right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

# MERTON CLINICAL COMMISSIONING GROUP
# GOVERNING BODY

**Date of Meeting:** 30th November 2017

**Agenda No:** 6.1 **Attachment:** 06

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| **Title of Document:** South West London Commissioning Priorities | **Purpose of Report:** For Approval |
| **Report Author:** Jonathan Bates: Director of Commissioning Operations, South West London Alliance | **Lead Director:** Jonathan Bates: Director of Commissioning Operations, South West London Alliance |

**Executive Summary:**
This document outlines the agreed Commissioning Intentions across SWL for 2018/19. Expectations for the commissioning and contracting round for 2018/19 will be a refresh of the two year planning round, and therefore the commissioning intentions have been refreshed from those agreed for 2017/18-18/19.

The Commissioning Intentions state the expected service changes across SWL in 2018/19 for the following:

- Urgent and Emergency Care
- Primary Care
- Mental Health
- Cancer
- Planned Care
- Maternity
- Learning Disabilities
- Integrated Community Care

**Key sections for particular note (paragraph/page), areas of concern etc:** NA

**Recommendation(s):**
The Governing Body is asked to approve the strategic priorities as laid out in the report

**Committees which have previously discussed/agreed the report:**
Local Delivery Unit Commissioning Intentions have been discussed at Executive Management Team.

SWL Commissioning Intentions have been discussed at the SWL Contract and Delivery Group and the STP Senior Management Team

**Financial Implications:**
Commissioning Intentions are expected to deliver quality and productivity improvements, which in turn will have a positive financial impact for the system.

**Implications for CCG Governing Body:**
Commissioning Intentions are expected to deliver quality and productivity improvements, which in turn will have a positive financial impact for the system.

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| **How has the Patient voice been considered in development of this paper:**<br>The STP is the product of, and has been subject to, significant public and stakeholder engagement. In addition, individual work-streams are also supported by targeted engagement and involvement with public, staff and stakeholders. |
| **Other Implications:** NA |
| **Equality Assessment**: The STP was subject to an Equalities Assessment. |
| **Information Privacy Issues:** NA |
| **Communication Plan: A**ll documents appearing on Part 1 of the Governing Body meeting will be accessible via the CCG's website. |

# South West London Commissioning Priorities

# Annual Commissioning Plan 2018/19

# Contents

# South West London Commissioning Priorities 2018/19

## 1. Introduction

### 1.1. South west London update

Commissioners and providers across South West London have come together in the South West London Sustainability and Transformation Partnership. Our joint priorities for improving healthcare in South West London shapes all that we do.

Our joint aim for South West London is set out below:

**People need beater 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 physical health issues go hand in hand. Mental health intervention 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.**

The Partnership has set the following strategic objectives:

- Supporting people to stay well
- Proactive, personalised care for people with long term conditions
- Delivering the right care in the best place
- Getting end of life care right
- Transforming access to outpatient services
- Getting the model of care right

The priorities set out in this Commissioning Plan support delivery of our Partnership's aims and objectives.

### 1.2 SWL Commissioning Intentions 2018/19

This document outlines the agreed Commissioning Intentions across SWL for 2018/19. Expectations for the commissioning and contracting round for 2018/19 will be a refresh of the two year planning round, and therefore the commissioning intentions have been refreshed from those agreed for 2017/18-18/19.

During 2017/18, commissioners and providers have been involved in developing the Delivery Plans for Five Year Forward View for the four major clinical priorities detailed in the Five Year Forward View Next Steps, including Urgent & Emergency Care, Cancer, Mental Health and Primary Care. In addition, further work is underway across SWL to implement consistent models for Planned Care (currently focussing on MSK services and Effective Commissioning Initiative); developing a Maternity Delivery Plan and responding to the Better Births national maternity recommendations.

In addition to refreshing the Commissioning Intentions across all of SWL, this document also details the specific local Commissioning Intentions for each of the four Local Transformation Boards: Croydon, Kingston & Richmond, Merton & Wandsworth and Sutton.

The Commissioning Intentions state the expected service changes across SWL in 2018/19 for the following:

- Urgent and Emergency Care
- Primary Care
- Mental Health
- Cancer
- Planned Care
- Maternity
- Learning Disabilities
- Integrated Community Care
- Further local priorities
    - Croydon
    - Kingston & Richmond
    - Merton & Wandsworth
    - Sutton

CCGs in SWL would like to signal clear intent to move to payment mechanisms that better reflect the sharing of system risk and incentive in 2019/20. This will include introducing tariff flexibilities such as capped contracts, risk/gain shares, payment floors and other alternatives to Payment by Results where appropriate. Local systems will be supported to vary contracts in 2018/19 if they can move at pace to this approach.

## 2. Urgent and Emergency Care (UEC)

The SWL UEC Delivery Plan 2017/18-18/19 details the priorities for delivery across SWL in line with the national and London regional expectations for improving urgent and emergency care and getting A&E performance back on track across SWL. Delivering timely access through the winter, as well as other periods, remains a top priority. A&E Delivery Boards have worked collectively through the SWL UEC Transformation & Delivery Boards to agree the collective delivery plan across 7 UEC pillars:

- **NHS 111 Online** – support the local roll-out of NHS 111 Online across SWL, including procurement of an online solution subject to pilot evaluation.
- **NHS 111 Calls** – continue to increase the number of calls transferred to a clinician by March 2018 so that patients access the right care first time. Achieve direct booking from 111 to GP in and out of hours by March 2019.
- **GP access –** Continue to achieve 100% population coverage for evening and weekend appointments and GP practices meeting the seven national standards by March 2019.
- **Urgent Treatment Centres** – All urgent care facilities to be designated by March 18 (we currently have 3 facilities where designation requires more work), and for designated UTCs to meet the London specification by December 2019.
- **Ambulance –** Continue to implement demand management plans with a reduction of Type 1 and Type 2 conveyances to hospital by March 2019. Fully embed the Ambulance Response Programme during 18/19.

- **Hospitals** – Deliver and sustain the 95% A&E 4 hour standard. Seek to achieve the 15 minute ambulance handover standard at ED. Providers are expected to implement initiatives around SAFER, Emergency Care Dataset and Early comprehensive geriatric assessment in time for Winter 17/18 as well as make progress towards implementing 14 hour-7 day a week Ambulatory Care (adults and CYP).
- **Hospital to Home –** A&E Delivery Boards and Local Transformation Boards will be expected to make considerable improvements to reducing the number of CHC assessments in hospital (<15% by March 18) and further work will be required to maintain this during 2018/19. All local systems are expected to continue to implement the 8 High Impact Changes by March 2018 and continuing into 2018/19.

