



**DRAFT**

# South West London Five Year Forward Plan



**Start well, live well, age well**

October 2016

## A plan for south west London

This document is the combined view of local NHS clinical commissioning groups and provider trusts, working with our local authorities and specialist provider, the Royal Marsden NHS Foundation Trust. This five-year plan is led by the south west London Strategic Planning Group, comprising the following organisations:

- Six clinical commissioning groups (CCGs): Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
- Four acute providers: Croydon Health Services NHS Trust, Epsom & St Helier NHS Trust, Kingston Hospital NHS Foundation Trust, St George's NHS Foundation Trust (of which two – Croydon and St George's – also provide community services).
- Two mental health providers: South West London & St George's Mental Health NHS Trust, South London & Maudsley NHS Foundation Trust.
- Four community providers: Central London Community Healthcare, Hounslow & Richmond Community Healthcare Trust, Royal Marsden NHS Foundation Trust, Your Healthcare.
- GP Federations in each of the six boroughs.
- Six local authorities: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.
- NHS England in their role as commissioners of specialised services and primary care (Croydon).
- All of our clinical workstreams have included patient and public representatives, selected through an open recruitment process.

## A new approach to joint working

The success of this plan is built on all services, across all areas of mental and physical health and social care, working together in an unprecedented way. All organisations who have signed up to this plan expect to be held jointly accountable for its delivery. Unlike previous proposals, this is not a plan developed solely by NHS commissioners; it has been developed through collaboration by all of the partners listed above.

To support the effective implementation and delivery of our plan, we will review and refresh our collaborative governance arrangements across south west London subject to agreement by the South West London and Surrey Downs Programme Board. Local organisations have been looking at their working relationships and how they might collaborate better.

For example, to support the effective implementation and delivery of our plan, the six CCGs in south west London have proposed to their governing bodies and to NHS England that from April 2018, five CCGs (Kingston, Merton, Richmond, Sutton and Wandsworth) will work collectively under one Accountable Officer, alongside Croydon CCG. All six CCGs have already agreed a joint financial strategy and governance arrangements and are working together to drive pace and momentum on the collaborative commissioning activities in SWL during 2016/17. Further work is being undertaken to agree the operating model which will be in place from April 2018; transition arrangements will be in place during 2017/18 with four CCGs (Kingston, Merton, Richmond and Wandsworth) working alongside Croydon CCG and Sutton CCG.



Epsom and St Helier NHS Trust and St George’s NHS Foundation Trust have also started to consider ways in which the two organisations might work together more, with the aim of understanding if there are realistic opportunities for joint working between the organisations to improve quality and efficiency for patients.

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# 1. Our plan

This is our Five Year Forward Plan - a product of unprecedented collaboration between all the NHS commissioners and providers in south west London, working with our six local authorities and GP federations. It sets out 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. The plan sets out a general direction of travel for local health services over the next five years, and is endorsed by all of the Boards and Governing Bodies of NHS organisations in south west London. All ideas put forward in this document will need to be further discussed and developed, including the timing of any proposed changes. We will also discuss our ideas in detail with local people, including formal public consultation if needed.

## We are clear about the challenges we face

The way in which hospital, community and primary care services are currently delivered in south west London means that people don't always get the best possible care from the NHS.

People tell us they want more care closer to home, but admissions to hospital are rising. National waiting time standards for A&E, cancer, and elective surgery are not being met in all of our acute hospitals. There is too much variation in quality depending on where you live, and we don't offer a consistent service seven days a week.

There is evidence that we can design better pathways for urgent and emergency care, mental health, maternity, children's care, and care of the elderly to deliver more care and support to people outside of hospital. A study in February 2016 found that 55% of people in acute hospital beds in south west London could have been offered better care elsewhere. Too many people are admitted to beds in mental health hospitals because we don't offer enough support in people's homes or in the community. We want to work together across health and social care to change this.

Better models of care will help us deliver more with the NHS and social care workforce in south west London, ensuring that we have enough doctors, nurses and care workers to support services in the future. It will also help reduce our reliance on expensive agency staff to keep services running.

We have a diverse population in south west London and it is growing rapidly every year. Life expectancy varies by more than nine years between our richest and poorest areas, and are even greater for individuals with serious mental illness. People are living longer, but with more complex and physical health needs – some of which need increasingly expensive treatments. We need to do more to help people live healthy lives to make sure NHS services are available for those who need them. When people do need help from health and social care, we want to help people stay well and keep their independence for as long as possible. And when people reach the end of their life, we want to respect people's choices about where they spend their days.

A growing population and more demand mean that there is unprecedented pressure on our local NHS. This is compounded by cuts to our local councils and social care budgets. Adult social care is a huge part of local authority budgets and these services are working every year to reduce spending and find more cost effective ways of working, while maintaining safe, high quality services. With demand growing, it is clear that the NHS and the social care system need to work better together if we are to deliver the high quality services people need.



As a result of population changes and growing demand – particularly for expensive acute hospital care – the costs of providing health and care services are rising more quickly than inflation and increases in the money we are allocated. Collectively, across south west London, we are already overspending by around £140m a year. If we do not take action to transform services now, south west London's NHS faces a gap of up to £828m by 2020/21 between the money it has to spend and the money it would need.

## Our principles

We want to take action now to improve standards and outcomes for our local population, while making sure services are clinically and financially sustainable. If we act now, the NHS can continue to provide the care people need in the years to come. This Five Year Forward Plan sets out how we can work together across south west London to support people to keep healthy and well, and intervene early and deliver the right care in the best place to support them if they do get ill.

To do this we want to move more care from our hospitals into local communities so we can provide more care closer to where people live. We also want to do more to help people live healthy lives, and make sure that they stay as well as possible for as long as possible.

## Our plan suggests we should:

- Set up locality teams across south west London to provide care to and improve health for defined populations of approximately 50,000 people. The teams will align with GP practice localities and have the skills, resources and capacity to deliver preventative health and support self-care.
- Use our workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospital admissions.
- Review our acute hospitals to ensure that we meet the changing demands of our populations, and to ensure that acute providers deliver high quality, efficient care. Our working hypothesis is that we will need four acute hospital sites in south west London, but we need to do further work on this
- Address both mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people with long term conditions.
- Introduce new technologies to deliver better patient care (e.g. virtual clinics and apps).
- Make best use of acute staff through clinical networking and redesigning clinical pathways.
- Review specialised services in south London. With NHS England, we have initiated a programme of work to identify the best configuration of the eight acute specialised providers in South London to be clinically and financially sustainable and deliver the best patient care.

## Key decisions

This is an ambitious strategy. To deliver it we will have to make difficult decisions about the configuration of our health and care services – including what services we provide in south west London; where and how we provide them; and how organisations work together in a different way, focused on the needs of their local



populations. With the right approach, we can maintain or improve the quality of our services while ensuring they are sustainable in the years ahead.

## Engagement

The interests of our patients, communities and NHS staff lie at the heart of our Five Year Forward Plan. Any changes that need to be made will be based on improving standards and the quality of care people receive. We will continue to engage widely and take account of equalities considerations. Any significant changes will be subject to public consultation.

## 2. Case for change

The future of health and care in our region must be based on every part of the NHS and social care working together to deliver joined up services to patients, as near to where they live as possible and built around their needs. To achieve this, we need to urgently address a number of challenges and transform the way in which we deliver care. These challenges make up our case for change and are set out below.

***“The future of health and care in our region must be based on every part of the NHS and social care working together to deliver joined up services to patients”***

## Health and wellbeing

The national Five Year Forward View sets out that a ‘radical upgrade in prevention’ is needed to improve people’s lives and achieve financial sustainability of the health and care system.

In south west London we expect to spend £202m in the next five years treating illnesses which result from preventable causes, such as tobacco and alcohol use (including falls resulting directly from alcohol use), obesity, hypertension and unhealthy levels of physical activity. There are also significant differences in life expectancy between some of our more affluent and socially deprived areas, and for those with a serious mental illness.

***“The national Five Year Forward View sets out that a ‘radical upgrade in prevention’ is needed to improve people’s lives and achieve financial sustainability”***

Physical health is inextricably linked to mental health. Poor mental health is associated with unhealthy behaviours such as alcohol misuse and smoking, and with diseases such as cancer, cardiovascular disease and diabetes. NHS organisations need to work closely with local authorities and other local partners to strengthen and implement preventative interventions that will close our physical and mental health and wellbeing gap.



## Care and quality

We have some excellent services in south west London, but we know we can and should do better if we are to bring all services up to the standard of the best.

### In south west London we know:

- All patients should get the best possible care but the quality and safety of our health services varies enormously depending on where and when they are treated.
- We are failing to meet minimum standards for acute urgent and emergency care – none of our hospitals is consistently delivering NHS constitutional standards for A&E, elective surgery or cancer waiting times. Neither are they offering consistent 7 day services.
- We are not treating patients in the most appropriate or most cost effective settings – in a recent audit of acute hospital beds we found that 13% of patients could have avoided admission and 42% would have benefited from early discharge to community based care.
- We can do more to improve the quality of general practice, including improving access to GPs.
- We are not consistently meeting the needs of people who have mental health problems or dementia. In mental health, we do not always provide the support people need at an early enough stage, which would prevent mental health hospital admissions.
- We need to diagnose and treat people with cancer much earlier in order to give them the best chance of survival.
- We need to improve the way we look after people who are nearing the end of their lives.
- We need all services to work together seamlessly in the interests of patients and service users – too often, people have to provide the same information several times to different professionals or the competing priorities of different organisations lead to services being fragmented.

### Three main factors underpin these gaps in the quality of our services:

- A lack of an available workforce to provide safe, effective care in the way our services are currently organised.
- Inadequate provision of preventative and proactive care, including primary care and health and care services supporting earlier discharge from hospital.
- The way in which current services are designed means we don't always get the best clinical outcomes.

## Financial Case for change

The cost of delivering services is rising much faster than inflation due to rapidly increasing demand and medical progress; this is creating a financial gap which will make current services increasingly unaffordable by 2020/21 if we do not make changes now. The south west London health economy is overspending by around £140m a year. Three of the four acute hospital trusts and three of the six CCGs are projecting deficits for

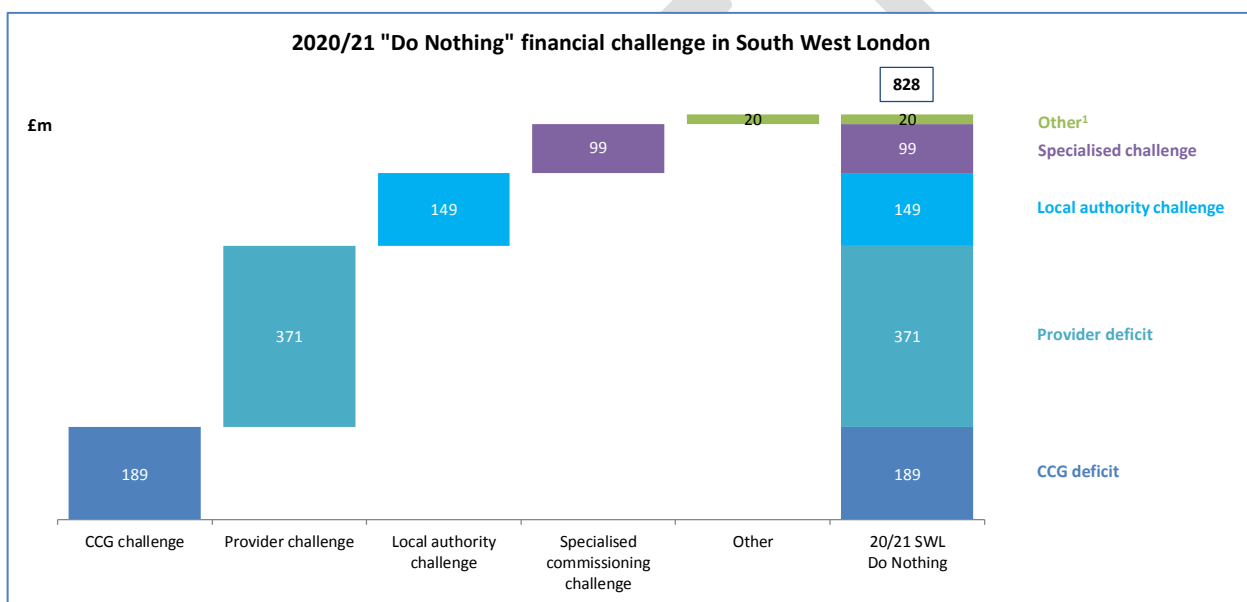


2016/17. We believe that by making changes to the way in which services are delivered we can improve the quality of care as well as making services more cost-effective to the taxpayer.

***“The cost of delivering services is rising much faster than inflation due to rapidly increasing demand and medical progress”***

South west London completed a ‘financial diagnostic’ in March 2016, which demonstrated a financial challenge of £726m on a “Do Nothing” basis by 2020/21.

Since then, we have made a number of adjustments including factoring in the costs of delivering primary care services in line with the standards we are committed to – the new London primary Care specifications – and the projected financial gap for the six local authorities. This gives us a total “Do Nothing” financial gap of £828m.



Note: <sup>1</sup> Other includes cost of CCG challenge to meet 1% surplus required by the business rules.  
 Source: SSHP Financial Diagnostic; 2020 Delivery analysis

We will address the £99m of specialist commissioning related financial challenge by measures that are currently under development by the Specialist Commissioners for London working in conjunction with the main specialist service providers in south London (notably St George’s within south west London).

This financial position and outlook makes it very challenging for us to deliver the high quality care that the public rightly expects. In addition, there is a need to invest in updating the health infrastructure in south west London. This will require access to very significant amounts of capital, which can only be accessed as part of a comprehensive plan to deliver a financially sustainable NHS in south west London.





### 3. Our approach to transforming care for patients

- We want people to live longer, healthier lives. Our vision is that local people should be supported to look after themselves and those they care for and have access to high quality, joined up physical and mental health and care services when they need them. We want to deliver better health outcomes within our budget.
- Our plan is being developed now because we know that if we do nothing, our services will not be sustainable in five years' time. We know that many of the problems patients face occur because our services are not set up in the best way to help them. We need all parts of the health and care system to work together. With the right approach, we can improve or maintain the current quality of care for patients while making our services sustainable in the long term.
- We can help people to start well, live well and age well by investing in prevention and early intervention, making sure patients are treated in the right place to meet their needs and reforming outpatient care to better meet patients' needs (see Diagram 1). Proactive, preventative care will mean fewer people need to access emergency or specialist services. If we are to deliver the services people need in five years' time – whilst maintaining or improving the current quality of care – we must act now.

