

South West London STP Commissioning Intentions 2017 to 2019

v1.4

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South West London Collaborative Commissioning

Commissioning intentions 2017/18 to 2018/19

1. Introduction to South West London STP

In June 2016, SW London submitted a draft Five Year Forward Plan to NHSE. This plan was a product of collaboration between all the NHS commissioners and providers in SWL, working with our six local authorities and GP federations. The plan sets out our collective challenges and how we could transform health and care services, so that local people receive the high quality care they rightfully expect, now and in years to come. As well as improving the quality of services and ensuring services meet the needs of our population, the plan describes how these transformational changes will address our financial 'do nothing' challenge of up to £912m by 2020/21.

Our plan centres around five key areas:

- Prevention and early intervention; supporting people to stay well, identifying those at risk of developing LTCs, and using model technology and a modern local workforce to develop proactive care and better support people at home and in the community
- Transforming community based care so we deliver right care in the best setting; transforming access to outpatient services, reducing A&E attendances and increasing timely hospital discharge, and helping people to die where they want
- Building capacity and capability in the community; establishing locality teams to provide care to populations of at least 50,000 people and transforming primary care services
- Reviewing the configuration of our acute hospitals; making best use of staff through clinical networking and redesigning clinical pathways, and reviewing the provision of specialised services
- All the above underpinned by a model workforce, making best use of our public estate and delivering an information revolution

Through our Commissioning Collaborative and Acute Provider Collaborative working arrangements, we have established a programme to deliver the STP. These workstreams are currently working up their workplans which will be reflected in contractual arrangements. This document sets out the proposed changes for 17/18 and 18/19.

In line with the direction set out in the STP the clinical leadership groups have devised a programme of action and change which will be incorporated into commissioning intentions and thereafter reflected in contractual arrangements. This also reflects the National Must-do's for 2017-19 as set out in the NHS operational planning guidance (September 2016)

The following state the 17/18 and 18/19 expected service changes

- Urgent and emergency care
- Planned care
- Cancer
- Maternity

- Children's and young people
- Mental health
- Primary Care
- Prevention and self-care
- Proactive management of patients with complex needs
- Re-commissioning
- Long term condition management
- Intermediate care

2. Urgent and Emergency Care

In south west London, we believe that the urgent and emergency system service model needs to be transformed by the end of 2018/19. An integrated service which achieves the core standards is a high priority. 24/7 integrated urgent care access, treatment and advice via an improved 111 service. Priorities include mental health crisis care, self-care support and 'see and treat' models for London Ambulance Service. The following service changes are expected:

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- Work across all acute providers to deliver sustainable London Quality Standards by 2020 in order to provide 7DS
- Implement a SWL AEC specification which will see all patients presenting at A&E considered for AEC unless clinically inappropriate
- Review of places of safety and psychiatric liaison capacity to improve access in south west London by 2017. This will contribute to a cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

3. Planned Care

Planned Care can be defined as the provision of routine services with planned appointments or interventions within community settings such as GP surgeries, health centres and other community facilities. This term also encompasses routine surgical and medical interventions provided in a secondary care setting and in some instances long-term conditions such as diabetes and musculo-skeletal conditions.

The Planned Care section of the five year strategic plan covers planned inpatient routine elective surgery. Day case procedures are out of scope (except where there is a significant financial and/or clinical benefit in centralisation), and routine medical outpatient appointments will be considered as part of the integrated care.

The following service changes expected for planned care:

- Deliver the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. Implement effective performance management to enable accurate benchmarking and assure achievement of RTT & cancer waiting time
- Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals

by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.

- Work with providers to identify priority pathways in order to introduce standardised pathways and protocols across south west London
- A Reduction in “Did Not Attend” through better use of technology eg Kinesis and the introduction of virtual clinics with a roll out in 17/18.
- Ring-fencing of elective care beds
- Improved access to diagnostics (08:00 to 20:00hrs) and the expansion of one stop diagnostics
- Improved networking and referral management
- Undertake a Theatre Productivity review and sharing best practice
- Strengthening and Consistent application of Effective Commissioning and “Procedures of limited clinical effectiveness” Policy
- For Outpatients:
 - Reducing variation in Outpatients activity across SW London
 - Eliminate non clinically valid appointments & unnecessary follow up appointments
 - Improved referral management and reduce non-attendance through effective electronic communication
 - Roll out new models that use technology to deliver better patient care (skype, remote monitoring, kinesis etc.)