## 3. Primary Care

Primary care is fundamental to the delivery of effective healthcare, is important in tackling local health needs and the things we know our local population want to see addressed. Our aim is to put primary care on a sustainable footing for the future, while maintaining or improving the current quality of care. Our work is informed by the London Strategic Commissioning Framework and the GPFV, and focuses on localised general practice (list based care) that is underpinned by quality and consistency of care. Our intentions are:

- Continue to support provider development through supporting implementation of the 10 high impact actions in General Practice to release time for care.
- Development of primary care at scale initiatives as part of integrated locality teams.
- Develop new roles in primary care and initiatives to support recruitment and retention of the primary care workforce.
- Increase access to primary care through delivery of the extended access specification.
- Improve the use of technology in primary care such as online consultations.
- Development of estates through delivery of ETTF initiatives.
- Revised primary care contracts to support implementation of the General Practice Forward View and strategic commissioning framework.
- Achieving national requirements in relation to peer review and support to practices in making high quality referrals.

All CCGs have been conducting their PMS reviews and are on track for contract start date of 1st April 2018. Further details are in section 11.

## 4. Cancer

SWL commissioners and providers are working in conjunction with RM Partners Cancer Vanguard to implement the Cancer Delivery Plan across SWL and NWL STPs. The vision is to achieve world-class cancer outcomes for the population by 2020/21. Cancer transformation funding is now secured and being released to help implement the delivery plan.

The Delivery Plan focuses on 3 major pillars:

- **Early Diagnosis –** significantly improving survival, experience and quality of life through earlier diagnosis and treatment. This will be achieved through:
    - Ensure delivery of all the access standards set out in the NHS constitution.

- Continue to achieve and maintain the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
- Improving targeted screening (particularly bowel screening) and early diagnosis interventions through reducing variation in primary care to tackle health inequalities, deliver better access to services and outcomes. This includes raising patient awareness and acting on symptoms of cancer. Providers have already made progress to achieve 40% of first attendances by day 7.
- Work across all acute providers to deliver sustainable waiting times to access diagnostics and treatment through delivery of new pathways, (including "straight to test"), reviewing PRL processes and improving MDT arrangements.
- Complete implementation across all providers of the Prostate and lung best practice pathway: Providers to complete actions as set out in the SWL Cancer Performance Improvement Plan.
- Undertake review of head and neck pathway to optimise care.
- All providers to continue to drive improvements in PTL management and MDT resources, including delivery of 38 day trajectory, to support whole system delivery.
- All providers to continue to complete root cause analysis and share learning from 62 day breaches.

- **Recovery Package –** Improve the quality of life for people living with and beyond cancer, defining cancer as a long term condition and ensuring it is managed as such across health and social care. This will be achieved through:
    - Ensuring all elements of the Recovery Package are commissioned, including Health Needs Assessments (HNAs), completion of treatment summaries and completion of holistic cancer care reviews in the community.

- **Stratified Follow-up –** Ensure stratified follow-up pathways are in place to appropriately see patients, with a focus on breast and prostate. This will be achieved through:
    - Implementing primary care-led follow-up for stable prostate cancer patients. Planning is underway to implement the primary care led model by Autumn 2017/18 and fully embed the model by the end 17/18 and into 18/19.

## 5. Mental Health

Our ambitions within mental health are to implement the SW London Mental Health Delivery Plan, aligned to the Mental Health Forward View, and deliver the transformation of MH services across SWL.

Key initiatives for 2018/19 include:

- Phased implementation of a SW London specialist perinatal community mental health team that meets Royal College of Psychiatry and London Clinical Network recommendations
- Implementation of CAMHS transformation plans, including:

    - improving access to ensure that approximately 2,000 additional CYP receive NHS-funded community support per year (approximate calculation of SWL share of FYFV ambition)
    - Review the designated SWL Eating Disorder Service to ensure that the requirements of the Access and Waiting Time Standards are met
    - Develop and implement plans to increase numbers of CAMHS workforce to meet national target of 1,700 additional clinicians by 2020
    - Commission SWL Neuro developmental pathway for children with ASD/ ADHD by April 2018
    - Improve access to crisis response for children and young people
    - Develop provision post needs assessment for specialist CAMHS services
- Complete a demand and capacity review of community mental health services, including Crisis Resolution Home Treatment Teams; LTBs will make decisions locally about how to address findings from the review
- Review the community mental health crisis pathway improvements from 16/17 and 17/18 and take forward any recommendations or changes arising
- Deliver psychiatric liaison services which meet Core 24 standards in all acute hospitals from April 2018
- Implementation of local suicide prevention strategies and action plans; plans to be produced by December 2017
- Increase access to psychological therapies across the population, including targeting Long Term Conditions and pathways, such as diabetes and MSK
- Improve the physical health interventions offered to people with SMI
- Increase the numbers of people receiving a timely dementia diagnosis, and ensuring they receive best practice interventions following diagnosis
- Contribute to the South London forensic mental health service pilot
- Implement recommendations from London wide work on Health Based Places of Safety and the section 136 pathway
- Develop and implement local plans to increase the numbers within the mental health workforce, in line with national ambitions

In addition to the above, we will be working to improve prevention and early intervention around mental health services, and to make progress on the integration of physical and mental health services as a common theme running across all our work (including specialist mental health services). Working in partnership with CCGs, our plans will support delivery of key local priorities:

- Supporting primary care to manage and prevent admissions
- Reducing lengths of stay and improving discharge processes, enabling more care to be delivered in the community
- Reviewing step-down rehab services

## 6. Planned Care

### 6.1 St George's NHS Foundation Trust

As St George's Trust impacts on all of the SWL CCGs, and faces particular performance challenges, we will work in partnership with the Trust and other local providers, to address the planned care access issues at St George's Hospital and Queen Mary's Hospital Roehampton, seeking to ensure patients have timely access to care.

### 6.2 Effective Commissioning Initiative (ECI)

SWL CCGs are collaborating increasingly to ensure that variation is reduced for clinical threshold for procedures with limited clinical effectiveness. As part of this collaboration joint clinical thresholds (version 2.0) are being developed and agreed in 17/18. To ensure adherence, a joint prior approval system went live in July 17 for all six CCGs, developed in collaboration with providers to ensure their effectiveness. SWL CCGs are expecting approximately 20,000 procedures per annum to go through the Prior Approval System. During 2018/19, providers are expected to continue embedding internal processes to send Prior Approval requests for relevant procedures.