#### Prevention and early intervention

##### We must:

- Support people to stay well.
  - Identify people most at risk of developing long term conditions and use modern technology and a modern local workforce to develop proactive care and better support them at home and in the community.
- The future health of our whole population, and the sustainability of our health and care system, depends upon people being supported to stay well, physically and mentally, and ensuring that if they do get ill, they get the care they need at the earliest possible stage.
  - People are not adequately supported to stay well in our current system. A patient with a long term condition like diabetes may have to endure regular trips to hospital, when they could be much better treated in the community – for example through a local specialist team, supporting them to monitor their condition and providing assistance when needed. Too often, people with emerging mental health problems are not supported early enough, meaning they can end up at A&E in crisis, or having to take time off work sick, when earlier intervention could have helped to improve their condition worsens.
  - Patients do not always have the information or the support to lead healthy lives or to reduce or stop unhealthy habits that can lead to them becoming unwell. In south west London, we expect to spend £202m in the next five years treating illnesses which result from preventable causes, such as smoking, drinking, and a sedentary lifestyle. The number of people in south west London over 65



years is also expected to rise from 189,000 in 2016 to 209,000 in 2021 – a rise of 10.6%. Many older people now live with more than one long term condition and complex care needs.

- People with poor mental health are at higher risk of developing cardiovascular disease, diabetes, chronic lung diseases, and a range of other long term conditions. Despite this, prevention of mental health problems and promotion of positive mental wellbeing often receives limited attention and is not well integrated with action on other public health issues such as smoking, drinking, and physical inactivity.

## How we could achieve our aim

We want to work in partnership across health and social care, with our local authorities, and our local population, to prevent ill health, reduce inequalities, and help people start well, live well and age well, both physically and mentally.

### Our aim for south west London:

People need better support to live healthy, active and independent lives for as long as possible. This includes advice and support to help them stop getting ill and to help them manage their condition themselves. Where people do get ill, we need to ensure they are diagnosed and supported at an early stage.

Mental and physical health issues go hand in hand. Mental health interventions can result in better wellbeing and outcomes for patients with certain conditions. Patients with long term conditions, like diabetes, medically unexplained symptoms and chronic pain need better care and support, that takes into account their mental as well as physical health needs.



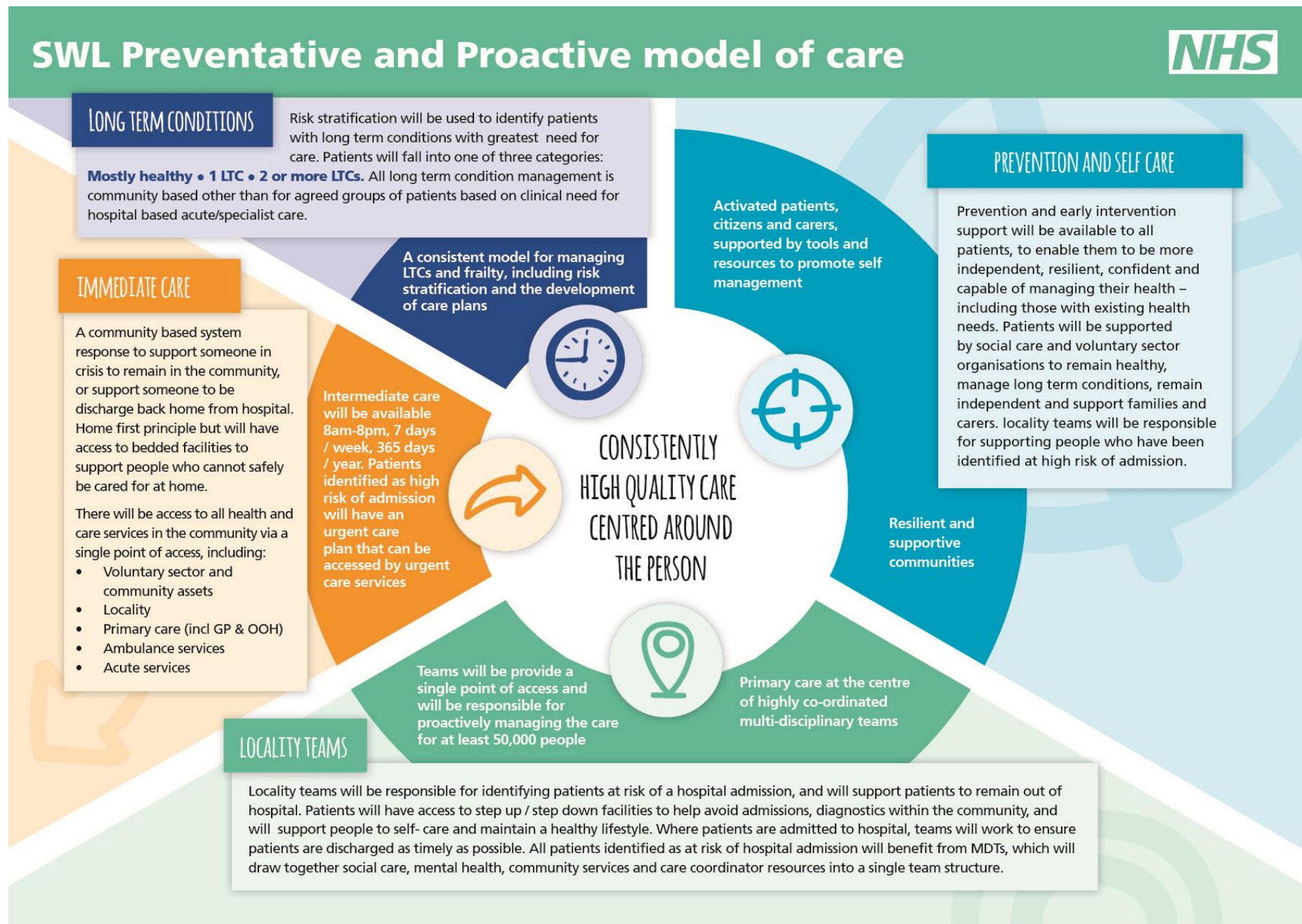


Diagram 1

## Supporting people to stay well

Supporting people to stay well is a central theme in this plan – all of the ideas we are putting forward include some element of prevention and supporting people to look after themselves where they can. By supporting people to stay well and live healthier lives, we can help them to avoid the need for specialist hospital care or an emergency admission to hospital. There are a number of different ways in which we can support people.

- Local authorities have a key leadership role in public health and the health and wellbeing of local people. We will explore new approaches to public health initiatives – scaling up existing schemes at a:
  - **population** based level - using interventions that reduce exposure to the risk factors for whole populations, for example alcohol licensing schemes.
  - **community** level - to build resilient communities by identifying and building on the strengths of individuals and communities to encourage positive health behaviour changes . Examples include rolling out the London Healthy Workplace charter and making every contact count.
  - **individual** level – using approaches that support people to understand and manage their own habits and lifestyles and develop the tools to make positive health behavior changes. For example, smoking cessation courses and weight loss referral services.
  - **digital** based level– these offer an alternative to group or 1:1 interventions and can reach a larger group of people at a lower cost. For example, online support, digital apps and text-based services.
- People can often manage minor ailments themselves without accessing healthcare services. By supporting provision of information and working with local authorities and through our new locality teams to develop robust, healthy communities, we can encourage more self-care where appropriate.
- People with a mental health diagnosis should be supported earlier to help stop them going into crisis.
- Having a job is a key factor in helping people with mental health conditions to stay well. We can help people attain and sustain employment, both as a service provider and as an employer. We will also work across south west London and with local authorities to support the implementation of the 'Work and Health Programme'.
- Building on the principle of 'making every contact count', we will also work with the Healthy London Partnership and London Fire Brigade to explore how 'Safe and Well' visits might be expanded to deliver health-related advice and preventative measures to those at risk of accidents or ill-health, alongside fire safety information.

## Proactive, personalised care for people with long term conditions

- Patients most at risk of developing long term conditions such as diabetes, respiratory disease, heart failure and conditions relating to frailty should **be identified and supported**. This includes the roll out the National Diabetes Prevention Programme in 2016/17 and a diabetes risk register and risk



scoring system to identify those at risk of developing the disease and provide support, guidance and care planning to help slowdown the development of the disease.

- The **Expert Patients Programme**, which provides patients with the insights and skills to manage their conditions, will be expanded in 2016/17.
- The **Cancer Vanguard**, which includes initiatives to support the early diagnosis and detection of cancer, and improve patient / family experience has set five priorities which we plan to roll out across south west London (see box).
- The ESCAPE **pain management** exercise programme will be extended across south west London and become part of the pathway for patients using musculoskeletal services.
- Those with long term conditions, cancer, and/or medically unexplained illnesses need better **primary care mental health services** and access to **psychological services**.
- We aim to take a system wide approach to supporting people with **dementia** and their carers, including:
  - rolling out 'dementia friendly communities';
  - commissioning carer services for those with dementia, including educating, training and developing peer support services to carers.

### National Cancer Vanguard

The National Cancer Vanguard is part of the national programme for new models of care. It comprises three cancer systems across England, including Greater Manchester (The Christie), North London (University College London Hospital) and West London (SW London and NW London) hosted by Royal Marsden (RM) Partners. The aims of the National Cancer Vanguard are to develop a new care model to leverage clinical, financial and contractual innovation to support the five major clinical deliverables of the Cancer Vanguard.

Early diagnosis and detection of cancer to improve one year survival.

Patient and family leadership to focus all care on improving patient / family experience.

Reducing unwanted variation across the patient pathway to all patients including populations who find it difficult to access cancer services.

Comprehensive delivery of the recovery package to improve living with and beyond cancer in partnership with Macmillan Cancer Care.

Improved access to high quality palliative and end of life care 24/7 including a more integrated and co-ordinated model of community palliative and end of life care and Advanced Care Planning to reduce hospital deaths for cancer patients.

The Cancer Vanguard is also focusing on driving improvement and innovation and reducing variation across a number of enabling work streams such as informatics, demand and capacity modelling, workforce and education, IT and real-time monitoring of patient feedback. The RM



Partners Cancer Vanguard, covering the population of South West London and North West London, will work closely with STP footprints including local providers, commissioners and NHS England Specialised Commissioning to accelerate delivery of the Cancer priorities across London, building on work of the London Cancer Alliance and existing pan-London and local work.

### ESCAPE Pain Management Programme

As part of our emphasis on patient activation and prevention, we will seek to extend the use of the ESCAPE pain exercise programme across our south west London. The ESCAPE pain programme is an award-winning and NICE approved six-week programme for people with joint pain which achieves compelling results relating to pain, mobility and weight loss, as well as improvements in mood scoring. Currently the programme is available in a number of boroughs and we will seek to make this a consistent part of the musculoskeletal pathway for all patients, working with our physiotherapy services and local council-led and commercial gyms to provide a service GPs can refer patients to.

The ESCAPE pain exercise programme is evidence to significantly reduce the burden on NHS services, particularly the number of GP appointments per annum, but also in prescription costs.

## Delivering the right care in the best place

### We must:

- Transform access to outpatient services
- Reduce A&E attendances emergency admissions and increase timely discharge from hospital
- Help people nearing the end of life to die where they want
- Get the model of care right going forward

- Patients are not always treated in the best place for their needs to be met. A study carried out across south west London in February 2016 showed that a 55% of patients were being cared for in hospital when they did not have to be there. Of these, 42% of patients could potentially have been discharged at an earlier stage and received their on-going care in a different setting and 13% could have received all their care in a different setting, and should not have been admitted to hospital at all.
- People tell us they would prefer to receive their care in the community rather than go to hospital. But over the last four years, the number of people attending local A&E departments and being admitted



to hospital has increased. This is despite ambitious plans locally, and across England, to try and care for more people in the community.

- Increasing A&E attendances and emergency admissions contribute to people having to wait a long time to be seen in A&E, put pressure on our A&E departments and hospital wards can also mean that a bed isn't always available when someone needs one.
- Our frail and elderly patients are particularly vulnerable to emergency admissions – they often have highly complex needs and are susceptible to complications from conditions like dementia. Because the care they receive is currently fragmented and variable they are not always supported in the best way to help them stay as well as possible.
- We know that if we treat people early enough, we can prevent avoidable admissions to specialist or emergency services in hospital.

#### Our ideas include:

- Implementing the recommendations of the national NHS Urgent and Emergency Care (UEC) review through the south west London UEC Network, which found that acute hospital admissions and attendances could be tackled by integrating primary care, 111, community and acute hospital services, and greater use of community pharmacy.
- **Better support** for our most vulnerable and frail patients and fewer emergency admissions through development of and investment in **locality teams** and other initiatives. Further detail on the model and focus for these locality teams and initiatives is included in section 4.1.
- Better support for people with **learning disabilities** and **autism** by improving community and crisis prevention and primary and secondary care liaison services, to reduce hospital admissions and length of stay.
- Developing **proactive support** so that people with learning disabilities and autism can live independently in the community.
- Providing a **psychiatric decision unit** to assess and develop treatment plans for more complex service users who are in crisis.
- Telephone access and improved treatment from our paramedics through '**Hear & Treat**' and '**See & Treat**' services.
- Ensuring all patients admitted in an emergency have a clinical assessment by a suitable consultant as soon as possible and at the latest within 14 hours of arrival at hospital.
- Work with **local housing associations** and providers of extra care housing care and support to reduce unnecessary admissions, reduce delayed transfers of care, and ensure that people are discharged back to home wherever possible.
- Working together across south west London to roll out the **Sutton Care Home Vanguard** - improving care and support for our frail and elderly patients, reducing emergency admissions to hospital and supporting timely discharge. Further work is needed on the funding implications of expanding the Sutton vanguard – to date there has been a level of national funding which we understand will not be available going forward.

### Sutton Homes of Care – Vanguard Programme



Our vision is to have a vibrant, high-quality care home market not just in Sutton but across south west London delivering care that embraces the national nursing values of patient care – the ‘six C’s’: care, compassion, competence, communication, courage and commitment. We believe our residents deserve and need high quality care, our care homes are an integral part of our health and social care system and the staff are valued and equal members of the MDT.

To achieve this vision, our three key areas of care home vanguard work focus on:

Integrated Care - designing a system of care wrapped around the health and well-being of our residents

Care Home staff education and development - providing the necessary training and education to up skill our staff, and provide them with the confidence and positive belief to want to deliver provide great care

Quality Assurance - increasing safety and improving quality by enabling the collaborative sharing, monitoring and evaluation of information

Wider system impacts to date on activity derived from the care home sector:

Reduction of 5.80% in LAS call outs and conveyances from 2014/15 to 2015/16

Reduction of 10% in A&E attendance from 2013/14 to 2015/16

Reduction of 4 days length of stay since implementation of Hospital Transfer Pathway (preliminary results)

Increase of 6% in residents achieving PPD from 2014/15 to 2015/16

Reduction of £50k in medicines costs from Nov15 to Mar16 through resident medication reviews

## Getting end of life care right

We know that our health and care services are not meeting the needs or preferences of people at the end of their lives in south west London. The dying person themselves should be the focus of care, which includes supporting them to exercise their preferences for the place of death and prevent any unwanted admission to hospital.