4. Cancer

South west London cancer services will focus on prevention of disease, early diagnosis and patient experience of treatment with an emphasis on patient choice and care provision in the community during active treatment, recovery, and, where necessary, at the end of life. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved.

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards
- Improve targeted screening and early diagnosis interventions through reducing variation in primary care to tackle health inequalities, deliver better access to services and outcomes. This includes raising patient awareness and acting on symptoms of cancer. Providers to achieve 40% of first attendances by day 7.
- Work across all acute providers to deliver sustainable waiting times to access diagnostics and treatment through delivery of new pathways, (including “straight to test”), reviewing PRL processes and improving MDT arrangements. Providers to develop plan for capacity at 65th percentile of demand; Access to pan endoscopy at KHFT (subject to diagnostic capacity fund bid); All Trusts plan for demand growth as per TCST modelling; KHFT faster diagnosis pilot site
- Identify the priority pathways to be commissioned to reduce variation in treatments rates and outcomes – particularly a greater role for primary care to help deliver improved diagnosis rates and improved care for people within with and beyond cancer.
- Improve the quality of life for people living with and beyond cancer, defining cancer as a long term condition and ensuring it is managed as such across health and social care.
- H&N pathway improvement within SLF plan:
 - Trusts to increase the number of H&N 2ww referrals seen by day 7 to at least 40%
 - Spoke sites (ESTH, CHS and KHFT) to establish additional capacity for pan-endoscopy
- Prostate and lung best practice pathway: Providers to complete actions as set out in the

SWL Cancer Performance Improvement Plan in order to implement the Lung and Prostate best practice pathways by April 2017

- Two week wait referrals to be quarterly reviewed to assess if patients have been given PIS and that they referrals achieve and sustain 40% referrals in 7 days.
- Providers to meet the trajectory for referring patients on a 62 day GP urgent pathway to RMH within 38 days
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned, including HNA, treatment summary and a holistic cancer care reviews.

5. Maternity

South West London will support women's choice in place of birth, increasing availability of home births and midwife-led care. Providing safe and sustainable hospital services for women who need obstetric-led care and a more personalised antenatal and postnatal care, including reviewing consistency of carer and provision of perinatal mental health support. In 17/18-18/19, SWL is a National Pioneer site for Choice and Personalisation which will enable us to test and trial ways of deepening and widening choice and personalisation to women and their families. Through the SWL Maternity Network, the SWL local maternity system will work to implement the recommendations of the National Maternity Review, Better Births, specifically focusing on the following below.

- Prepare women and their partners for pregnancy and parenthood through education and up-to-date, evidence-based information
- Provide care to women as individuals, with a focus on their needs and preferences
- improve continuity of care and carer, with a strong emphasis on midwifery led care for normal pregnancy and birth
- Provide care which meets the London quality standards for all women and their babies. A timeline for achieving the standards will need to be agreed between providers and CCGs.
- Values and takes on board feedback from the women we look after and their families in order to drive continuous improvement in the quality of care.

6. Children and Young People

Most children who are unwell should be treated in primary care and the community; better access to and availability of community-based care will reduce the need for hospital attendances. Children who need hospital care for a short period to be assessed, observed and treated in paediatric assessment units sitting alongside A&Es. Quick access to specialist inpatient care for the small number of children who need it. Increased networking between hospitals and between GPs/primary care and hospitals.

Expected outputs and changes in 17/18-18/19:

- **Acute Care Standards for CYP and Peer Review -**

The HLP CYP Acute Care Standards are a compilation of all standards for in-patient care deriving from Royal Colleges, NICE, the Department of Health and other bodies. They represent the standards of care which should be delivered within paediatric inpatient units.

HLP has commenced a programme of supportive peer review using expert clinical panel members in conjunction with local CCG commissioners. The output of the review is an action plan held jointly by the provider trust and CCG.

SWL CCGs will work with all SWL Trusts to make progress towards achieving the actions described in the agreed plan following the peer review

- **Level 1 and 2 Paediatric Critical Care**

High Dependency Care for children (Royal College of Paediatrics and Child Health 2014) changed the nomenclature of critical care and proposed that a degree of intensive care (formerly known as high dependency care) should be delivered in all in-patient units (level 1 PCC). Some units should be designated as level 2 units providing level 1 care plus the ability to look after CYP receiving long term ventilation. HLP published a set of standards to support this model. Bringing all units up to the standards required will be a large leap in quality, requiring extensive development of the medical and nursing workforce. In order to undertake this, HLP has secured funding to develop an educational package with online and face to face elements to support extensive workforce development. In addition, work is underway to develop a commissioning framework for L1 and L2 PCC.