### 6.3 Musculoskeletal Services (MSK)

SWL CCGs have agreed a shared direction of travel for Musculoskeletal (MSK) services (Physiotherapy, Pain Management, Rheumatology and Trauma/Orthopaedics). The goal is to achieve an integrated MSK Single Point of Access with clinical assessment triage by the end of 2017/18. There is agreement to achieve as much commonality as possible in terms of specification and delivery.

### 6.4 Ear, nose and throat (ENT)

SWL CCGs will work with providers during the second half of 2017/18 to discuss a networked approach to secondary and tertiary ENT provision in order to provide consistency of access and pathway across the sector.

### 6.5 Advice and Guidance

Evidence suggests that up to 65% of patients attending outpatient specialty clinics are discharged without the need for treatment. This can waste patient's time and money. Evidence also shows that many of the unnecessary referrals can be avoided when GPs have ready access to expert clinical advice, including real time information.

'Advice and Guidance' is a tool that supports GP decision making. It is a key component of 'best practice' referral management strategy. It allows one clinician to seek advice from another before making a decision about the best treatment for a patient.

South West London CCGs currently commission advice and guidance services, (Kinesis and e-referral), which directly links GPs to local hospital consultant for rapid access to expert advice about their patients' condition.

Benefits:

- Patient - ensures that the right care and services are offered at the right time and it gives the patient confidence that their needs are being quickly assessed by clinical specialists.
- GP – support in making the right decisions for 'when and how to treat and when to refer' their patient to hospital
- Hospital - ensures that only patients that need their services are seen by the specialist, helping to reduce demand on hospital services

By using advice and guidance, we have reduced unnecessary outpatient appointments and improved financial efficiency. For every 100 patients that the GP has sought advice and guidance for their condition, we have evidence that 45 (45%) first outpatient appointments were avoided.

Currently, our GPs can receive advice and guidance from 37 different specialties across two local trusts. We want to maximise the benefits of using advice and guidance across the whole system. Our aim is to extend advice and guidance to all suitable specialties and in all our local trusts by October 2018.

### 6.6 Other areas of focus

SWL CCGs expect to transform the approach to Planned Care and Long term conditions through a phased transformation programme which aims to:

- Embed and promote health and wellbeing and empowers patients to take control of their health through self-care, self-management and shared decision making.
- Shifting care out of hospital, integrating and bringing it closer to patients through the speciality working groups.
- Workforce development across the system through education and up skilling.
- Development of Primary Care to manage demand, variation and capacity whilst improving patient care.

## 7. Maternity

South West London will provide consistently high quality healthcare to women and families, delivered by a skilled workforce that is confident in supporting both low and high risk women to have safe, healthy births. Women and families will be empowered to make informed choice of where they receive their antenatal care and preferred place of birth, increasing the availability of home births and midwifery led care. Providers will continue to deliver safe and sustainable care for women and babies who need obstetric-led and specialist care. Women and families will be able to access personalised antenatal, intrapartum and postnatal care, as well as improved access to additional support where required such as high quality and responsive perinatal mental health services.

During 2017/18, SWL Trusts and CCGs have participated in the Maternity Choice and Personalisation Pioneer, funded by NHS England. Personal Maternity Care Budgets (PMCBs) are currently being piloted by midwifery teams in each Trust across SWL, with each Trust recruiting 25 women in the pilot. "My Maternity Journey in SW London" is a booklet that has been developed to support women to make informed choices about their maternity care. It contains information on the Local Maternity Offer across SWL Trusts for antenatal, place of birth and postnatal care. It also includes questions to support personalised care planning. There will be an end of pilot evaluation by end 2017/18. It is anticipated that during 2018/19, "My Maternity Journey in SWL" is further developed into a single point of access for maternity services and rolled out across SW London.

The SWL Maternity Network evolved into the SWL Local Maternity System (LMS) from April 2017, in line with expectations from NHS England for LMS's to be established across each STP footprint. The LMS is developing its delivery plan in line with the Better Births national maternity review recommendations by end October. The draft priorities agreed for 2017/18 and onwards are as follows:

- **Personalisation and Choice -** Complete the pilot and evaluation of "My Maternity Journey in SW London" (Personal Maternity Care Budgets) by end 2017/18. Preparing women and their families for pregnancy and parenthood through consistent antenatal education and up-to-date,

evidence-based information through to the postnatal stage of the maternity pathway including supporting women to access perinatal mental health services. Women are provided with individualised care, with a focus on their needs and preferences, and supported to develop personalised care plans.

- **Continuity of Carer** – All Trusts are developing plans for roll-out of continuity of midwifery carer from 17/18 onwards. This will ensure continuity of midwifery carer throughout the pathway (initially with a focus on antenatal and postnatal care), contributing to better clinical outcomes and improved patient experience. Continuity of Carer will have a strong emphasis on promoting midwifery led care and normal birth for low risk pregnancies.

- **Improving safety of maternity services** – Reduce the rate of stillbirth, neonatal and maternal deaths and the number of brain injuries occurring during or soon after birth, in line with the national "halve it" ambition by 2030. This will be achieved through improving learning from incidents and implementing a single Maternity quality and performance framework and dashboard across SWL. This also means providing care which meets the clinical quality standards for all women and their babies, including maintaining safe midwifery and obstetric staffing levels.

- **Improving access to and quality of postnatal care and perinatal mental health services –** working across providers to level up the quality of postnatal care and availability and access to community-based perinatal mental health support. It is anticipated that funding will be available to support the increased access to perinatal mental health in 18/19.

## 8. Learning Disabilities

The South West London Transforming Care Partnership's (TCP) plan aims to support people with a learning disability and/or autism, who display behaviour that challenges, including mental health, to have the same life chances as other people, and to live as independently as possible, with the right support from mainstream health and care services.

We will achieve this through:

- Implementing the National Service Model across SWL
- Developing intensive support and crisis management mechanisms in a community setting
- Ensuring comprehensive dynamic risk registers are in place, covering adults and children, and that the registers are proactively used to manage people at risk of admission
- Through regular meetings between NHSE Specialised Commissioning, CCG commissioners and the TCP, create robust person centred plans to discharge identified in-patients from mental health institutions and delivery the TCP trajectory
- Embedding the voice of the service users, their families/carer into the programme and incorporating feedback into the work
- Ensuring the workforce in the community are appropriately trained and supported, particularly with regard to roll out of Positive Behavioural Support approaches

## 9. Children and young people

Our commissioning will focus on early intervention and prevention and to ensure that children are seen in the most appropriate settings as close to home as possible

- Strengthening community based support for children and young people for physical and mental health;
- Strengthening the provision of CAMHS including reviewing the SWL Neurodevelopmental pathway;
- Providing case management and co-ordination for children with complex needs;
- Rapid response in primary and community settings;
- Enhanced hospital front door assessment and streaming to reduce the need for admission; and
- Continue to work towards the achievement of the London CYP Acute Care Standards.