We need to:

- Proactively identify patients who should be receiving palliative care to ensure that all people at the end of their life have high quality and compassionate care.
- Train staff across the health system to help people at the end of their life, their families and carers, plan and proactively manage their care.
- Promote ‘Coordinate my Care’ across south west London to ensure that important information about people at the end of their life and their preferences for the care they wish to receive is recorded and known.
- Roll out the implementation of the national cancer vanguard to improve access to high quality palliative and round the clock end of life care.





## Transforming access to outpatient services

Most patients who access hospital care do so through outpatient services. There is substantial scope for making improvements in these services. We want to deliver a more consistent service across south west London, stop people from having to attend unnecessary appointments in hospital, and where appropriate bring outpatient care closer to home.

For example, we can standardise variation within and between GP practices, expand the use of referral management systems and set up one-stop clinics where possible. We can standardise protocols and procedures for all diagnostic services and reduce non-attendance among patients by using digital technologies and better explaining the implications to patients. We can also eliminate unnecessary follow-up appointments by only providing annual reviews where clinically necessary, ideally in primary care, stopping automatic follow-up appointments and making the process of re-referral easier. We can also roll out new models that use technology to deliver better patient care, such as offering patients virtual appointments via telephone or Skype.

Other ways in which we can improve these services include:

- supporting people by remote monitoring, follow up advice and support (e.g. via smartphone apps)
- increasing online services (e.g. by April 2017 an online portal for sexual health services will be available in south west London)
- enabling information sharing and advice between primary and secondary care clinicians
- providing community based clinics for patients (for example providing dermatology and musculo-skeletal outpatient services in a community setting)
- up skilling the primary care workforce to support community- based care
- increasing ambulatory care in the community

## Getting the model of care right

We must ensure that people only receive care in an acute hospital when they genuinely need to by offering people the most clinically appropriate care in the setting that best suits their needs. We are currently developing new care pathways to lead people away from unnecessary acute stays, including:

- **Maternity:** We will support women's choice in place of birth, including increasing the availability of home births and midwife-led care. For women who require obstetric-led care, we will ensure safe and sustainable services are in place. We will also explore new models for antenatal and postnatal care to ensure more personalised and patient-centred care. This includes reviewing continuity of carer and the provision of perinatal mental health services. Our vision for maternity services is to provide consistently high quality care that supports women to have a normal, healthy experience as well as caring for higher risk more complex births. We are committed to delivering against the recommendations of the Better Births - National Maternity Review (2016). South West London has been appointed as a National Pioneer for Maternity Choice and Personalisation which will enable us to accelerate delivery of our plans to transform Maternity services across south west London.



- **Paediatrics:** There are significant opportunities for improving the quality and sustainability of care for children across south west London. Our proposed model for paediatric services would ensure that most children who are unwell will receive their care and treatment in primary and community care, through better access and availability of services to reduce unnecessary visits to hospital. We need a new model of care for those children who require hospital treatment for a short period of time so that they receive the right assessment, observation and treatment. This model would better support the use of the acute paediatric workforce across south west London through increased networked arrangements between hospitals. This model of care would support better use of the acute paediatric workforce across south west London through increased networked arrangements between hospitals. It would ensure timely access to paediatric specialist input when it is required most and will address the issues around sufficient availability of paediatric trained staff to provide safe and sustainable care. Closer working between primary and secondary care can help to ensure that for the majority of children who are unwell, the right care can be provided close to home by GPs and community services.
- **Urgent and Emergency Care (UEC):** Patients need an integrated urgent and emergency care service which achieves the core delivery standards and implements the recommendations of the national NHS Urgent and Emergency Care review.- this is a high priority across south west London. The south west London Urgent and Emergency Care Network has worked closely with its CCGs to commission a 111 service that provides patients with 24/7 integrated urgent care access, treatment and clinical advice. The UEC network are currently putting in place a robust plan (outlined in appendix Xv.) to ensure that patients receive the highest standards of care within the most appropriate environment and time frame. The UEC Network have identified a number of local priorities which include crisis care for mental health patients, self-care support for patients and the development of see and treat models with the ambulance service.
- **Ambulatory emergency care (AEC):** Some acute treatments, like deep vein thrombosis or cellulitis, are delivered in hospital, but could be provided without requiring an admission. AEC is a way to avoid unnecessary hospital admissions; providing timely treatment and improved experience for patients. All CCGs across south west London have signed up to a shared specification for developing AEC and will continue to support the further delivery of the AEC pathways. Each CCG is also adopting a different approach to support and encourage the shift in activity towards AEC. For example, Kingston are introducing a payment framework called a “Model of Care CQUIN” (including AEC) and Wandsworth & Merton are introducing an AEC CQUIN. We also know that people with a mental health condition are likely to attend A&E three times more frequently than people without. We set out in appendix xiv how we will improve support, out of hospital, for people with mental health conditions.
- **Care for the frail elderly:** Our ageing population presents new challenges for healthcare and we need to adjust the way care is provided to support people to live healthy lives for as long as possible. We will build on the good work taking place across south west London, like in Croydon, where our acute hospitals are working with other providers to improve care outside of hospital. Some of the scenarios for the future configuration of care could include concentrating activities on certain sites to provide specialist elderly care focused on getting people as fit as possible, as quickly as possible, and then helping them to stay well. We recognise that the work on the number of patients that could be moved out of acute hospital beds to date has focused on acute hospital provision. Going forward, we will need to include the beds for people with dementia in South West London and St George’s Mental Health Trust in the planning for this area.



## 4. Building Capacity and Capability to Deliver

The delivery of our Five Year Forward Plan requires the right people and infrastructure to be in place. We have developed proposed strategies for:

- Building capacity and capability outside of the acute sector
- Acute configuration
- A modern workforce
- Making best use of our public estates
- Delivering an information revolution

These strategies are designed to ensure we have the right services and support in place for patients in the years ahead. They are still being discussed and will be further developed through engagement with local people and stakeholders.

### 4.1 Transforming community and primary care

#### We will:

- Establish locality teams to provide care to populations of at least 50,000 people
- Establish a robust and integrated community crisis and intermediate care response
- Transform primary care to provide accessible, proactive and coordinated care

#### Our aim for south west London

To enable us to deliver our strategy we will need to:

- Develop community and primary care services that take account of the whole person, rather than individual conditions, and support people to take responsibility for their health and wellbeing.
- Establish a coherent and consistent set of services in the community through a 'community hub' model, combining physical and mental health care services, in order to support our acute hospitals.
- Develop our digital capability – for example, digitisation of clinics (through use of digital technologies such as Skype and other forms of online consultations, e.g. Web chat).
- Make changes to financial systems to reduce the importance of internal flows (between providers and commissioners) in creating disincentives to demand management (for example, moving away from systems where providers are paid on the basis of activity rather than outcomes).



## How we could achieve our aim

We want to deliver what local people need: more care and support in the community closer to where they live. We are therefore highly ambitious about moving many more services into community settings and away from acute hospitals. To do this we recognise the importance of developing and implementing our plans at a local level, within each locality or borough, to reflect the differing needs of our population as well as local services and delivery models. Where it makes sense to do so our plans will initially be developed at scale, either around the acute providers or across the whole of south west London. This will ensure that we limit duplication of effort and really understand each locality's needs prior to local implementation.

## Locality teams

We are setting up locality teams across south west London to provide care to a defined population of at least 50,000 people (with variation to reflect local population groups). These teams will be aligned to GP practices, and bring together existing staff across primary care, social care, mental health, community services, and hospital specialists. They will place greater emphasis on prevention and early intervention, so that we can help people to stay well and access the right care for them in the right place. They will work together with GPs to help manage the health of people with long term conditions.

### Locality teams will:

- **Help people to stay well:** Teams will support implementation of cross partner public health plans, creating the demand for healthy lifestyle, ensuring incentives support this, and supporting their defined population to self-care.
- **Take action early:** Working together, the teams will identify people in their geographical area who are at high risk of hospital admission. These people will be allocated a care coordinator who will work with them to develop a care plan to avoid preventable and unnecessary admissions to hospital. This will be shared with all relevant professionals. The care coordinator will carry out regular reviews and update the care plan as required.
- **Work closely with the voluntary sector and communities:** Locality teams will work closely alongside voluntary and community sector services in their locality to ensure people have the support they need to stay healthy and well, manage their long term conditions, remain independent and support families and carers.
- **Align with GP localities:** Locality teams will align with GP localities (groups of GP practices working together in a small geographic area to plan, monitor and improve services for patients) to create close working relationships, putting primary care at the centre of these highly coordinated multi-disciplinary teams, particularly in managing long term conditions. Locality teams will also work alongside existing GP Federations to deliver services at scale.
- **Be easy to access:** Professionals will refer to locality teams via a single point of access, which will be the single route to access all preventative and proactive care services.



*“Locality teams will work closely along- side voluntary and community sector services in their locality to ensure people have the support they need to stay healthy and well.”*

We are also working to ensure that the right incentives are in place for organisations to work together to deliver preventative activity. In doing so we will build on the work that we have already undertaken in Croydon and Richmond to develop commissioning contracts, based on outcomes achieved for patients, and we are considering where else in south west London we could further develop this approach.

## Community crisis and intermediate (‘step up’ and ‘step down’) care

A bed audit carried out in south west London in February 2016 showed that a large proportion of people who could have had their admission avoided, or who could have left hospital earlier, needed support from a more intensive service than our proposed locality teams could deliver. To address this, we want to transform our community crisis and intermediate care response, to ensure that patients can receive more intensive support in the community, reducing the need for hospital admissions and enabling people to be discharged from hospital as soon as possible.

### Our community crisis and intermediate care response will:

- **Be easy and quick to access.** Care will be available 8am-8pm, 7 days per week, 365 days per year. Assessment will take place within two hours of referral for prevention of admission.
- **Be part of a joined-up system.** These services will bring together social care, physical and mental health and the voluntary and community sector, working together with primary care and hospital specialists in a joined-up service for patients. Care will be provided by social workers, nurses, allied health professionals and GPs, as well as community outreach from hospital specialists, to ensure the best system response for an individual in crisis, or has been admitted to hospital but can now be cared for at home if the correct services are in place. Care plans will be jointly created by all relevant parts of the system.
- **Have an expanded remit.** The crisis and intermediate care response will have an expanded remit, and be able to offer assessment, support packages and interventions on top of those provided by the locality teams. Crisis and intermediate care teams will operate at borough or sub-regional level and will work closely with locality teams
- **Work on a ‘home first’ principle.** The response will deliver enhanced care at home; this is where people tell us they would prefer to receive care. However, sometimes it will not be possible to meet someone’s needs at home and bedded facilities will be available to meet people’s needs in these situations.



## The importance of local delivery

We want to deliver what our local residents need: more **care and support in the community closer to where they live**. We are therefore highly ambitious about moving many more services into community settings and away from acute hospitals. To do this we recognise the importance of **developing** and implementing our plans at **a local level**, within each locality or borough, to reflect the differing needs of our population as well as local services and delivery models. Where it makes sense to do so our plans will initially be developed at scale, either around the acute providers or across the whole of south west London. This will ensure that we limit duplication of effort **and really understand each locality's needs** prior to local implementation.

We propose to amend contracts from 1st April, 2018 so that we can put in place our new approaches of working in locality teams and improving our community crisis and intermediate care response.

The ideas we are putting forward for locality teams, community crisis and intermediate care are closely linked to our ideas for transforming primary care.

## Transforming Primary Care

Primary care is fundamental to the delivery of effective healthcare across south west London. It is important in tackling local health needs and the things that we know our local populations want to see addressed. We need to address those needs now, so that we can put primary care and the wider NHS on a sustainable footing for the future, while improving or maintaining the current quality of care. Our vision has been informed by the London Strategic Commissioning Framework for primary care and focuses on localised general practice (list-based care) that is underpinned by quality and consistency in care. Our aim is to provide:

- **Accessible care:** Care which is timely and responsive to individual needs for routine and urgent advice and is not limited to consultations in the surgery.
- **Coordinated care:** Care which is holistic, and provides continuity and reassurance for patients whose condition and complexity require it.
- **Proactive care:** Care which focuses on prevention, encourages self- management, patient activation and supports the overall health and wellbeing of the population.

*“Primary care is fundamental to the delivery of effective healthcare across south west London.”*

Our aim is that nine in ten people will get accessible and coordinated proactive care by the final quarter of the 2017/18 financial year. The same proportion should receive proactive care by the first quarter 2018/19. By the end of 2017/18, all patients should have access to 8am-8pm extended care.




Delivery of this vision is dependent on investment, workforce, technology and premises, reviewing workload (by applying the 10 High Impact Actions identified in the General Practice Forward View) and supporting care redesign not just around access but in delivering integrated primary and community health services.





This vision of primary care is aligned with our vision for delivering more care in the community, and implementing robust multidisciplinary community working through our locality teams, supported by the crisis and intermediate care response. GPs would work alongside locality teams and hospital specialists to deliver long term condition management in the community, with only agreed cohorts of patients requiring acute care, based on clinical need.

This new way of working will be supported by:

- locality teams and community based specialist nurses working together to support patient care
- patients having single, integrated care plans, with care planners trained in patient- focused care planned and development of patient-led outcomes
- access to social prescribing
- evidence-based patient education programmes.

Key Priority Areas	South West London Primary Care Forward Plan
<p><b>Investment</b></p> 	<p>Investment is required to cover the cost of developing primary care hubs to assist with enhanced access, continued federation development on a south west London basis will also require a level of financial support and there will be increased workforce costs amongst others.</p> <p>As a result, a level of investment is required in primary care over and above base line core contract allocations between 16/17 and 20/21 (this is after factoring in south west London's share of the £2.4bn set out in the General Practice Forward View).</p>
<p><b>Workforce</b></p> 	<p>South west London Collaborative Community Education Provider Networks (CEPNs) will coordinate and deliver a range of training to practice staff across a number of areas such as personal productivity and productive work flows (per the 10 high impact actions)</p> <p>Roll out of care navigator role on a greater scale and explore recruiting practice based clinical pharmacists (for example building on work undertaken by Merton CCG) and mental health therapists or variations that provide this skill set.</p> <p>Work with the Healthy London Partnership (HLP) and Health Education England on the outputs of the HLP Primary Care Workforce model for south west London and develop an action plan especially for nurse and GP recruitment and support clinical networking.</p>
<p><b>Technology &amp; Infrastructure</b></p> 	<p>Estates will need to be used differently and there will be a need for a level of investment to support 'new' requirements and provision of 'fit for purpose' services.</p> <p>Consistent roll out of apps to empower patients to take increased responsibility for their health.</p> <p>On-going roll out for patient online for online appointment booking and repeat prescriptions as well as care record access.</p> <p>Technologies deployed to support remote access and virtual consultations.</p>
<p><b>Workload</b></p>	<p>Roll out of the 10 high impact actions supported by the south west London GP Federation Collaborative and delivery of the 17 specifications on accessible, coordinated and proactive care.</p> <p>Extended care with other professionals providing services to support GPs being freed up to focus on the more time intensive patients.</p>



	<p>Rolling out learning from the Healthy London Partnership's 'Perfect Week' looking at what can be done differently.</p>
<p><b>Access &amp; Care Redesign</b></p> 	<p>Primary care hubs established with social care, physio and mental health 'wrapped' around them.</p> <p>Effective integration of primary care hubs with urgent and emergency care system.</p> <p>Roll out across south west London of Sutton Care Home Vanguard and the role of primary care staff in supporting care home patients.</p> <p>Population health management and multispecialty community provider type models embedding, building on Wandsworth's Enhanced Care Pathway work - integrated proactive delivery of care for frail older adults.</p>

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## South west London GP Federation Collaborative

Six federations are established that map across to the six south west London CCG populations (2 established over 5 or more years and 4 established within the last 2 years).