SWL CCGs will work with all SWL trusts to make progress towards achieving delivery of L1 PCC standards. We will work across the SPG/STP area to determine which trust/s should be commissioned to deliver long term ventilation to CYP.

- **Paediatric Assessment Units (PAU) and out of hospital care**

Across, SWL we have already begun developing the model of care and operational standards for PAUs. HLP will be publishing standards for PAUs in September 2016 and we will explore the feasibility of implementation the PAU model against these standards to support delivery of our paediatric model of care.

Linked to this, we will also work across SWL to make progress towards developing the Out of Hospital provision for CYP.

- **Asthma Care**

The HLP CYP asthma standards describe the level of care which should be delivered across the system, from pharmacies to primary, secondary and tertiary care. Consistent delivery of these across London will reduce the high morbidity and mortality associated with asthma in CYP.

We will work collectively across primary care and trusts to make progress towards achieving delivery of the London asthma standards for CYP.

7. Mental Health

Develop and implement Initiatives that meet the growing demands in mental health and increase the focus on viewing mental and physical wellbeing as an integrated whole. These will be developed to increase their scale and consistency across south west London with a need to deliver the 5 Year Forward View.

The initiatives include:

- Phased implementation of community Perinatal MH service that meets London wide service specification
- Implementation of CAMHS transformation plans, including ensuring that approximately 2000 additional CYP receive NHS funding community support p.a (approximate calculation of SWL share of FYFV ambition)
- Implement enhanced 24/7 crisis services
- Delivering Core 24 psychiatric liaison in all acute hospitals (20% achievement minimum standard by 18/19 – from FYFV)
- Improved access to Psychological Therapies for patients with long term conditions or those who are being treated conservatively (e.g. chronic pain).
- Developing Primary Care Mental Health Services (including services to address the physical health needs of patient's with SMI)
- We will make progress against dementia strategy including maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.

For more detail please refer to mental health appendix.

8. Primary Care

- Delivery of 8am-8pm GP access 7 days a week, meeting the London specification for extended access by end of 17/18
- Commitment to accessible, coordinated and proactive primary care, delivering the 17 specifications for primary care by end of 18/19

Wider commissioning intentions for primary care will be taken forward at a local level.

9. Prevention and self-care

SWL will ensure that people have access to greater preventative and early intervention support so they can become more independent, resilient, and capable in managing and improving their health.

The direction of travel is towards promoting of healthy lifestyles, promoting self-care for minor ailments, ensuring appropriate use of health and social care services, facilitating effective self-management by people diagnosed with long-term conditions, building a strong culture of Shared Decision Making and partnership among patients and clinicians, and embedding of Making Every Contact Count (MECC) culture across services to improve health of the public and service users.

- Whole population/place based interventions
 - integrated communications campaigns
 - common programmes across SWL to address wider determinants of health and unhealthy behaviours
- Community based interventions:
 - Expand use of health champions and expert patients
 - Implement Asset Based Community Development schemes to activate communities
 - Increase existing provision of social prescribing schemes

- Individual interventions to ensure patients are routinely and systematically involved as active partners:
 - Decision aids are widely utilised to support decisions that take account of the individual's preferences
 - Increase use of personal health budgets
 - Embed person-centred care planning and self-management
 - Enhance use of digital technologies and resources
- Local providers to work together to promote information and access to community based resources and help build local capacity to support vulnerable people

10. Proactive management of patients with complex needs (frailty as first priority) delivered by locality teams

As part of delivering an enhanced offer to support adults to receive treatment, support and care to enable them to remain at home, SWL will establish a network of MDT locality teams across sub-regional areas.

The locality teams will be centred around primary care and responsible for managing the care of c. 50k people in a geographical area (around a group of practices). They will build on existing community based health and social care infrastructure to establish integrated teams. While working collaboratively teams will operate using a single point of contact and named care co-ordinator model, carrying out care planning and review in partnership with patients to improve patient experience and outcome and reduce unscheduled care needs. The focus is on enabling people to stay well and avoid healthcare instances.