## 10.Integrated community care

A key aim of the SWL STP is to ensure that people receive the right care in the best setting, and that people can remain in their home wherever possible, which is what they tell us they want. Local Transformation Boards are driving the production of local plans to transform health and care services and deliver this objective. These plans will be locally tailored but have some common core elements which have been agreed at SWL level.

Adults with frailty and complex care needs

Across South West London this patient population use and need a diverse range of health, social care and voluntary services. They require and use services from multiple agencies, public and private sector providers, often around the clock, for multiple contacts, sometimes several times a day.

There are a range of national and regionally initiated programmes that strive to improve and transform service satisfaction, experience, safety, quality and efficiency for patients and carers. SWL commissioners and providers, working in partnership, are strategically aligning and evaluating service delivery for this patient population, using national and regional guidelines, evidence and quality standards.

Services are locally commissioned, planned and delivered, based on local demography and population need. Each local delivery group has a strategically aligned, delivery plan that is locally planned, designed and delivered against strategic themes. These themes or service principles promote person centred care, risk stratification, collaborative multidisciplinary pathways and networks and the promotion of cross organisational and geographical boundaries and digital technologies to share information.

These programmes comprise: Enhancing Care in Care Homes (National Vanguard) including specific schemes such as rolling out the red bag, Continuing Health Care and End of Life Care. They are closely aligned with locality teams and intermediate care.

Locality teams

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

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

- Establish locality based MDTs managing populations of at least 50,000; risk stratification and cross system working to proactively manage identified cohort in the community
- Embedding effective care planning processes within the locality team, including integrated care plans, personalised outcomes and regular MDT reviews

Integrated intermediate and crisis care

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

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

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

# 11. Further local priorities

## 11.1 Croydon

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| **Health profile** | ▪ Growing population from 386,300 in 2017 to 422,700 by 2027, an increase of 9%<br>▪ Increasing younger population: The latest population projections estimate that the number of people aged under 18 will increase by 7% over the next ten years, from 95,200 in 2017 to 102,200 in 2027.<br>▪ Life expectancy is increasing, bringing an aging population: life expectancy at birth in the borough has risen from 76.8 years in 2001-03 to 80.4 years in 2013-15 for males, and risen from 80.7 years to 83.4 years in the same time period for females. The latest population projections estimate that the number of people aged 65 and over will increase by 28% over the next ten years, from 51,200 in 2017 to 65,500 in 2027<br>▪ Life expectancy is 9.7 years lower for men and 6.1 years lower for women in the most deprived areas of Croydon than in the least deprived areas<br>▪ An estimated 17.1% of adult smoke and an estimated 66.0% of adults are overweight or obese |
| **Strategic context** | The strategic context within which these are set include:<br>▪ The Five Year Forward View and the STP<br>▪ The Strategic Review of the Croydon Health and Care System and the development of an accountable care system<br>▪ Building stronger relationships and partnerships both locally and across South West London.<br>▪ Whole system transformation programmes across all care groups to create a sustainable system through strong clinical and managerial leadership.<br>▪ Reviewing further joint commissioning opportunities with Croydon Council<br>▪ Embedding Outcomes Based Commissioning<br>▪ Embedding of health and wellbeing programmes across the local population<br>▪ RightCare Benchmarking and variation against peer CCGs.<br><br>Following the Strategic Review of the Croydon Health and Care System undertaken with McKinsey & Co commissioned by the CCG and CHS, the Croydon Transformation Board has accepted the findings as the roadmap for the system wide response, including the development of an Accountable Care System. An Accountable Care System will need to lead transformation which delivers on both commissioner and provider efficiency requirements. A vision and plan for implementation will be developed over the next month. This direction of travel will further influence our commissioning intentions, our potential contract model as well as the consolidation of functions. Detailed discussion with providers will be needed regarding the move to future **contracting options** e.g. a block contract, and agreed risk share for 2018/19. A key principle of those discussions will be to ensure that we can collectively focus on delivering the necessary system wide transformation. |
| **Financial context** | ▪ The CCG has to deliver an efficiency target of £45.7m over a period of 2 years (2017/18 – 2018/19)<br>▪ CCG has a 2017/18 deficit target set by NHSE of £6.9m.<br>▪ This is underpinned by a £29.3m QIPP programme - £21.2m identified and £8.1m not yet identified<br>▪ There is a significant risk to the 2017/18 position around QIPP delivery:<br>  ▪ slippage on OOH / Planned Care transformation<br>  ▪ no plans currently in place to deliver the £8.1m unidentified<br>▪ For 2018/19 CCG is required to breakeven (£nil deficit). Based on current growth assumptions, this would require a QIPP programme of £24.5m. Any slippage to the 2017/18 position would increase the QIPP gap for 2018/19.)<br>▪ NET £24.5 million **QIPP** saving for 2018/19 (£10m FYE and £14.5m new). The full year effect for all our current Planned and Urgent Care schemes is £11.6m (gross) and £2.6m for mental health<br>Cross cutting enabling programmes: governance and system optimisation, digitisation, analytics and public health, communications and engagement, OD (Workforce), medicines management, capital and estates |
| **Procurement** | We will be reprocuring the following intermediate services: Community Ophthalmology Services and ENT. We will be re-procuring the beds required to support the Community Intermediate care service (CICS). We will be reviewing the remaining intermediate services to ensure full integration into our transformation plans: Anticoagulation, Dermatology, Gynaecology and MSK |

## Croydon summary

Through an ambitious programme of innovation

Through working together with the diverse communities of Croydon and our partners

Through using our resources wisely

We will transform healthcare to help people look after themselves and when people need care they will be able to access high quality services

Croydon LDU will deliver….