The six federations have formed a collaborative (South West London GP Federation Collaborative) which recognises that they are at different stages of development but commits to supporting each other and sharing resource.

Federations in Kingston and Wandsworth already have contracts in place for example community diabetes and ophthalmology services, dermatology and MSK outpatients' activity. Wandsworth also have a contract in place with their federation which focuses on care planning for patients with LTCs (this is called PACT - Planning All Care Together). Croydon are key partners in both the Accountable Provider Alliance for over 65's and the Croydon Urgent Care Alliance, which has been awarded the contract to deliver Croydon's Urgent Care services from April 2017.

The federation in Richmond is delivering 4 GP hubs, providing 8am-8pm access seven days a week for pre-bookable appointments (via the practice or NHS 111) and using an interoperable medical record.

As a result the south west London GP Federation Collaborative have held several sessions to support the south west London STP development and have committed to work with commissioners during 2016 and onwards to start delivery on the following:

Development of primary care access hubs (supporting 8 to 8, 7 days a week) and effective integration of hubs with the urgent and emergency care system

A shared strategy and operations team for the south west London federations to support the HR, finance and operational delivery skills needed for rapid delivery

Training and education for the primary care workforce via a south west London Collaborative community education provider network (CEPN)

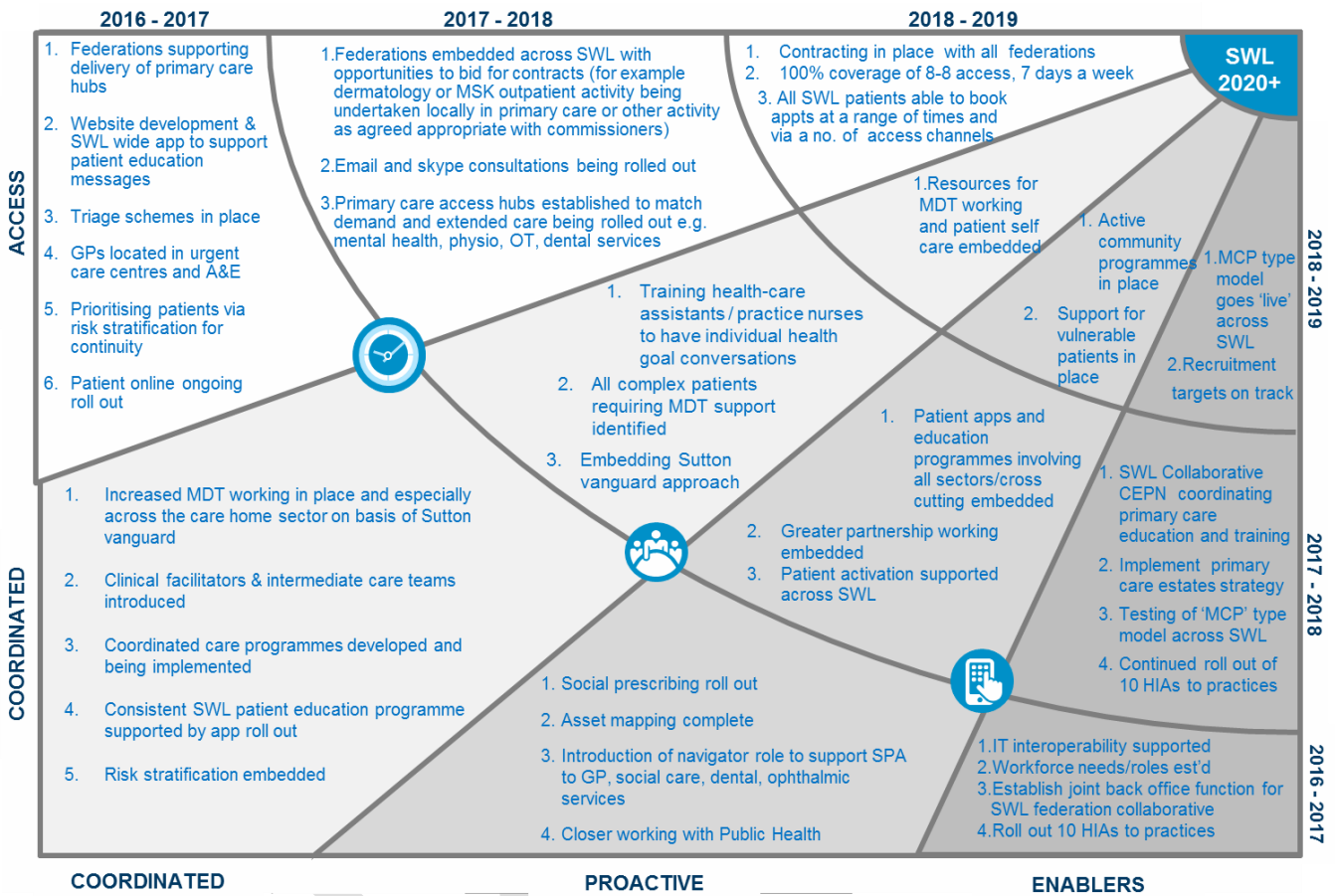
How the 10 high impact actions are applied to benefit local practices and support releasing capacity

Planning and progressing towards greater integration between primary and community care, which could be via multispecialty community provider type models or locally defined approaches (for example OBC work in Croydon and the role of the Croydon GP Federation being part of the OBC Accountable Provider Alliance).



**Suggested timeline and key activities across south west London to deliver primary care transformation and vision**

Please note that all ideas set out below will require further consideration and discussion with local people. If proposals for significant changes to services emerge, we would hold a formal public consultation before making any changes.



## 4.2 How we organise acute hospital services

### We must:

- Make the best use of staff through clinical networking and redesigning clinical pathways
- Review the provision of specialised services
- Get the acute configuration of services right, with an estate that is fit for purpose

### Our aim for south west London

The five acute hospitals (Croydon, Epsom, St Helier, Kingston and St George's) in the south west London STP are facing a number of challenges around their clinical and financial sustainability. Our most urgent priorities are:

- Improving quality and optimising our workforce, in particular meeting our standards for acute services, including 7 day services.
- Improving specialised services, improving quality and reducing the duplication of services across the specialised tertiary providers in south London.
- Addressing the financial deficit in the provider sector.
- Delivering at the right scale, with catchment areas that are large enough to deliver high quality efficient care.
- Responding to increased demand and the changing need for care, ensuring that patients receive care in the most appropriate place, rather than ending up in an acute hospital by default.

## Introduction

This five year forward plan makes a series of proposals to help the south west London health economy to improve the quality of care and deliver financial balance by 2020/21.

This plan will tackle many of the key issues in the health economy, but will not alone resolve some major concerns for the acute providers in south west London. Our analysis of the clinical and financial viability of the acute trusts over the next 5 years suggests that:

- We are very unlikely to be able to deliver services that meet clinical quality standards across five acute hospital sites. In particular, clinicians do not believe that we will be able to recruit or pay for sufficient workforce to deliver 7 day services at five acute sites;
- While we aim to balance the financial position for the whole health economy, we will have individual Trusts remaining in recurrent deficit by 2021 because they are running acute services below an



efficient size. There is good evidence that for some specialties, centralising care improves patient outcomes;

- We have hospital buildings on all acute sites which need capital investment, and two sites with buildings which are increasingly unfit for purpose (St George's and St Helier).

We have therefore looked at whether we can design a more appropriate configuration of acute services that improves the clinical and financial viability of our acute Trusts. We intend to engage with the public further on this shortly.

The time taken for public engagement, consultation, decision making and implementation suggests that this is likely to fall outside of the five year plan period. As a result no provisional capital or revenue costs for reconfiguration are reflected in our financial modelling.

## Hypotheses

The evidence suggests that we could reduce the number of acute sites run by the four acute trusts from the current five and this could improve the quality of care. Through the development of this five year forward plan the system has tested two hypotheses:

- That **four** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London; and
- That **three** acute sites is an appropriate configuration to deliver clinically and financially sustainable care in south west London.

The system has tested these against some initial considerations. These have been used only for the purpose of testing the hypotheses at this stage; a full list of formal criteria will be discussed in public engagement before being used to make decisions about which options would be formally shortlisted for consultation:

## Clinical quality and workforce availability

The main driver for reconfiguration of the acute sector is the view of clinicians, as expressed through the Clinical Board, that south west London will not be able to meet key clinical quality standards across five acute sites. The Clinical Board that reached this view is made up of a range of clinical leaders working in hospitals, primary care and NHS commissioning across south west London and in a range of disciplines.

The main clinical quality standards against which we are assessing three, four and five site options, are the 7 Day Clinical Services standards (7DS), which have been identified as the key priority in recent national guidance.

The key marker of quality that we are using at this point is whether the number of consultants in south west London meets requirements in the 7DS (or, where the consultant requirements for 7DS are still being identified, the London Quality Standards (LQS)). Delivery of a 7 day service is intended to be a key driver of improved quality of and access to care for patients.



The south west London Clinical Board have looked in particular at our ability to deliver the six services which were identified as being most important to an acute site: A&E; ITU (using the availability of anaesthetists as a proxy); acute medicine; emergency surgery; consultant-led maternity; and paediatrics.

As of October 2016, we have 434 consultants in south west London, across the six core specialties, with funding for 453 (ie 19 vacancies against our funded establishment).

- To continue to deliver care on five acute sites, even if we were able to recruit to all 19 vacancies, we would still be 98 unfunded posts short of delivering the LQS (the shortfall against 7DS will be slightly lower than this but would not close the gap).
- To deliver care on four acute sites, with all vacancies filled, we would be only 15 consultants short of delivering the LQS. With the lower requirements for 7DS, this suggests that we are likely to be able to deliver the workforce requirements of the clinical standards for four acute sites.
- For three acute sites, we would be able to meet the LQS comfortably.

The Clinical Board agreed that, from a workforce perspective, four sites would be able to meet clinical standards. However, they said that these four sites would need to work very differently from the current structure. The four sites would be the 'front doors' to a system that was heavily clinically networked. This might mean, for example, that some services were provided on fewer than four sites; or that staff worked across two or more sites, to ensure access to a wide range of training opportunities.

## Non-Clinical Standards

- **Travel times:** We have tested three and four sites against travel times analysis that was done in 2012. Although there is no clear evidence linking patient outcomes to travel times, we recognise the critical importance of travel time to patients and their family and visitors. This suggested that three sites have average travel times that are in line with the national average, while four site travel times are substantially shorter than the national average.
- **Support from commissioners:** input from some CCG clinical leaders across the system suggests that three sites is unlikely to be supported by the communities they represent, while some permutations of four sites would be;
- **Broad clinical support:** Medical Directors and Directors of Nursing advised that a three site option is unlikely to gain consensus, whereas some permutations of four sites would be likely to be supported;
- **Robustness against a range of future scenarios:** four site options are more able than three to absorb a higher level of risk in the future, for example if the demand for beds is higher than anticipated;
- **Level of risk during transition:** Any reconfiguration would involve some disruption during transition, but clinicians advise that this would be more pronounced and difficult to manage for three sites.



## Capital Costs of Reconfiguration

In the context of limited availability of capital funding at a national level, one issue that we have considered is how much it would cost to re-provide acute services for south west London on three or four sites, using all the assumptions in the STP.

Initial evidence from our costs of capital analysis shows that, under comparable scenarios for three and four sites, four sites are expected to require approximately £150m less capital than three, if care is re-provided using existing acute sites.

At present this does not include the costs or benefits of any new build on a currently non-acute site, but we will look at this as part of exploring all possible options for south west London.

At this stage we have not been able to model the revenue consequences of different options. We expect to have an initial assessment completed over the next few months, as part of the work to assess possible options.

## Overall assessment of three and four sites at this stage

System leaders in south west London have reviewed the evidence available at this stage and our view at this point is that:

- Five sites does not allow us to meet the clinical standards
- Three sites is unlikely to be deliverable, and is likely to have higher capital costs than four sites
- Four sites performs better against most of the considerations identified above. In order to optimise our clinical outcomes (including 7 day standards) it is likely that the four sites will need to work very differently from the current approach, for example by networking clinically and working collaboratively to provide the best solution for patients.

The Programme Board recognises that the assessment to date is at a high level and against a limited set of considerations that need to be developed in full in conjunction with the public and other stakeholders. In particular, we will need to model the revenue consequences of any options.

At this stage, recognising those limitations, the Programme Board's hypothesis on information currently available is that four acute sites is more likely than other options to address the issues laid out here.

We will need to undertake further work, including analysis of revenue implications on 3, 4 and 5 site options, and engagement with the public and other stakeholders, to test this further.

## Sites



The assessment of the five, four and three site options has been carried out in a non-site specific way, i.e. without proposing which combination of sites should make up the different numbers of options.

In considering the approach we take to reconfiguration going forward, we will need to consider the current condition of the estates in the acute sector. The cost implications of the capital requirements to address current problems with the estates are laid out in section 5.2, and in Appendix J.

- **Croydon, Epsom and Kingston hospitals** all have individual areas of estate which need improvement and investment going forward. Some of these are areas which have been identified by the CQC as requiring immediate action, while others are required as backlog maintenance to ensure that the estate remains fit for purpose, or to improve it.
- **St George's** has significant estates problems, and the CQC has issued a Section 29A warning letter requiring action on patient safety grounds. The estate issues have particularly affected the renal unit (which the CQC has required the Trust to relocate) and theatres. St George's have identified a total funding requirement of £295m over the course of the next 5 years, to address safety-critical maintenance and bring the estate up to standard.
- **St Helier** has been assessed by the CQC as having the 16<sup>th</sup> highest critical infrastructure backlog requirements nationally. Its 1930s structure prevents it from ever being made compliant with modern standards for safe and high quality healthcare, for example insufficient side rooms to provide the appropriate standards of infection control practice.
- The building requires some immediate investment in 2016-17 and 2017-18 to ensure that it remains safe for the next two years. Dependent on decisions made on reconfiguration, we may need an investment of more than £200m towards the end of the five year period to bring the building up to standard and to replace the existing ward capacity.