- Establish locality based MDTs managing populations of at least 50k; risk stratification and cross system working to proactively manage identified cohort in the community
- An agreed integrated pathway for managing frailty at sub regional level (first priority cohort for locality team model)
- Embedding effective care planning processes within the locality team, including integrated care plans, personalised outcomes and regular MDT reviews

11. Long term condition management (diabetes initially but principles of the model could be extended to other LTCs)

A significant amount of LTC management is currently delivered within acute settings. This model of care does not deliver value for money in terms of patient experience or clinical outcomes. There is a growing body of evidence to show that more personalised care delivered in community settings has better outcomes for patients and frees up hospital capacity to deliver high quality specialist care.

The SWL vision for the management of LTC shifts activity primarily to primary care settings supported by effective networks and links to other parts of the system such as specialist nurses and locality based MDTs. GPs take an enhanced role in creating and reviewing care plans and they support patients to take an active role in the management of their LTC(s) through involvement in their care planning, social prescribing, and signposting to virtual advice and support. Patients will also have access to structured patient education programmes.

- Primary care is developed to be at the centre of LTC management including:
 - Extended care planning appointments
 - Care plans with defined review schedules
 - Each care plan has a named clinical lead and regular and timely reviews
 - GPs have access to social prescribing for patients with LTCs
- Primary Care have access to urgent and routine advice to support patients to be managed in the community.
 - Urgent and routine advice via Kinesis (or similar system)
 - Diabetologists (as part of the community team) – as part of a phased roll out beginning with Diabetes
 - Specialist nurses based in the community and integrated with primary care team

Patients have access to structure education programmes and virtual advice and support

With regard to End of Life Care:

- Identification of patients in their last year of life and support them to die in the location of their choice
- Developing a SW London specification for acute End of Life care
- Co-ordinated care planning, with enhanced use of Co-ordinate My Care (CMC) to share care plans between professionals and across organisational boundaries
- Work with care homes & the Sutton Care Home Vanguard to improve end of life care in residential care

12. Intermediate care (step up and step down, bedded and home based)

A significant number of people are admitted to hospital because they have experienced a change in their health and/or social situation. While it is acknowledged that a proportion of these people will continue to require admission to an acute setting, a proportion could be supported in a non-acute setting. Additionally, a number of people could be discharged earlier from the acute setting with adequate support and management of risk.

To ensure patients receive appropriate care in the right setting while reducing the demand on acute settings, SWL's intermediate care services will provide enhanced access and rapid response supported by multi-disciplinary teams.

- Anticipatory care plans are in place to support OOH management of crisis
- Timely access to advice and assessment to prevent hospital admissions including
 - rapid response assessment within two hours 7 days a week
 - real-time access to geriatrician advice
 - Geriatrician review available within 2 hours in ED
- Rapid access to alternative services to prevent hospital admissions and enable timely discharge
 - Health and social care packages available within 4 hours 7 days a week, including access to equipment
 - Step-up/down beds available to prevent hospital admission.
 - 24-hour care packages can be delivered in patients' own home where appropriate
 - Rapid response GPs have admitting rights to frailty wards
- There is an integrated team responsible for planning discharges of patients with complex needs which includes community health and social care

- A home First/Discharge to Assess approach is adhered to across all providers

Through items 9, 10, 11 and 12, we aim to see a shift in acute spells and bed days by the end of 18/19 which is in line with the level of ambition agreed in the STP June Submission

13. Re-commissioning

Within SW London there is an imperative that savings are made to aid recovery of financial positions of any of the organisations that are in deficit. Within this requirement we need to ensure we engage appropriately and proportionately with local people and stakeholders and partners over these decisions and ultimately look at each within the wider context of prioritising the limited resources available to us.

Given our continued efforts of delivering savings, there is an increasing need to consider other areas including re-commissioning, reducing provision and disinvestment decisions. The significant in-year savings we are required to make will require service changes, with the aim of achieving the best possible value for money. Potentially, some of these changes may require wide scale engagement/and or consultation. This includes statutory, voluntary sector and third sector contracts.

14. Collaborative productivity

We can no longer rely on traditional cost improvement programmes within single organisations. Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries.

Savings are estimated at £12.6 million in 17/18 and £22. Million in 18/19 through economies of scale and removing duplication, and we expect to see improved outcomes and quality.

