need to be agreement as to the business cases required and who will lead them (commissioners or providers). • Modelling to support development/review of business cases • Decisions making processes for business cases • Continued wide engagement	• Any consultation, if required. *Note: In the event that consultation is not required, and for any elements of implementation where consultation is not required, the timetable will be shortened, but for planning purposes this paper assumes that there will be some formal consultation, although the subject of such consultation has yet to be established.*	• Conclusion of any consultation • Further modelling if required • Decision making • Preparation for implementation	• Continuation of strategy implementation. *Note: as per CCG level implementation roadmaps*
Key Outputs					
• Detailed implementation plan • Presentation to NHSE • Provider outline of steps required to operationalise the Whole System Model • Development of the supporting strategy by providers • Equality Impact •	• Modelling Impact Assessment • Publish Equalities Impact Assessment and action plan • Refinement of implementation plan • Recommendation options	• Refinement of detailed implementation plan • Gateway review • Business Case sign off			• For mobilisation of the strategy

Live implementation and continuous quality improvement

Governance Groups	Continuous input throughout the process with regular meetings
Comms & Engagement	Continued aligned plan to ensure the programme continues with a high level of engagement
Finance & Modelling	Modelling to establish the baseline position, required investment and quantify benefits to be realised
Supporting Strategies	Continue the commissioning framework, LCN, workforce, IM&T systems and estates configuration needed to realise the change

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