South west London is seeking to fund as much of this investment as possible from internal sources, and is prioritising the most safety-critical areas. However it is likely that some trusts will need to submit business cases for additional capital funding to address some of these areas.

The next stage of work will see engagement with the public on all the considerations above and other factors including the possible implications and options for specific sites.

We have considered whether, amongst the existing acute sites (excluding the specialised and mental health organisations i.e. the Royal Marsden and South West London and St George's) there are any sites which we think would retain acute services whatever combination of three, four or five sites we had.

The only site which we believe is a 'fixed point' is St George's Hospital in Tooting, since it provides hyper-acute stroke, major trauma and other services which are serviced by highly specialised equipment and estates, which would be very expensive to re-provide elsewhere in south west London. St George's is currently part of the review of specialised services for south London (see next section) but we anticipate that in any scenario it will continue to provide major trauma and hyper-acute stroke services, as well as some other specialised services and acute care.



Going forward, through public engagement on decision-making criteria, we will consider whether any other sites should be designated as fixed points, as well as looking at the options more widely.

As part of the analysis required to support this process, it will also be important to consider our neighbouring STP footprints and the flow of patients into and out of south west London.

The five STPs in London are working jointly to understand the implications of out of area flows on constituent STPs and ensure these implications are accounted for, and where necessary mitigated, in local plans. An approach is expected to be defined by December. This is being taken forward by a working group of the STP finance leads, and will be overseen by the London Strategic Finance Group. Further work is also underway within specialised commissioning, overseen by the London Board and Executive.

## Next steps

Over the coming months, we will:

- **Engage with the public and other stakeholders on the criteria** that we will use to evaluate the options which should be modelled. The draft evaluation criteria are likely to include the considerations we have used in this chapter, as well as other issues which we have not been able to assess at this point:
  - The current physical condition of the estate and the overall capital cost to south west London in ensuring that all of our estate meets the necessary requirements. Some of the existing sites have significant structural issues and capital investment is required on most of the sites in order to address urgent back log issues. The capital issues are laid out in more detail in section 5.2;
  - The need to ensure that the configuration of acute services in south west London provides good geographical coverage and preserves access in the main population centres of the area;
  - The revenue consequences of any options;
  - The impact on equalities.
- **Develop a longlist of all the viable options**, and engage on these. This longlist will include options around developing services on sites which are part of the NHS acute trusts covered by the south west London five year plan. This will include the scenarios that Epsom and St Helier have been identifying in their Strategic Outline Case as well as scenarios involving the other acute providers.
- **Apply the criteria to the longlist**, in order to develop a shortlist
- **Model options and implications for the shortlisted options** in more detail. This will include developing the capital modelling to test out options to consider which of the scenarios for south west London are most likely to provide a clinically and financially sustainable solution
- **Based on further modelling, develop a preferred option or options** for public consultation.

Our aim is to undertake engagement with the public on the longlist and the criteria by the end of January 2017. By the end of the financial year 2016-17, we will then aim to identify a shortlist of options that are most likely to provide a clinically and financially sustainable solution. We would do the detailed analysis necessary, and take the preferred option(s) forward to public consultation, later in 2017.





## 4.3 Reviewing the provision of specialised services across south London

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospitals that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

In south west London the main providers of specialised acute services are St George’s hospital (where £231m is spent each year), and Epsom and St Helier, which provides renal services (£51m each year). Specialised cancer services are provided by the Royal Marsden (£107m) and specialised mental health services are provided by South West London and St George’s.

The specialised services provided by hospitals in south west London are accessed by a population that goes well beyond London. For example, one third of all activity at St George’s is from the south of England (mainly Surrey). People living in south west London also access specialised services from hospitals located outside of south west London. These include the two other major providers of acute specialised services in south London (Guy’s and St Thomas’ and King’s College Hospital), and South London and Maudsley, which provides mental health services. All three of these hospitals are included in the south east London Sustainability and Transformation Plan.

### The case for change in specialised services

We are facing a number of challenges around specialised services:

<p><b>We need to do more to manage demand and the rising costs of provision</b></p>	<p>At a national level we are seeing a rising demand for specialised services, driven by advances in science and an ageing population, which has prompted an increased demand for specialised care. We are also experiencing an increase in spending at a much greater rate than other parts of the NHS which is expected to continue, in a large part due to the increasing volume of expensive new drugs and new technologies.</p> <p>In south London we are experiencing an increase in the number of patients coming to be treated from the South East, which is driving the majority of growth at St George’s.</p>
<p><b>We are not always joining up services and treating patients in the most appropriate place</b></p>	<p>Across London there is pathway fragmentation in specialised services, with duplication of services, gaps in provision, disconnects between specialised, non-specialised and local services, and treatment not being provided in the most appropriate place. There are particular issues in mental health, with London patients being referred to beds/services outside of London and children and young people cannot always access age appropriate inpatient mental health services when they need them.</p>



<p><b>Services are not being delivered in the most efficient way</b></p>	<p>We also have a high level of services overlap in south London – the majority of which aligns to areas of high spend. This close proximity of similar services across south London offers opportunities for efficiencies, but attempts to change specialised services to create larger and more effective units have often been contested.</p>
<p><b>The quality of our services varies and we are not always meeting our own standards</b></p>	<p>In south west London specifically, we have significant performance challenges and are not consistently achieving targets across acute specialised services, including issues with RTT compliance. Estates issues described elsewhere in the STP also impact on the delivery of specialised services.</p>

**Our aims for south west London:**

We are committed to delivering high quality and sustainable specialised services in south west London, both for our own population and for those that travel here to receive care. To achieve this, we, together with NHS England, are considering alternative ways to deliver and plan specialised services. We will:

- Reduce the number of people requiring specialised services by developing a whole system, pathway led approach to provision and commissioning of services, maximising primary and secondary prevention;
- Eliminate unwarranted variation to ensure equity of access, outcomes and experience for all;
- Build on our knowledge of patient flows and the relationship between services to determine new and innovative ways of commissioning and providing services to improve quality, safety and cost effectiveness

**Focus areas**

Through reviewing our performance and quality issues and areas of highest spend, we are suggesting three area of focus to explore further: Pathway transformation, Drugs and Devices and Improving Value. In delivering these, we will take a more collaborative approach to commissioning services on a STP or multi STP footprint. This will include planning and designing services together and providing financial incentives for pathway improvement, supported by the pooling or delegation of budgets as appropriate as well as reforms to the payment and contractual system. We will take this forward in 2016/17 through a collaborative commissioning approach to adult secure mental health services. As part of New Models of Care work will put Lead Provider/Alliance arrangements in place to develop proposals to secure future sustainability and improve the quality of service.



## Pathway Transformation

We are working to improve the quality and effectiveness of services for patients and ensure resilient provision by concentrating on five key themes:

- Pathway inefficiencies
- Ineffective prevention
- Operational inefficiencies
- Fragmented service provision
- Inefficiencies due to patient flows

This work could lead to some changes in service delivery, so we will take the views of patients and a wide range of other stakeholders before taking these forward.

### i. Aligning services across south London

In south London we have eight acute specialised providers, including three large providers with contracts over £150m (Guy's and St Thomas', Kings College Hospital and St George's) which are geographically extremely close – the furthest distance between them is just 7 miles. There is considerable overlap in the services provided at these hospitals. We have initiated a programme of work to identify the future optimal configuration for these services to be clinically and financially sustainable and deliver the best patient journey. This work will also consider the patient flows into London from the South East of England.

### ii. Pathway reviews

We are reviewing how we deliver the most effective and high performing services, with an initial focus on:

- **Paediatrics** – supporting and implementing the recommendations of the national strategy to address fragmentation and coordinate services
- **Cardiovascular** – supporting and implementing the recommendations of the London review to improve value, reduce variation and address issues with referrals
- **Specialist Cancer** – this will be led by the cancer vanguard and cancer alliance in south east London to ensure the delivery of commitments for improved quality and cost effectiveness, working closely with the STPs. There is STP SRO representation on the Cancer Vanguard Boards.
- **Renal** – review the disposition of renal services in south west London, reduce variation, empower patients and improve the patient experience
- **Neuro-rehabilitation** – streamlining pathways and enabling better, more efficient services, with a particular focus in supporting patients who are stepping into mainstream rehabilitation
- **Adult secure mental health** – Improve access to and experience of care for our population whether they receive treatment in or outside of south west London
- **CAMHS** – review services and implement changes with the ambition by 2020/21 that there will be no inappropriate admissions of children and young people with mental health needs to adult or paediatric beds and patients will be treated in local care pathways



- **Transforming Care Partnerships** – minimising the number of patients admitted into specialised mental health services and facilitating appropriate discharge into the community

Further detail on objectives of these reviews is set out in the Specialised Commissioning Appendix.

## Drugs and Devices

We will work closely with clinical colleagues and partners to bring forward system-wide benefits to improve the value that the NHS gets from our significant investment in high cost drugs and devices through:

- Aligning priorities and improving efficiencies relating to medicines optimisation and the “Hospital Pharmacy Transformation Programme”.
- Working with NICE and the CRGs to ensure that treatment algorithms for medicines reflect optimal use of the most cost effective treatments and enable a reduction in unwarranted variation.
- Implementing digital developments such as e-prescribing, electronic prior approvals and standardised contract reporting.
- Completing the centralisation of the high cost device supply chain and reducing the variation of specifications for devices.
- Incentivising Trusts with a medicines optimisation and devices CQUIN for 2017-19 to support implementation.

We will engage with patients and carer representatives on the CRGs on the medicines optimisation programme to improve the value and outcomes for patients.

## Improving value

In line with the national commissioning intentions we will engage with these important areas of work to drive improved value:

- Fragile services – reduction in occasional practice, non-contracted activity, and address non-compliant services which do not meet agreed activity thresholds;
- Improved clinical and operational efficiency, and reducing variation, including the use of the clinical utilisation reviews, Rightcare and Getting It Right First Time;
- Implementation of national reviews;

Clinical Reference Group initiatives which will set out opportunities to deliver improvements, whilst achieving a reduction in overall cost;

London QIPP programme for 17-19, and use of national CQUINs.



## 4.4 How our staff, digital technology and buildings support transformation

### A modern workforce

In south west London we have over 25,000 staff working across the mental health, primary care, community, and acute settings and a further 32,000 jobs within social care. Over 18,000 people work within the acute sector with only around 2,500 staff working in a community setting. We have identified issues with the recruitment and retention of staff in south west London and if we continue to deliver care in the same way demand for staff will significantly outstrip supply.

Nationally there is a shortage of some qualified professions including GPs, nurses and specialist children's doctors. Currently across South West London we do not have enough staff in post to deliver care using the current model, and rely on expensive agency staff to ensure the provision of safe services and cover rotas. Changing the service model will reduce some of this pressure

Our local councils are facing unprecedented demand for their services. Adult social care forms a large percentage of any local authority budget and these services are tasked with reducing spending finding more cost effective ways of working, while maintaining safe, high quality services. Demand is growing with increasing numbers of older residents with complex care and health needs, increased mental health needs and the continued need to support people to live as independently and as full a life as possible. It is clear that the NHS and the social care system in south west London need to work better together if we are to deliver the high quality services people need.

#### Our aim for south west London:

We will develop a health and social care workforce that can work across existing organisational and clinical boundaries, delivering care in an integrated way We will Enable our workforce to .support and respond to the individual needs of patients safely and in a consistently high quality fashion in the most appropriate setting and cost effective way.

### How we will achieve our aim

We are focusing on four core priorities to develop our workforce (further work is included in the appendices):

- Working differently
- Securing a sustainable workforce and improving retention and recruitment
- Capacity and skill mix
- A healthy workforce, including both physical and mental wellbeing



Education and training is a key enabler running through each of our priorities. In taking this work forward, we will work with local academic institutions and education providers to ensure we have a sustainable workforce with the right skills and competencies to deliver new ways of working.

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## Making best use of our public estates

### Our aim for south west London:

Service transformation and population needs resulting from this strategy can drive a fundamental change in the way we manage the combined Health & Social Care estate across south west London. This will require 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.

### Our vision is for community buildings to:

- become catalysts for health and wellbeing
- act as a central hub for an integrated range of health-related services;
- be at the heart of the community;
- be able to engage with patients and the wider community; and
- co-produce and shape the services to meet their needs.

The emerging view of future service models suggests better use of existing premises and that a number of multi-specialty community hubs are required across the region to meet future demand. The solution is likely to involve mostly refurbishment/conversion of existing premises where acute sites allow, with a small amount of new build, requiring capital investment of between £80m-£135m depending on the solution and level of construction required. We will look to make the best use of existing acute sites such as Purley and Queen Mary's Roehampton.

There are three emerging factors which could impact on the future acute estate requirements:

- The results of the bed audit, early discharge and its impact on bed volumes;
- The reconfiguration of clinical services across acute sites from new clinical models;
- The review of specialised services and the impact that this might have across south west London.

Reconfiguration of the acute estate may release space that could be re-purposed for community uses or sold for capital release. The future configuration could also have a major impact on future backlog maintenance requirements. The potential to release surplus land will become clearer as the acute configuration work reaches its conclusions at which point it may be appropriate to consider a real estate joint venture (or other delivery vehicle) for redevelopment of surplus site areas for commercial uses and a long-term revenue stream to south west London.

## How we will achieve our aim

Before the end of 2016 we expect to:



- Establish the baseline for the Local Authority health and social care estate baseline which will enable us to map Health and Local Authority assets across the region and identify any immediate opportunities for rationalisation;
- Complete the activity analysis for the shift of activity out of an acute setting and assessment of increased number of community beds/consulting rooms required;
- Complete the programme of utilisation studies and condition surveys for primary care and community assets to determine existing capacity and ability for existing estate to absorb growth in non-acute settings;
- Complete any further feasibility studies for key community/primary care schemes to inform investment requirements;
- Progress the ETTF primary care applications and proposals;
- Re-assess St George's backlog maintenance position;
- Revise CCGs' Strategic Estates Plans and confirm future multi-specialty community hub locations (existing assets and new investment) and investment requirements;
- Develop a detailed regional south west London Estates Strategy and 5 year Implementation Plan through the Capital & Estates Forum.

From 2017 onwards we will implement the Estates Strategy and 5 year programme:

- Take forward a regional One Public Estate approach to property across south west London working more closely at a strategic and opportunity level with local authorities and other public sector agencies;
- Consider a suitable governance structure and commercial delivery model to take forward the Estates Strategy and incentivise appropriate behaviours across the Health economy in south west London.

## Delivering an information revolution

### Our aim for south west London:

Technology is a critical enabler of many of the recommendations that are being made within our Five year forward plan. We know that information sharing, so that clinical information about an individual follows them between different health and social care services, is key to delivering more joined up care that we describe in the 'right care in the best place' chapter. We also know we can better support patients to look after themselves and manage their own conditions, as set out in the 'preventative and early intervention' section, such as using technology to monitor symptoms remotely. We are committed to ensuring that as many citizens in SWL are digitally enabled through education and targeted support, as part of delivering the information revolution.