| Commissioning Intentions 2018/19 | Impact |
|---|---|
| **Outcomes Based Commissioning**<br>The OBC Transformation Plan covering years 2-10 is currently still being drafted. However, the emerging scope of the plan is set out below. Further discussion is underway to ensure this links across to work streams for the under 65 population to ensure an integrated approach:<br>▪ Planned Care & Repatriation<br>▪ Care Homes<br>▪ Falls, Frailty & End of Life<br>▪ Mental Health & Wellbeing<br>▪ Active & Supporting Communities (i.e. Social Isolation)<br>▪ Workforce Reform & Organisational Development | ▪ Reduced activity in an acute setting<br>▪ Increased self-care and self-management<br>▪ Increased activity in the community<br>▪ Improved personal outcomes |
| **Urgent and emergency care**<br>▪ Improving Quality & Performance through:<br>  ▪ Providing clinicians with Alternative Care Pathways (ACPs) that will give patients more appropriate setting than attending ED<br>  ▪ Increasing staff rotation across the full Urgent & Emergency Care (UEC) service in Croydon<br><br>▪ Continue integrated working by :<br>  ▪ Collaborate work with SWL partners to develop Hot Clinics that reflect and support community needs<br>  ▪ Working with LAS to review Category Red pilot processes including use of motorbike paramedics, to reduce ambulance response times<br>  ▪ Creating a better process for safeguarding adults and children across the UEC service<br>  ▪ Improved engagement and communication for the people of Croydon & NHS staff of UEC services | ▪ Reduced unnecessary admissions<br>▪ Reduced ED attendance<br>▪ Reduced NEL admissions |
| **Primary care**<br>▪ Increase GP involvement in coordinated care planning through commissioning additional appointments, care planning and support services<br>▪ GPs actively creating My Life Plans using Coordinate My Care<br>▪ Peer Review of Referrals and increasing use of E- Referral<br>▪ Commissioning new models of care i.e. Huddles & Integrated Care Networks<br>▪ PMS review focusing on key clinical conditions for Croydon's Population<br>▪ Enhancing primary care skills and capacity to support out of hospital care<br>▪ Reviewing Locally Commissioned Services | ▪ Delivery of primary care at scale<br>▪ Transfer of care into the community<br>▪ Proactive, coordinated care<br>▪ Increased capacity in primary care<br>▪ Increased self-care and self-management<br>▪ Reduced variation of care and treatment<br>▪ Contribution to QIPP target |
| **Planned care**<br>▪ Consider opportunities repatriation of activity.<br><br>This programme of work to deliver **QIPP efficiencies** to the value of £22m over a period of 2 years (2017/18 – 2018/19 is:<br>▪ **Phase 1** - MSK/T&O, ENT, Dermatology, Gynaecology & Ophthalmology<br>▪ **Phase 2** - Diabetes, Urology and Digestive Diseases<br>▪ **Phase 3** - Cardiology, Respiratory, Neurology and Cancer<br>▪ **Phase 4** – Other specialities including general medicines, general surgery | ▪ Increased capacity in primary care<br>▪ Increased self-care and self-management<br>▪ Reduced variation of care and treatment<br>▪ Potential repatriation of activity into Croydon<br>▪ Contribution to QIPP target |

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| | | | | | **Mental health**<br>The Local Vision for Service Delivery of mental health services is: enhanced crisis services that include preventative support, increased integration with the Local Authority to manage step down and residential placements, enhanced primary care and integration between secondary and primary mental health, increased community provision, effectiveness of teams and reduced acute activity. The key priority areas are:<br>▪ Continued emphasis on reducing LoS and improving discharge processes<br>▪ Exploring how to deliver more care in the community<br>▪ Supporting Primary Care with management and prevention of admissions<br>▪ Review and redesign step down rehab services with a focus on in borough provision | ▪ Reduced length of stay<br>▪ Increased hospital admission avoidance<br>▪ Care closer to home |
| | | | | | **Children's Mental Health**<br>▪ Implement Local Transformation Plan for children's mental health services including improve access for CYP in crisis via out of hours service<br>▪ Maintaining the current waiting times for urgent and routine access to mental service assessment and treatment<br>▪ Improving the responsiveness of the Neuro/ASD Pathway to ensure that we meet the National Waiting Time Targets<br>▪ Continue to develop the Single Point of Access, with a view to further integrate assessment with MASH for CYP with multiply vulnerabilities<br>▪ To further enhance the LA parenting programmes with specialist provision for CYP with challenging behaviours, diagnosis of either ASD/ ADHD and supporting parents with a personality disorder to parent effectively<br>▪ Develop an integrated response across statutory and voluntary sector services for CYP with multiple vulnerabilities, with a view of preventing escalation into T4 services<br>▪ To support ED and social care staff to ensure services support CYP that are the victims of violent physical and sexual assault<br>▪ Ensuring at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019<br>▪ Integrating the physical and mental health needs of Looked After Children into one care pathway<br>▪ Development of more integrated/aligned social care referral and treatment routes.<br>▪ Scoping of shared working protocols and assessments for families and CYP with multiple acute vulnerabilities. | ▪ Better after care and support for young people who experience mental health problems<br>▪ Improved access to community eating disorder services<br>▪ Reduction in wait times<br>▪ Improved outcomes for CYP in crisis<br>▪ Reduced DNA |
| | | | | | **Children and Young People**<br>Implement children's health transformation programme including:<br>▪ Develop and agree a model for community and acute paediatrics with CHS<br>▪ Develop a new pathway for diagnosis of autism spectrum disorder<br>▪ Recommendations from review of health services for children with SEN and Disability including opportunities for further integration with the Local Authority<br>▪ Exploring pathways for children with long term conditions within the children's transformation programme | ▪ Reduced waiting times for ASD diagnosis medical services |
| | | | | | **Learning disabilities**<br>▪ To ensure commissioned specialist SLAM MHLD services and the CHS Community Learning Disability team effectively deploy additional resources allocated to provide care coordination for current in patients and people in transition as well as assist with risk management, admission avoidance strategies and intensive support/management across the system<br>▪ To work with MH and forensic commissioners to ensure pathways are inclusive of people with LD as appropriate and to reduce reliance of specialist inpatient care<br>▪ To commission providers (with social care) who can enhance community provision for people with learning disabilities and/or autism.<br>▪ Work with SLAM to ensure that adult mental health services to make reasonable adjustments to support people with MH and LD under the Green Light Toolkit<br>▪ To further explore opportunities to integrate specialist Mental Health, the community LD team and social care pathways for people with LD and complex needs. | ▪ Improved quality of life for people with LD<br>▪ Improved access to wider health care services<br>▪ Greater parity of access for people with LD to primary and secondary care<br>▪ Reduction of inpatient use for people with LD<br>▪ Increased health checks for people with LD |