Opportunities for collaboration include:

1. **Clinical Workforce:** We need to develop a health and social care workforce that can work across organisational and clinical boundaries to deliver care that is more integrated, which better supports and responds to the needs of patients, is safe and of consistent high quality staff, and offers best value for money.
2. **Medicines Optimisation:** In addition to the provider schemes, pharmacy teams across the six south west London CCGs are working together to identify opportunities for medicines related saving that go beyond the usual quality, innovation, productivity and prevention (QIPP) savings through collaborative approaches, these include:
 - Pathway reviews to identify opportunities in high cost drugs in secondary care (with a focus on differences in practice between hospitals and doctors) (£1m)
 - Opportunities to reduce or stop prescribing medicines which are considered to be less clinically effective and/or significantly more expensive than their alternatives (£2.9m)
 - Opportunities to reduce medicines wastage (particularly through changes in doctor, pharmacist and patient behaviours around ordering, dispensing, and repeat prescriptions (£3.9m)
 - New models of care – in stoma, wound management, continence, and malnutrition

(£2.2m)

3. **Procurement:** The creation of a single procurement and supply chain solution for the SWL trusts.
4. **Estates & FM:** A fundamental change in the way we manage the combined Health & Social Care estate across south west London that includes a coordinated, strategic and integrated approach. Development of new models of care will require growth in primary care provision and the location of appropriate acute and mental health services within primary and community healthcare settings.
5. **Corporate & Admin:** Multi-functional shared service centre primarily focussed on transactional services in HR, Finance, IT and Payroll
6. **STP Benchmarking**

15. Provider position

We have estimated a cumulative savings impact for FY17/18 to 18/19 across each provider and opportunity as:

Cumulative APC savings (£000 for financial year 17/18)

Name of APC solution	Recurrent Expenditure Adjustment	CHS	ESUH	KHFT	SGH	HRCH	TRM	SWLStG	Total
Clinical workforce	Workforce - Substantive and Bank	£475	£665	£380	£0	£0	£0	£0	£1,520
Clinical workforce	Workforce - Agency	£200	£450	£300	£304	£0	£0	£0	£1,254
Medicines optimisation	Drugs	£0	£0	£0	£0	£0	£0	£0	£0
Procurement	Procurement	£2,080	£2,627	£1,302	£3,596	£0	£0	£0	£9,605
Estates & FM	Provider Other	£0	£0	£0	£0	£0	£250	£0	£250
Corporate & Admin	Provider Other	£0	£0	£0	£0	£0	£0	£0	£0
STP Benchmarking - Waste Reduction	Provider Other	£0	£0	£0	£0	£0	£0	£0	£0
STP Benchmarking - Pharmacy	Provider Other	£0	£0	£0	£0	£0	£0	£0	£0
STP Benchmarking - Radiology / Pathology	Provider Other	£0	£0	£0	£0	£0	£0	£0	£0
Estimated Provider Collaborative	Provider Other	£0	£0	£0	£0	£0	£0	£0	£0
Total	-	£2,755	£3,742	£1,982	£3,900	£0	£250	£0	£12,629

Cumulative APC savings (£000 for financial year 18/19)

Name of APC solution	Recurrent Expenditure Adjustment	CHS	ESUH	KHFT	SGH	HRCH	TRM	SWLStG	Total
Clinical workforce	Workforce - Substantive and Bank	£500	£700	£400	£0	£0	£0	£0	£1,600
Clinical workforce	Workforce - Agency	£380	£855	£570	£577	£0	£0	£0	£2,382
Medicines optimisation	Drugs	£0	£0	£0	£0	£0	£0	£0	£0
Procurement	Procurement	£2,340	£2,956	£1,464	£4,046	£0	£0	£0	£10,806
Estates & FM	Provider Other	£78	£0	£316	£1,608	£0	£1,000	£0	£3,002
Corporate & Admin	Provider Other	£1,155	£510	£270	£945	£0	£0	£0	£2,880
STP Benchmarking - Waste Reduction	Provider Other	£76	£112	£69	£223	£0	£0	£0	£480
STP Benchmarking - Pharmacy	Provider Other	£66	£98	£61	£195	£0	£0	£0	£420
STP Benchmarking - Radiology / Pathology	Provider Other	£71	£105	£65	£209	£0	£0	£0	£450
Estimated Provider Collaborative	Provider Other	£0	£0	£0	£0	£0	£1,160	£510	£1,670
Total	-	£4,666	£5,337	£3,215	£7,803	£0	£1,000	£0	£22,020