These digital requirements for supporting the plan can be categorised as:

- **Digitally-enabled self-care:** using technology to help patients to capture and share information relating to their condition, or provide information, such as their record, to help them make informed decisions about managing their health.
- **Channel shift:** using technology like video conferencing to break down barriers to access between patients and clinicians and to help clinicians get rapid specialist input where necessary e.g. before referring a patient.
- **Information sharing for the point of care:** helping health and care professionals make the best decisions possible by providing access to all relevant information about an individual, including clinical records and care plans.

**“Technology is a critical enabler of many of the recommendations that are being made within our Five year forward plan”.**

- **Information sharing for whole systems intelligence:** combining clinical, operational and financial information to derive insights into how we can improve how services are commissioned and delivered.
- **Mobile infrastructure:** making sure digital technology is available to clinicians and care professionals when and where they need it.

The multiple specific technology requirements that will support our hypotheses are detailed in Appendix I.

There are pockets of good practice across south west London. These will be the foundation for expanding the use of these technologies to the scale required to deliver our ambitions. However, we know from our recent assessments of ‘digital maturity’ across NHS and social care organisations that we have some way to go in south west London to make best use of technology. In particular we need to look at how we share clinical information within the NHS and across NHS and social care boundaries.

## How we will achieve our aim

Alongside the five year forward plan, the NHS and local authorities in south west London will be publishing a local ‘Digital Roadmap’, which includes further detail on the plan for digital technology over the next five years. The roadmap incorporates three phases to deliver a significant increase in digital maturity over five years (see Appendix I for detail):

- 1) Developing a Collaborative Future - a SWL collaborative capability that supports the successful delivery and utilisation of the tactical and strategic solutions (years 1 to 5)
- 2) Building on the Current Position - a tactical foundation that achieves establishes proof of concept in information sharing across SWL in the short term (years 1 to 2)
- 3) Delivering a Strategic Platform - a strategic solution that achieves the long term aims of the *Five year forward plan* (years 2 to 5)



South west London intends to secure resource from the Estates and Technology Transformation Fund for Phases 1 & 2 of the Roadmap over years 1 and 2. Subsequent phases will look to draw on national funding earmarked for the 'paperless NHS' initiative.

We will also work with the Healthy London Partnership digital programme to ensure we adopt digital solutions and processes that support patients wherever they are treated across London.

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## 5. Closing our financial gap and capital requirements

We are committed to addressing our already significant current year financial deficit and the large projected financial gap of £828m by 2020/21. Over the last several months an intensive collaborative effort between commissioners and providers, along with local authorities, has identified sufficient measures to fully address this financial challenge<sup>1</sup>.

The scale of the challenge has meant that all areas of spend have needed to be considered as potential sources of savings and also that the traditional incremental approach to delivering financial improvement (so called “Business as Usual savings”) has needed to be supplemented by a large contribution from “transformational savings”.

As a result the scale of change being contemplated goes well beyond that which south west London has targeted previously. For example, relative to the 2020/21 “do nothing” base-line, the plan requires:

- a 44% reduction in acute inpatient bed days by developing new models of care which we believe will improve outcomes and patient experience
- a ~20% reduction in unnecessary outpatient appointments
- a ~13% reduction in elective surgical activity by better organising the process of elective care

It is recognised that this degree of change will be challenging to deliver but there is collective commitment that the proposals are based on sound analysis and that with the appropriate support, can be achieved with no reduction in the quality of care provided.

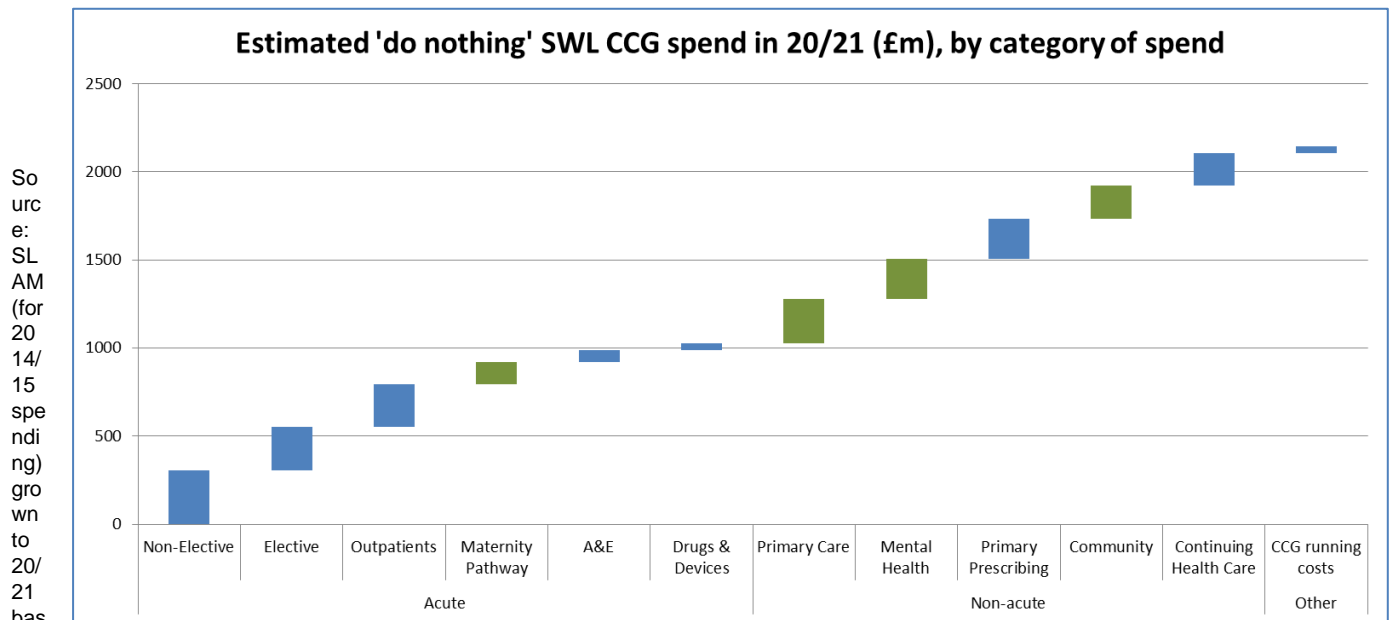
Commissioners and providers recognise that, while the plan laid out here is intended to close the financial gap in the health economy by 2020, it will not itself address underlying problems with the clinical and financial viability of the acute sector. This will require changes to the configuration of services, which are explored in chapter 4.

<sup>1</sup> It is assumed that the £99m of specialist commissioning related financial challenge is addressed by measures that are currently under development by the Specialist Commissioners for London working in conjunction with the main specialist service providers in south London (notably St George’s within south west London).



## 5.1 High level approach to identifying savings opportunities

A systematic approach was taken to reviewing all possible savings areas which arise either from improved productivity (providing the same activity at lower cost) or from commissioning savings (avoiding unnecessary activity or re-providing the care more cost effectively). Estimated CCG commissioner spending in 2020/21 by area of spend was used to identify potential areas for savings, as set out below:



Not all categories of acute spend are included (e.g. unbundled diagnostics). Non-acute spend is taken from CCG submissions as part of the wider STP, with primary care grown assuming delegated commissioning, and including additional investments to meet the primary care specifications. Specialised commissioning has been excluded.

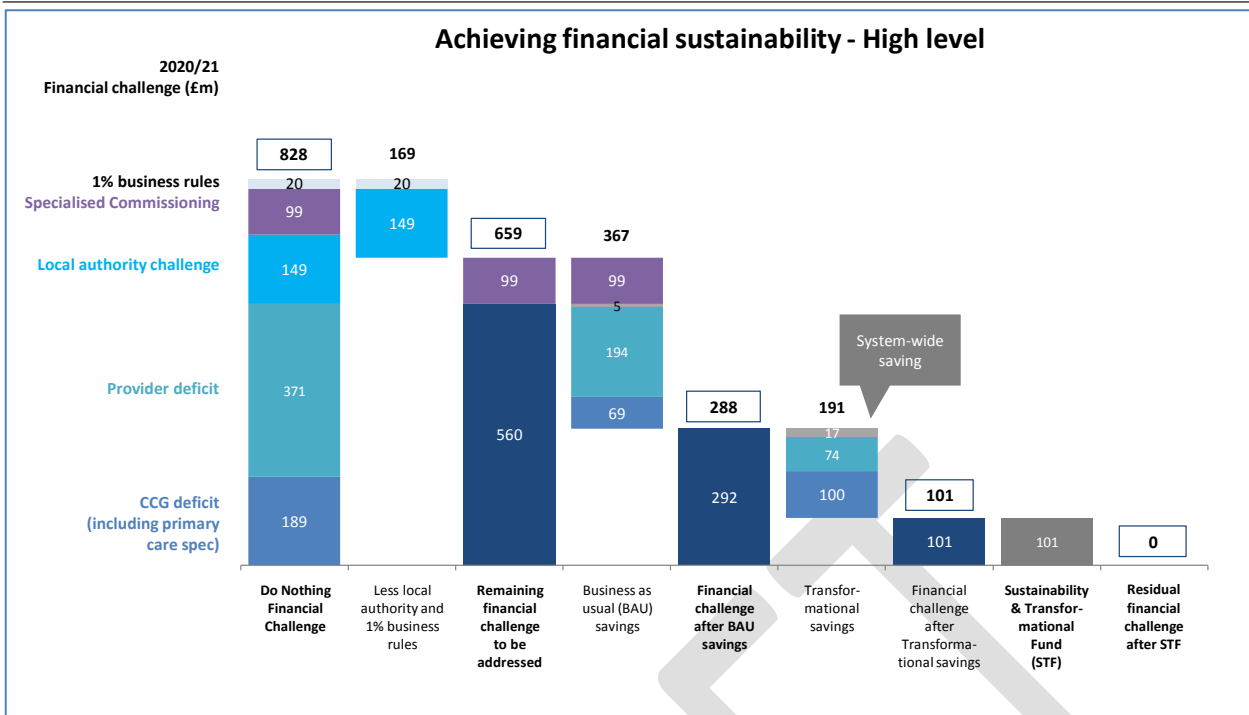
Some areas of spend were excluded from further analysis (shown in green) due to being areas where additional strategic investment is required and therefore savings have not been envisaged; for example, this includes primary care, mental health and community care.

Provider productivity savings have been drawn largely from providers' existing standalone cost improvement plans ("CIPs") and then augmented by savings developed through working on a collaborative basis.

In developing these savings, the importance of having system-wide participation has been recognised through regular weekly meetings of finance representatives of all south west London providers and commissioners. In addition, a Core Finance Group composed of senior commissioner and provider professionals has acted as a Quality Assurance group and undertaken a careful review of all the proposed savings elements. All the work has been overseen by the Finance and Activity Committee comprising all the south west London provider and commissioner Finance Directors as well as representatives from NHSE and NHSI.

Through these work streams, measures been identified that reduce the CCG and provider gap in 2020/21 to £101m. If provider sustainability can be demonstrated in 2020/21, an additional £101m of recurrent funding through the Sustainability and Transformation Funds can also be assumed, which then reduces the remaining financial "gap" to zero. A high level presentation of the impact of the different types of measure on the financial position of south west London is set out in the chart below.





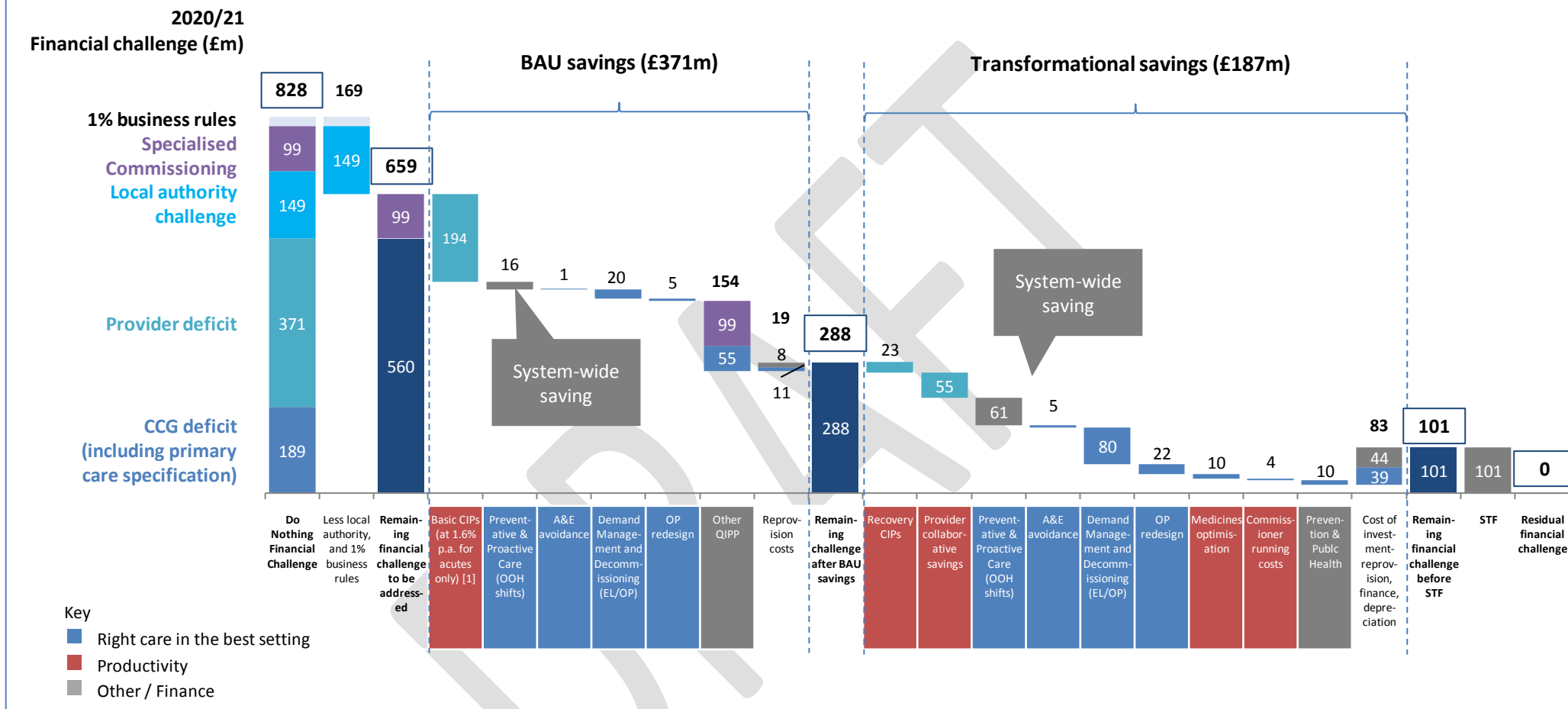
Source: South west London Financial Diagnostic and STP modelling; 2020 Delivery analysis

The chart shows that, based on currently developed plans, transformational and business as usual savings (“BAU”) contribute approximately in the ratio of 1:2 to closing the financial gap. It should be noted that re-provision costs have been netted off against the gross savings. A more detailed version of the finances is shown on the next page, and shows the savings by main source as well as aggregate re-provision costs.