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| | | | | | **Out of Hospital**<br>The priority for the CCG in 2018/19 will be delivering the out of hospital strategy with alliance partners. Working with alliance partners in 2018/19 the CCG will lead on:<br>▪ Continued development of the Integrated Community Networks (ICNs) and Complex Care Support Team (CCST),<br>▪ LIFE programme initiatives such as discharge to assess, and integrated reablement and intermediate care teams.<br>▪ Continued development of the role of the Personal Independence Coordinators (PICs),<br>▪ Re-procurement of the beds required to support the Community Intermediate care service (CICS).<br><br>A system wide approach to how falls are managed will focus on:<br>▪ Early identification of susceptibility to Falls<br>▪ Promoting Healthy living over 65s – Keeping fit & healthy<br>▪ Centralised and comprehensive Falls service and community bone health<br>▪ Proactive case management and Osteoporosis Advice & Management in the Community<br>▪ Medication reviews<br>▪ Other services (Careline /TH/Counselling, LAS Alternate pathways)<br><br>There will be a number of new initiatives for supporting care homes, including:<br>▪ A team to provide advice to GPs and care home staff,<br>▪ Exploring the role of vocational education aligned national developments,<br>▪ Exploring possibilities for better use of IT in care homes, and<br>▪ Considering integration of clinical work with the practice development role<br><br>Partnering with St Christopher's Hospice, Marie Curie, and others, the CCG will:<br>▪ Deliver End of Life Care (EoLC) training and education to all care homes<br>▪ Deliver a community engagement programme, providing events and training volunteers on EoLC to converse and normalise dying matters<br>▪ Make further training available to health and social care professionals<br>▪ Integrate EoLC into all out of hospital initiatives with alliance partners | ▪ Reduced A&E attendances and non-elective admissions<br>▪ More services in the community<br>▪ Patients are treated as close to home and living as independently as possible<br>▪ Reduction of deaths in hospitals (EoL) |
| | | | | | **Medicines Management**<br>▪ Maximising biosimilars includes continued work with rheumatology, IBD and diabetes services.<br>▪ Collaborative working to improve adherence and reduce waste.<br>▪ Supporting the care home initiative and high cost patients<br>▪ Reducing Medicine related admissions-Eclipse, high risk patient reviews attending huddles.<br>▪ Maximising opportunities for fall preventions with medication reviews.<br>▪ Continuation of the intentions set out in last year's SWL High Cost Medicines Commissioning Letter | ▪ Reduction in medicines waste |

## 11.2 Kingston & Richmond

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| **Health profile** | Richmond<br>• Life expectancy at birth: 82 years for men and 85.4 years for women<br>• Over 10,000 A&E attendances for under 5 year-olds – significantly higher than both the England and London averages<br>• Highest in London for young people displaying multiple risky behaviours (22%); 15-year-olds drunk in the previous month (25%); tried smoking tobacco (36%) and cannabis (19%)<br>• Third highest rate of hospital admissions for self-harm in 10-24 year-olds in London<br>• 18,000 adults are estimated to smoke<br>• Nearly one in ten has three or more long term conditions<br>• 28,900 to 43,100 – the projected increase in number of over 65 year-olds between 2015 and 2035 (almost 50%)<br>• An average of 4 admissions in the last year of life for those aged 85 years and over; and who died in hospital (including the terminal admission).<br><br>Kingston<br>• Life expectancy at birth (2013-15) : 81.5 years for men and 84.5 years for women<br>• 7,440 A&E attendances for under 5 year-olds (2015/16) – significantly higher than England average<br>• Prevalence of obesity in 2015/16 for reception year was 5.5% and that in year 6 was 17.0% (nearly 3 times)<br>• 15 year olds, 2014/15: Percentage with 3 or more risky behaviours (13.0%), Percentage who have ever tried cannabis (10.9%), Percentage who have tried other tobacco products (20.8%), Percentage who have been drunk in the last 4 weeks (15.3%)<br>• Ranks Seventeenth in London for rate of hospital admissions for self-harm in 10-24 year old (2015/16)<br>• In 2016, 13.8% adults were estimated to be smoking, around 19,000 adults aged 18 years and above.<br>• 23,000 to 35,900 – the projected increase in number of over 65 year-olds between 2015 and 2035 (almost 56.1%)<br>• Percentage of deaths in hospital in 2015, persons, aged 85 years and over = 222 (45.6%) |
| **Strategic context** | • As an overriding principle behind our commissioning intentions, Kingston and Richmond LDU will work with partners, through the Local Transformation Board arrangements to achieve financial and clinical sustainability across the health and care system.<br>Our priorities for this work in 2017-18 will be:<br>○ The five year forward view and the STP.<br>○ To agree a comprehensive work programme and implement the pathway changes across the partner organisations by March 2019.<br>○ To model and implement the bed base changes according to agreed assumptions. |
| **Financial context** | • The forecast outturn for 2017/18 is in line with the targets set by NHSE.<br>• This is underpinned by a £24m QIPP programme across the two CCGs in 2017/18.<br>• There is a significant risk to the 2017/18 position around QIPP delivery, in relation to our transformation programmes. We are working with partners to try and close our QIPP gap.<br>• For 2018/19 the LDU is anticipating a QIPP programme in the region of £20m across the two CCGs. Any slippage to the 2017/18 position will increase the QIPP gap for 2018/19. |

## Kingston & Richmond summary

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| Through involvement of patients and carers | Through working in partnership with stakeholders | Through effective integration with social care and the voluntary sector | Through making best use of our people, buildings and digital opportunities | Kingston and Richmond CCG LDU will deliver…. | **Urgent and emergency care**<br>• Commission an ambulatory model of care at Kingston Hospital and across the out of Hospital pathways in Kingston. Agreeing a timescale and implementation plan to increase the type and amount of ambulatory activity seen in 2018/19<br>• Agree and implement an Urgent Care Treatment Centre which aligns to the 0 to 1 Length of Stay pathway and supports the whole urgent and emergency pathway and supports sustainability across the system<br>• Commission pathways between the Urgent Treatment Centre's and primary care that will prevent unnecessary attendances at A&E and support system sustainability.<br>• We will be reviewing the activity on the less than 2 day length of stay activity associated with Clinical Decision Unit admissions to ensure the opening of the unit has not increased unnecessary admissions. | • Reduced NEL admissions<br>• Reduced attendances in ED<br>• Reduced emergency activity |
| | | | | | **Primary care**<br>• Kingston have in place one local contract named Kingston Medical Services that combines the KMS and LCS funding into one contract that supports a range of local KPIs supporting service transformation<br>• We will implement a review of PMS practices.<br>• Continue to use the levers in delegated commissioning to drive up quality in primary care and achieve the best outcomes for patients and value for money.<br>• Continue the programme of work addressing variation in primary care including OP referrals, NEL admissions, A&E attendances and health outcomes.<br>• In 2018/19 Kingston and Richmond CCG will implement the outcomes of the Quality in Primary Care engagement programme.<br>• Support technology based access to primary care advice<br>• Recommission the Kingston model of extended primary care services to include the interoperability standards as set out in the National Urgent Treatment Centre guidance<br>• Recommission the Richmond Primary Care Centre and Walk in Centre sited at Teddington Memorial Hospital potentially as one integrated extended primary care service that provides both bookable and walk in appointments<br>• Develop and implement a systematic approach to improving workforce development, introducing and expanding student placements and co-ordinating access to continuing personal and professional development (CPPD) for all staff.<br>• Continue to support the development of the local GP federations Richmond GP Alliance and GP Chambers to enable both to provide universal high quality primary care services and support the STP primary care and out of hospital objectives<br>• Pilot a Referral Management Programme - The aims to provide the capacity to practices to peer review referrals to outpatient appointments before the referral leaves the practice.<br>• Develop Enhanced Care Management to reduce the number of avoidable attendances at A&E and the number of unplanned admissions (Non Elective)<br>• To commission direct access phlebotomy from primary care | • Repatriation of outpatient follow-ups to primary care<br>• Increased capacity in primary care<br>• Reduced variations in outcomes between practices<br>• Increased resilience in primary care by operating at scale<br>• Increase in self-management |
| | | | | | **Mental health**<br>• Re-procure Primary Care Mental Health and Substance Misuse services<br>• Review community mental health service provision<br>• Implement a Locally Commissioned Depot prescribing Service where GPs can prescribe depot medication in primary care with the aim of removing a stable cohort of secondary care caseload into primary care.<br>• Implement annual physical health checks for patients with serious mental illness (SMI) who do not routinely attend for annual health checks<br>• Re-commission a shared Learning Disabilities specialist health service for Richmond and Kingston<br>• Implement a pilot to work with police officer to reduce 136 presentations/admissions especially for Physical Disabilities across Kingston and Richmond.<br>• To implement an Outcome Based service model for Mental Health services in Richmond with payment linked to the delivery of outcomes<br>• Design and agree contract model in line with NHSE guidance for Mental Health Improving Access for Psychological Therapies. | • Reduction in unnecessary emergency attendances to ED<br>• Improved access to community mental health services<br>• Improved quality of care for LD and SMI |