The Local Authority financial gap and the likely reductions in services it implies is recognised as potentially having a significant impact on the ability of the south west London health services to deliver the proposed changes to services and address its own financial gap. For the purposes of this STP however it is assumed that Local Authorities will close their financial gap through their own actions.



## Achieving financial sustainability – Detailed view



Notes: [1] also includes £58m of "Do Minimum" CIPs from non-acute providers  
 Source: South west London Financial Diagnostic and STP modelling; 2020 Delivery analysis



## 5.2 Sources of Savings

This section outlines the savings from each of three core areas – these relate to reductions and shifts in acute activity; productivity measures by SW London providers and other savings through CCG collaboration and business as usual savings. More detail on the schemes described in brief in this section can be found in Appendix J.

### Right Care in the Best Setting

This section outlines savings areas relating to acute activity and demand levels achieved by re-providing care in a more appropriate setting or alternative pathway, or by preventing it being required. The savings from reductions in non-elective admissions, earlier discharge, fewer outpatient appointments and elective admissions and reduced A&E attendances are summarised in the table below.

Savings area	Savings category	BAU savings (£m)			Transformational savings (£m)			Total
		Gross saving	Re-provision costs	Net saving	Gross saving	Re-provision costs	Net saving	Net savings
Preventative & Proactive Care	Non-Elective Admissions and Early	16	-11	5	61	-44	17	22
Planned care & Re-commissioning	Outpatient appointments	8	-2	6	34	-9	25	31
	Elective Admissions and Procedures	6	-1	5	23	-5	18	23
	Elective Re-commissioning List	6	-2	4	23	-7	16	20
Outpatient radical redesign	Outpatient appointments	5	-3	2	22	-14	8	10
A&E	A&E savings	1	0	1	5	0	5	6
<b>Total (£112m net savings)</b>		<b>42</b>	<b>-19</b>	<b>23</b>	<b>168</b>	<b>-79</b>	<b>89</b>	<b>112</b>

### Savings from Right Care in the Best Setting

#### Preventative & Proactive Care

A south west London commissioned bed audit in acute hospitals in February 2016, identified that 13% of hospital bed capacity is used by patients who could have been seen in a non-acute setting, and a further



42% is occupied by patients who could have been discharged earlier. Based on these findings, and using international best practice as a benchmark, the south west London Clinical Board, local health providers and commissioners agreed to the ambition of achieving a reduction of 44% of bed days by 2020/21, compared to the 'do nothing' position<sup>2</sup>.

The total system-wide net saving from this reduction and re-provision of non-elective care is £22m, which can be broken down into provider and commissioner net savings.

On the provider side, there is a total net saving of £45m that comes from a significant reduction in non-elective operational costs, and which is only partially offset by a corresponding decrease in tariff income. On the commissioner side, there is a total net cost of £23m. This is due to the costs associated with re-providing the shifted non-elective activity in alternative settings – including community and intermediate care - which significantly outweighs the reduction in tariff payments to acute trusts. Investment in additional Primary Care capacity that is included in the Do Nothing baseline is also expected to be a source of re-provision.

In addition to the direct re-provision of care, the expansion of locality-based teams giving care oversight and coordination to the highest-risk patients is considered a key enabler of the non-elective shift. It is estimated an additional £1m would be required from CCGs to allow for this expansion, which forms part of the net cost to CCGs above.

It is recognised that under current system incentives the net saving falls very asymmetrically, with acute trusts significantly benefitting and CCGs bearing the costs of re-provision. Accordingly, in order to successfully implement this key initiative, it is anticipated that there will need to be a change in the tariff arrangements which govern payments for non-elective admissions; discussions are expected to address this issues in the next few months.

### Planned care & Recommissioning

To estimate the potential cost savings from reducing excess demand for outpatient attendances across south west London, benchmarking analysis was performed at two levels:

- GP surgery-level variation analysis within each CCG
- CCG-level variation within south west London, by clinical specialty

This analysis indicates a potential ~20% reduction in outpatient appointments, with gross savings of £42m compared to the 2020/21 "do nothing" scenario. Re-provision costs of 25% have been assumed to accommodate sufficient investment in primary care demand management systems and on-going training to maintain improved referral rates. This leaves a net savings figure of £31m.

To estimate the potential cost savings from reducing excess demand for elective admissions across south west London, benchmarking analysis was also performed at two levels:

- CCG-level variation within south west London, by clinical specialty
- National-level benchmarking (using NHS Right Care "Commissioning for Value" packs), comparing each CCG to 'similar' CCGs nationally

<sup>2</sup> Although there are significant reductions in activity projected for acute providers totalling ~£180m in value this is relative to the baseline under which activity grows at its underlying rate over the 5 years to 2020/21. While it is recognised that there may be stranded costs in the short term, it has been assumed following discussions amongst the finance community that 100% of the associated costs can be removed over the longer timescale of the STP.





This analysis indicates a potential ~13% reduction in elective admissions, with gross savings of £29m compared to the 2020/21 “do nothing” scenario. This gross value includes a specific £5m savings opportunity identified through on going work of the south west London Effective Commissioning Initiative (ECI), which has identified a significant number of elective procedures of limited clinical effectiveness. The overall net savings across these two components, after accounting for re-provision costs, total an estimated £23m.

In addition, CCGs are in the process of identifying further areas of recommissioning. Savings of £20m are estimated after £9m of implementation costs for South West London acute providers.

### Outpatient radical redesign

The net savings for outpatient care identified under Planned Care & Re-Commissioning relate more to incremental improvements than transformational change. Opportunities to radically transform the provision of specialist input into patients’ care pathways include:

- Changing the setting of care
- Using technology to deliver care remotely
- Optimizing the roles and responsibilities of different workforce groups

The net savings achievable from more radical improvements have been estimated at ~£10m through more detailed assessment of national best practice across key pathways, and are in addition to the outpatient savings identified under Planned Care & Re-commissioning.

The analysis suggests a further reduction of outpatient spend of 14% (~£27m) vs. the 2020/21 “do nothing” scenario. The re-provision costs to deliver this shift are higher than recommissioning (63% of gross saving) meaning a net saving of £10m.

### Accident and Emergency (A&E)

There is an estimated saving of £5.6m by 2020/21 through a reduction in A&E attendances in south west London and other out of area providers. Potential savings are achieved through preventative and pro-active care policies that reduce non-elective admissions, and also the planned increase in opening hours for GP appointments each day.

For the reduced non-elective admissions, the saving is driven by more activity in preventative and pro-active care measures, such as rapid response teams and increased community care provision that remove minor, i.e. do not require significant treatment or investigation, A&E attendances from occurring. This results in an expected net saving of £1.4m across south west London. As all re-provision costs here are already incorporated elsewhere in the analysis, the gross and net savings are the same.

There is also a larger expected saving from reduced A&E attendance as GP surgeries extend their opening hours from 8am to 8pm, 7 seven days a week. Based on previous trials in London, Manchester and elsewhere in the UK, we have forecast a 10% reduction in A&E attendance from the do nothing baseline, as people increasingly utilise the longer opening hours of primary care facilities rather than attend A&E. We have assumed that those attending a GP instead would be costed at the lowest tariff in A&E, i.e.



attendances that require no significant treatment or investigation. The expected net saving for South West London is forecast at £4.3m as a result of this extended primary care. Again, as the costs of providing this service have been included elsewhere, the net and gross savings are the same.

## Savings from productivity

### Sources of savings: Provider and Commissioner Productivity

Three types of organisational provider productivity have been considered as contributing to the closing of the financial gap in south west London. These are shown in table below.

Savings area	Savings category	BAU savings (£m)	Transformational savings (£m)
Provider productivity - standalone	Basic CIPs ("BAU")	194	-
	Recovery CIPs	-	23
Provider productivity – collaborative (£55m)	Provider collaborative savings	-	55
Commissioner productivity – collaborative (£14m)	Medicines optimisation	-	10
	Commissioner running costs	-	4
<b>Total (£293m)</b>		<b>194</b>	<b>92</b>

### Standalone Provider Productivity

This section shows the level of ambition among providers through their cost improvement plans ("CIPs") to drive efficiencies in their individual organisations.

The 'Basic' cost improvement plan (CIP) figures totalling £194m are based on year on year efficiency savings of 1.6% p.a. across all four acute trusts (£135m), with an additional £49m of CIPs from non-acute providers. The figure of 1.6% p.a. was agreed by Provider Finance teams following an assessment of what level of productivity gains could be expected on an "every year" basis, based on historical performance.

Recovery CIPs of £23m are identified separately and represent the standalone savings in excess of 1.6% p.a.; they mainly comprise the savings expected from the financial recovery and turnaround programmes in place at three of the south west London acute providers.

### Collaborative Productivity Opportunities for Providers

At present the proposals have largely been developed between the four acute trusts since there is the greatest degree of overlap between them. The proposals around optimising the workforce include South West London and St George's, and going forward we will explore productivity opportunities across the providers more widely.



The acute trusts, working together as the south west London Acute Provider Collaborative (APC), have identified productivity savings in a number of key areas. Some of these are already being developed or implemented, while others are being scoped and a business case developed.

- In development / being implemented
  - Develop a shared approach to procurement and supply chain, including looking at a shared procurement function for south west London;
  - Set up a shared staff bank (this also includes South West London & St George's MHT);
  - Closer working on pathology;
- Being scoped / business case being developed
  - Explore options to further reduce backoffice costs, including increasing the efficiency of estates management; reduce waste; reduce pharmacy costs
  - Reduce reliance on locums in fragile services (such as vascular surgery) which have been heavily reliant on locums.

In total these savings amount to £55m.

Detailed information on the costings and methodology is provided in Appendix J.

Key Areas	Initiative(s)	2020/21 Est. Benefits (£m)
Collaborative procurement and supply chain	Joint procurement and supply chain cluster	12
Workforce optimisation	Pan south west London staff bank across all staff groups including nursing, medical, AHP's and administrative staff	4
Corporate and administration costs	Multi-functional shared service centre primarily focussed on transactional services in - HR, finance, IT and payroll	19
Estates management efficiencies	Efficient use of south west London estates	14
Waste reduction	Reducing waste	2
Pharmacy	Reducing pharmacy costs	1
Radiology and pathology	Optimisation of radiology and pathology	2
Fragile services	Optimisation of fragile services	1
<b>Total</b>		<b>55</b>

## Collaborative Commissioning Productivity

### Medicines optimisation



In addition to the provider schemes, pharmacy teams across the six south west London CCGs have worked together to identify opportunities for medicines related saving that go beyond the usual quality, innovation, productivity and prevention (QIPP) savings through collaborative approaches.

CCGs have identified specific opportunities within the prescribing budget of around £10m which could be achieved through collaborative working. 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)

### Commissioner running costs

At the organisational level, CCGs have identified that there are likely to be opportunities to improve productivity by working together more closely, and have estimated total savings at £4m (~10% of running costs) by improving effectiveness and reducing transactional costs. Other collaborative opportunities to explore include sharing 'back office' functions across commissioners, Commissioning Support Units providers or across councils.

**“CCGs have identified that there are likely to be opportunities to improve productivity by working together more closely.”**

## Sources of savings: Other

Savings area	Savings Category	BAU savings (£m)	Transformational savings (£m)
Other QIPP	Other prescribing savings	24	-
	Continuing Care	18	-
	Primary Care	4	
	Other savings identified outside of STP process	8	
Public health initiatives	Community Health Services - NHS	-	10
<b>Total</b>		<b>46</b>	<b>10</b>



The additional savings identified in this section comprise the normal savings from CCG Quality, Innovation, Productivity and Prevention (QIPP) programmes of a business as usual nature. These are set out in the table below.

£m (STF)	2016/17 STP place-based allocation	2020/21 STP place-based allocation	2020/21 indicative STP allocation including S&T	Indicative 2020/21 S&T funds
South west London	2,418	2,760	2,861	101

### Other sources of savings

CCGs have identified £48m of other QIPP over the 5 year period to 2020/21. This is comprised of £24m other prescribing savings, and £18m savings in continuing care, based on a review of the opportunities to bear down on the large and rising costs CCGs have been and expect to continue to incur. In addition, £4m of savings are expected from primary care and £8m of savings in areas outside of the STP (largely non-acute).

### Sustainability and Transformation Funding

In May 2016, NHS England published indicative allocations for 2020/21 STP funding including Sustainability and Transformation Funding ("STF") of £101m for south west London.

This funding will be available on the basis that south west London is planning for provider sustainability by 2020/21.



## 5.3 Costs of key Enablers

### Transition costs and investment requirements

A preliminary high-level estimate of the necessary transition costs to support implementation of the STP indicates that a total of £121-140m of non-recurrent revenue costs and an additional £19m of capital costs, with the latter estimated to generate £4m of recurrent revenue cost.

There are approximately £50m of non-recurrent revenue costs and £17m of capital costs across three enablers which support delivery of the STP. These are:

- IT costs are estimated to be £10m of revenue and £17m capital costs – this includes STP transformational costs but excludes individual organisational upgrades
- Training costs are estimated at £15m based on 1,500 staff members
- Programme costs of £25m are expected with an average of £5m p.a.
- The capital costs of estates are excluded here- these are addressed separately in section 4.4

### Costs of delivering initiatives

For each of the savings areas, we also estimate transitional costs of £71-90m revenue and £2m capital associated with delivering the required initiatives. These are:

- Provider Cost Improvement Programmes (CIPs) costs of £27-41m, based on 10-15% of savings
- Back-office rationalisation across providers - costs of £10m for redundancies
- Out of Hospital services double running costs of £20-25m for three months of services
- Planned care - allowance for £6m to support clinical training and £2m capital for IT
- Commissioner running costs - allowance of £2m, based on 50% of assumed cost savings
- Recommissioning – allowance for £1m of project costs to deliver savings (c5% of gross savings)
- Clinical priorities - allowance of £5m based on £1m per annum for new initiatives

### Sources of funding

No assumptions have been made about specific sources of funding for the investments above. Possible sources could include:

- Commissioners' 1% non-recurrent investment funds (~£50-75m from 2017/18 to 2020/21)
- Access to central Sustainability and Transformation funds for the balance (~£75-100m) over the course of 17/18 to 19/20.

<sup>5</sup> An example could be extending the NICE approved ESCAPE Pain management programme for knee/hip pain.