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| | | | | | **Children and young people**<br>• Commission a paediatric Enuresis service to address a service gap.<br>• Children's and Adolescent Mental Health Services (CAMHS) - Transformation - ADHD Nurse. To provide community based nursing support and medication for those families with Children and Young People with a diagnosis of attention deficit hyperactivity disorder (ADHD).<br>• Commission CAMHS Early Intervention for under 5s service. The Early Intervention and Prevention services aim is to support parents in the care of their children and foster good attachment and healthy development for children under five, encouraging them in a more positive and healthy trajectory.<br>• Commission an Enteral Feeding service to provide dietetic service to special needs schools, Joint MDT clinics, specialist MDT feeding clinics and also provide domiciliary & community based visits to families within the Kingston and Richmond Boroughs. The service will also help various staff to improve the identification of children who are at risk of malnutrition (including over and under nutrition).<br>• Commission Psychological Wellbeing Counsellors to increase access to evidenced based treatments<br>• Recruit to train Autism spectrum disorder / Learning Disabilities CAMHS workers to increase access to evidenced based treatments<br>• Re procure paediatric speech and language therapy services | • Better after care and support for young people who experience mental health problems<br>• Improved access to community services<br>• Reduction in wait times<br>• Improved outcomes for CYP in crisis |
| | | | | | **Planned care**<br>• Review of Core Podiatry (provided by AQP providers) to ensure patients with the appropriate medical conditions and need gain access for podiatry assessment and treatment<br>• Implement a new model of Dermatology care to improve efficiency in service and patient care<br>• We will be reviewing all outpatient specialties by April 2018 and will work with the acute trust to redesign pathways to reduce the number of patients seen in secondary care through 2018/19<br>• Re-commission direct access phlebotomy from primary care<br>• Implement a new model of ophthalmology care across Richmond and explore the provision in Kingston<br>• Commission services in primary and community care for patients with stable long-term conditions including, diabetes, heart failure and respiratory problems. | • Reduction in new and Follow-up out patients<br>• Reduction in elective procedures due to improved community management<br>• Reduction in unnecessary diagnostics |
| | | | | | **Integrated community care**<br>• Building on the Kingston Co-ordinated Care programmes of work we will, in partnership with Royal Borough of Kingston, commission an integrated person centred model of health and care to deliver care at home and closer to home (focussed on community health and adult social care services)<br>• Develop and roll out of locality multidisciplinary teams to care plan and manage people with long term conditions. This will support a shift in activity from acute and mental health secondary care to primary /community care settings. This will also reduce delayed transfers of care.<br>• Continue to build the capacity and capability within community through our healthy active communities to support self-management and reduce non-elective admissions.<br>• Within Richmond we will continue to work with our transformation partners to deliver the outcomes based commissioning to strengthen our community services to support more people through the development of locality teams and multi-disciplinary working.<br>• Avoid unnecessary admissions to hospital through improved management of long term conditions, embedding new pathways of care developed in 2016/17 and supporting people to return home as quickly as possible after an admission.<br>• Improve the care model for the most vulnerable people in our communities, specifically those in care homes (in line with enhanced health for care homes) and those people within the last year of life to avoid unnecessary admissions. | • Reduction in NEL admissions<br>• Reduction in ED attendances<br>• Reduced number of deaths in hospital<br>• Improved resilience in community services |

## 11.3 Merton and Wandsworth

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| **Health profile** | • Significant health and social inequalities in both boroughs with an associated gap in life expectancy (up to 9% for men living in the most deprived areas of Wandsworth)<br>• Population growth across both boroughs, particularly for under 16s and over 65s. With a significant number living in deprived circumstance.<br>• Growing BME population, particularly in East Merton and Tooting where over half the population is from a BME group. Disproportional representation of BME groups among Job Seekers Allowance claimants.<br>• Alcohol related hospital admissions remain high; although below the London average. With many patients being treated concurrently for MH conditions.<br>• High proportion of 25-39 year olds, particularly in Wandsworth which has highest number of any local authority, this impacts on preferences for how services are accessed.<br>• Increase in the number of adults living alone, leading to increase demand for homecare support.<br>• Higher than average mortality among under 75s, predominantly as a result of cancer and CVD |
| **Strategic context** | • For the first time Local Transformation Boards (LTBs) across SWL will be overseeing the development and delivery of sub regional commissioning intentions aligned to year two of the SWL 17/19 commissioning intentions. Commissioners in the Merton and Wandsworth LDU are signalling a move towards an agreed set of priorities which will be delivered in partnership by commissioners and providers over the next year. The 18/19 priorities will build on the partnership working already underway this year and overseen by the Emergency Care and Planned Care Delivery Boards.<br>• While there is agreement that transformation can bring longer term benefit to patient care and affordability, it is also understood that it can create financial risk or pressure for individual organisations in the short term. We need to find ways to work around short term disincentives and to manage financial risks and benefits in a fair and transparent way across the local health and care economy. Work is needed to explore an LTB partnership agreement which would allow further development of system wide working, setting out clear principles and a framework for allied contracts and risk benefit sharing.<br>• The initial opportunity is to create a single system wide CQUIN for 18/19 which would allow us to test the approach before embarking on a wide risk/benefit sharing agreement. This would signal a move away from small scale commissioner QIPP schemes towards system wide ownership of large scale transformation programmes which bring longer term benefits. Through a more transparent and inclusive planning process we would like to change the way we negotiate contract baselines by having a shared understanding of areas where activity can be reduced, both through improved community support and timely inpatient flow and discharge. We will explore opportunities for minimum income guarantee and block arrangements where we have shared plans for managing demand. |
| **Financial context** | ▪ The forecast outturn for 2017/18 is in line with the targets set by NHSE.<br>▪ This is underpinned by a £32m QIPP programme across the two CCGs.<br>▪ There is a significant risk to the 2017/18 position around QIPP delivery, particularly in relation to the planned care transformation.<br>▪ For 2018/19 the LDU is anticipating a QIPP programme in the region of £40m across the two CCGs. Any slippage to the 2017/18 position will increase the QIPP gap for 2018/19. |