## 5.4 Capital Requirements

### Capital Requirements

As part of developing the STP, there has been a need to understand the capital requirements needed to support the implementation of the various initiatives, ongoing "BAU" capital needs as well as capital to



address the estates challenges identified elsewhere in this STP. The capital needs have been classified into “Do nothing” and “Do something” depending on whether the capital is internally generated/part of BAU or requires external funding/is part of the STP programme.

Historically, there has been significant underinvestment in capital in south west London. The STP has identified:

- capital that has already been agreed;
- capital that has not yet been signed off but will be needed during the 5 years of the STP;
- capital that will be needed after 2020-21.

Further work is ongoing to scope those areas where business cases have not yet been prepared; and some capital asks will be dependent on the approach taken to acute reconfiguration.

The majority of the funding requirements at this point are in the acute, mental health and specialised care providers. We are doing further work to understand the capital requirements in the primary and community sectors.

### Capital funding which has already been agreed and signed off

The largest capital programmes that have already been signed off are:

- **Mental health:** A £169m Estates Modernisation Programme is in place for South West London and St George's, supported by the south west London Joint Health Overview and Scrutiny Committee and approved by HM Treasury.
- **The Royal Marsden:** £67m of approved funding is being invested

### Capital funding which will be needed during the next five years

There are very significant capital requirements across the health economy, particularly in the acute sector, to address historic issues.

- **Safety critical capital and backlog maintenance:** Much of the capital which will be needed is 'safety critical', i.e. has been identified either by the CQC or by providers themselves as being essential to allow the delivery of safe care in south west London. Areas of safety critical and backlog maintenance have been included as part of the 'do nothing' scenario, as areas which are essential to maintain the current delivery of services.
- **Strategic capital:** In addition, organisations have identified strategic capital development to improve their sites, which has been included in the 'do something' scenario.

Wherever possible, we have identified sources of internal funding (totalling £834m) to address the costs, of which £384m is funded from depreciation, £139m from land sales and £310m from other internally generated sources, e.g. grants, accumulated cash. Organisations have prioritised their own internal funding to support essential works.

Where it is not possible to fund safety critical work from internal funds business cases will be submitted or have been submitted to NHSI.



**Summary of capital requirements for south west London to 2020-2021**

£m	Do Nothing			Do Something		
	Providers	CCGs	Total	Providers	CCGs	Total
Internal funding	856	0	856	856	0	856
External funding - Approved	146	0	146	146	0	146
Commercial funding - Yet to be approved	5	0	5	5	0	5
External funding - Yet to be approved	74	0	74	74	0	74
ETTF	0	0	0	0	14	14
Other CCG sources	0	0	0	0	225	225
<b>Total</b>	<b>1,082</b>	<b>0</b>	<b>1,082</b>	<b>1,082</b>	<b>239</b>	<b>1,320</b>

**Acute sector capital**

All the acute sites have areas of capital which they must urgently address in response to requirements from the CQC, or as part of ensuring that their sites are fit for purpose. The two largest capital requirements come from two trusts: St George's, and Epsom and St Helier. Further detail on all the trusts is laid out in the reconfiguration chapter (section 4.5) and in the appendices.

Trusts have prioritised their available internal funding to address the most safety critical issues. However we anticipate that there will be some further requests for DH funding as per the table above.

**Primary care estate**

The existing primary care estate in SWL requires development and investment to deliver the scale of provision required to support the new models of care. Overall there is a shortfall of space against standard measures and a preponderance of unsuitable premises. Meeting STP objectives for modern standards and greater capacity will require significant investment over many years along with optimised utilisation.

As a first step, increased capacity will be achieved as far as possible by better use of existing premises, for example, by delivering extended hours at multiple GP primary care centres across SWL. A delivery plan is already in place to achieve this by the end of 2017/18. Across SWL there is little void space although there is known under-utilisation across the estate and some community assets that could be optimised to off-set future space requirements and enable greater co-location of services.

The current primary care estate comprises some 137 properties of which 88 are GP owned. An investment of £138m is anticipated to support delivery of the STP. This includes a combination of funding supported by Estates and Technology Transformation Fund (ETTF) bids, new self-funded investments, depreciation, improvement grants and GPIT investments.

To develop the primary care strategy and secure funding, a number of bids have been submitted to ETTF. These bids support a mix of improved physical access, relocation to improved 'fit for purposes' premises and to support compliance, such as health & safety requirements, and infection control.





## Community estate

The STP sets out to deliver future services through a combination of locality teams, planned local community crisis and intermediate response teams. All initiatives will work on a 'home first principle'. Patients tell us that they prefer to receive care at home. It also has clinical benefits by helping people to maintain independence / social connections and reduces some of the risks associated with bedded care, e.g. deconditioning.

However, the community crisis and intermediate response will include some bedded capacity, to manage patients in the community who cannot safely be cared for at home. Current bedded community capacity will be reviewed at a SWL level – in terms of capacity and current use of the beds – to ensure correct capacity across the SWL system and that beds are used as effectively as possible.

A provision of £10m has been included for future development of community beds. There are likely to be some minor disposals to support this investment.

## Digital Road Map

SWL capital includes £80m to support implementation of our digital roadmap. This covers the delivery of cross-boundary technologies to support our new models of care, including phases of our interoperability solution for record sharing, standardised channel shift technologies for patients and clinicians across SWL, and developing shared read-write care planning solution to support our new locality teams. Capital relating to individual provider roadmaps, including point of care solutions, is not included

This is a notional value supplied by the NHSE finance team in discussion with the Digital Road Map Leadership Team. The figure is subject to change and is derived from the LDR investment exercise which is currently underway.

## Capital requirements after 2020-21

As laid out in chapter 4.5, we anticipate that there will be some significant capital requirements resulting from decision making on reconfiguration of the acute sector. If the number of acute sites is reduced we are likely to need some capital investment to reprovide the capacity for those patients on the existing sites.

While some costs could materialise towards the end of the five year period, the majority of capital requirements resulting from reconfiguration are likely to fall outside the period of the STP, owing to the lead-in times for business cases and implementation.

Further detail on these capital requirements will be developed as engagement and consultation on the reconfiguration go forward.

## 5.5 Risks/Dependencies

A programme on the scale proposed with many transformative elements will be complicated to deliver and has many inherent risks and dependencies. This is dealt with in more detail in the Implementation section.

Here we highlight some of the key financial factors and dependencies on which the return to financial balance for the system depends.



**Dependencies for key saving areas:**

Savings initiative	Key dependencies
Recovery CIPs	Drawing up robust initiatives to deliver savings
Provider Collaborative Savings	Strong cross-organisational co-ordination to enhance collaborative working;
Preventative and Proactive Care	Community & primary care additional workforce & capacity; Training and skills changes; Creation (or conversion) of additional non-acute beds; Understanding the impacts of sensitivity testing (i.e. how changes in the scale or pace of delivery affect capacity requirements and savings)
Planned care & Re-commissioning	Ability to change GP behaviours around referrals; Community and primary care capacity; Strong cross-organisational co-ordination to maximise pathway efficiencies into the community; Ensuring minimal impact to patient care quality from re-commissioning
Medicines Management	Resources for more detailed planning and implementation; Clinical and pharmacy engagement (CCG and acute pharmacists)

Alongside dependencies in specific areas there are broader uncertainties, some external factors, which could negatively impact the system’s ability to reach financial balance.

**Broader financial risk areas:**

Area	Description
Current financial performance	At the time of submission a number of the STP region’s organisations are undergoing reviews of their financial performance. This could mean the region’s financial challenge could substantially worsen shortly after the STP has been agreed. Current financial challenges within organisations in the STP footprint, limit the region’s ability to invest in the delivery of the STP as fast as would be
System incentives and collaboration	Further work is in progress to develop robust risk sharing agreements and system incentives to enable the system to implement changes at sufficient pace. The quality and timing of these arrangements will impact delivery.
Capacity	Organisational and operational capacity to implement large scale change across multiple areas concurrently is a significant challenge. The system is working hard to ensure it has sufficient skill mix to manage this
External factors	The successful delivery of neighbouring STPs will support the ability for South West London organisations to reach financial balance by reducing the inefficiency of out of area activity and contracts. Public acceptance of the changes within the STP will be essential to enable better use of the NHS resources.



Medicines Management	Resources for more detailed planning and implementation; Clinical and pharmacy engagement (CCG and acute pharmacists)
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## 5.6 Next steps

The level of change being contemplated in this plan in order to address the financial and other challenges goes well beyond the scale of change that the south west London healthcare economy has targeted previously. Within the financial challenge £99m relates to Specialised Commissioning where a process led by NHS England (as the lead commissioner) and involving commissioners from south west and south east London, as well as the main specialist providers (St George’s, Guy’s and St Thomas’ and King’s) is underway to generate appropriate solutions.. Although this work is not expected to report until at least December 2016, it has been assumed that the specialised commissioning gap will ultimately be bridged as a result of the work underway.

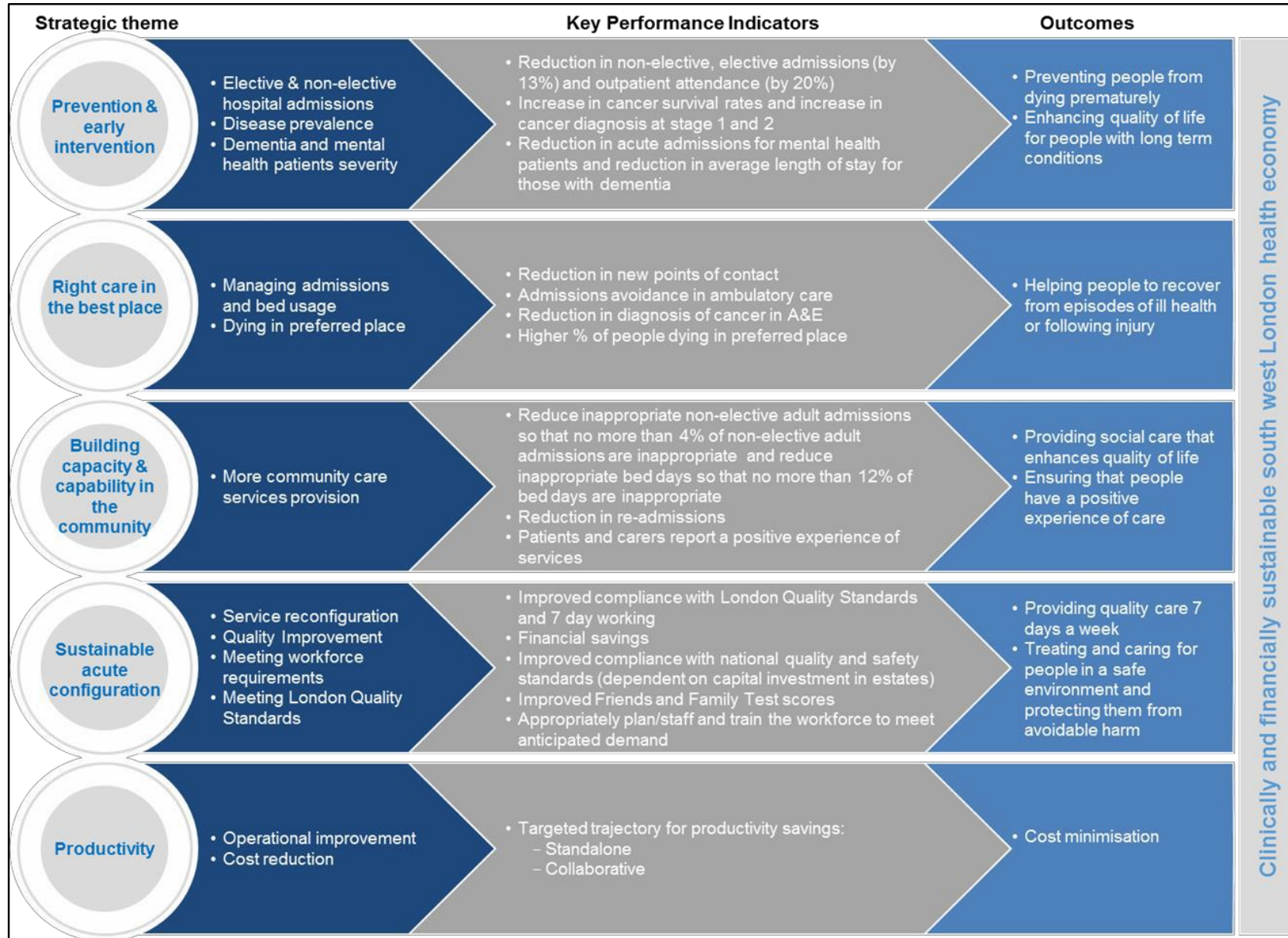
It is recognised that further work is required to understand the impact of the potential cuts in local authority provided social care services on the projected health sector deficit, and the opportunities from increased integration. It has been assumed that there is likely to be a need for some funding of social care services by the NHS as part of the programme to facilitate the early discharge initiatives that underpin the ability to deliver the large shift of activity from the acute to non-acute settings; however no detailed analysis has been completed at this stage.

<sup>5</sup> An example could be extending the NICE approved ESCAPE Pain management programme for knee/hip pain.



## 6. Measuring success

To measure the success of our plan, we have set out the strategic outcomes we want to achieve across our five strategic themes. These will be further refined and targets agreed as we develop our initiatives and agree detailed implementation plans through Q2 16/17.



## 7. Glossary

7DS	7 Day Services	LQS	London Quality Standards
A&E	Accident & Emergency	MCP	Multi-specialty Community Providers
AEC	Ambulatory Emergency Care	MDT	Multi-Disciplinary Teams
AHP	Allied Health Professionals	MHT	Mental Health Trust
APC	Acute Provider Collaborative	MSK	Musculoskeletal
BAU	Business as Usual	NICE	The National Institute for Health and Care Excellence
CCG	Clinical Commissioning Group	OBC	Outline Business Case
CEPN	Community Education Provider Network	PACT	Planning All Care Together
CIP	Cost Improvement Plan	PAU	Paediatric Assessment Unit
CQUIN	Commissioning for Quality and Innovation	PPD	Preferred Place of Death
CRG	Clinical Reference Groups	QIPP	Quality, Innovation, Productivity and Prevention
DGH	District General Hospital	RM	The Royal Marsden NHS Foundation Trust
ECI	Effective Commissioning Initiative	RTT	Referral to Treatment
ENT	Ear, Nose and Throat	SLAM	South London & Maudsley NHS Foundation Trust
ESCAPE	Enabling Self-management and Coping of Arthritic Pain through Exercise	SRO	Senior Responsible Officer
ETTF	Estates and Technology Transformation Fund	SSHP	South West London & Surrey Downs Health Partnership
HIA	Health Impact Assessment	STF	Sustainable Transformation Fund
HLP	Healthy London Partnership	STP	Sustainable Transformation Plan
IRP	Independent Review Panel	SWL	South West London
ITU	Intensive Therapy Unit	UEC	Urgent & Emergency Care
LAS	London Ambulance Service		