## Merton and Wandsworth Summary

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| Through involvement of patients and carers | Through working in partnership with stakeholders | Through effective integration with social care and the voluntary sector | Through making best use of our people, buildings and digital opportunities | Merton / Wandsworth LDU will deliver…. | **Urgent and emergency care**<br>Our commissioning will focus on avoiding admissions through improved crisis response in the community and robust front door streaming to appropriate care pathways;<br>• Embed robust reporting on agreed front door pathways (AEC, older adults, paediatric assessment, psychiatric liaison, primary care, UTC), based on activity targets set in 17/18 front door streaming CQUIN<br>• Extend the frequent attenders initiatives<br>• Increase access to rapid response home visits within 2 hours, ensuring 7 day availability and integration with OOH service<br>• Undertake a demand and capacity review of bedded intermediate care to inform future commissioning decisions<br>• Commission a multi-agency Integrated Discharge Team to manage all complex hospital discharges at SGH | • Significant improvements to pathways and quality of care leading to:<br>• Significant reductions in A&E attendances<br>• Reduction in emergency admissions, particularly for those with frailty and complex needs<br>• Reduction in DTOC and LoS |
| | | | | | **Primary care**<br>Our commissioning will focus on equitable access to an enhanced range of primary care support, enhancing capacity through working at scale, developing the primary care workforce and harnessing digital innovation:<br>• Continued development and expansion of the MCP model in each Borough<br>• Ensuring delivery of high quality primary care through a Primary Care Quality Contract, Protected Learning Time initiatives and use of Resilience funding<br>• Roll out of e-consultation software and continued promotion of Patient Online<br>• Expansion of social prescribing initiatives including the Self-Management Service and Wellbeing hub model to include practice based patient navigators<br>• Review and extension of Primary Care Diagnostic Services – ensuring that all patients have access to a range of diagnostic services locally | • Improved access to primary care<br>• Greater resilience within primary care<br>• Greater demand management capability leading to fewer referrals to hospital |
| | | | | | **Mental health**<br>Our commissioning will focus on enhancing primary and community support, improving access to effective crisis response, shorter admissions and better outcomes through effective rehabilitation;<br>• Integrated commissioning for children and young people with multiple needs, with a particular focus on Children Looked After and those requiring behaviour support packages<br>• Enhancing integration of community mental health services with primary care, through extending the Primary Care Plus model. | • Improved outcomes for children and young people with complex multiple needs. Likely to result in fewer emergency attendances<br>• Improved access to the right services at the right time. |
| | | | | | **Children and young people**<br>Our commissioning will focus on strengthening community based support for children and young people, providing case management and co-ordination for children with complex needs, rapid response in primary and community settings and enhanced front door assessment and streaming to reduce the need for admission:<br>• Proactive case management and integrated care planning for children with complex needs and LTCs,<br>• Increase rapid response home visits for children 0-5, 24/7<br>• Embed a Hospital at Home model for admission avoidance and early discharge<br>• Embed integrated commissioning arrangements for children with EHC plans and continuing care needs<br>• Increase uptake of personal health budgets<br>• Implement new model for community based paediatric outpatient care, with an emphasis on care closer to home and integration<br>• Review school based therapies service<br>• Embed robust KPIs for all services commissioned by CAMHS transformation funding<br>• | • Reductions in emergency admissions for children<br>• Reduction in A&E attendances for children<br>• Improvements in access and speed of service provision for children with complex needs |

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| | | | | | **Planned care**<br>Our commissioning will focus on delivering better outcomes through integrated primary and community based care and timely access to acute care and treatment wherever clinically appropriate;<br>• Reduce practice variation in referral thresholds through standardised pathways and guidance<br>• Further roll out community models for holistic management of LTCs<br>• Implement the new models of care developed through the 17/18 planned care CQUIN<br>• Baseline the activity reductions agreed in Q3 of the 17/18 planned care CQUIN<br>• Extend the new multiple LTC clinic model to include further specialties (rheumatology, respiratory and diabetes)<br>• Extend the SGH clinical hub model to streamline outpatient pathways and increase one stop clinics.<br>• Extend diabetes community model to management of other LTCs including COPD and CVD<br>• Develop community pathways for paediatrics, ophthalmology, dermatology and urology | Significant reduction in referrals to hospital for common conditions, leading to a reduction in first outpatient attendances<br>Reduction in outpatient follow up appointments<br>Improved clinical outcomes through more accessible community based services leading to a potential impact on elective admissions |
| | | | | | **Integrated community care**<br>Our commissioning will focus on extending the number of people with complex needs managed by multi-disciplinary locality teams, providing proactive ongoing care and effective step up and step down support;<br>• Extension of rapid access clinics at QMH and Nelson<br>• Reduction of bedded intermediate care beds<br>• Increased access to integrated health and care reablement<br>• Rapid response in reach to nursing homes<br>• Extension of medicines use reviews | • Significant improvements to pathways and quality of care leading to:<br>• Significant reductions in A&E attendances<br>• Reduction in emergency admissions, particularly for those with frailty and complex needs<br>• Reduction in DTOC and LoS |

## 11.4 Sutton

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| **Health profile** | Sutton has a registered population of 198,000. This number is projected to rise to around 223,300 by 2024 The proportion of young children in Sutton is projected to rise through to 2024. The proportion of older children in Sutton is projected to increase by 2024. At time of the 2011 census there were 34,523 older children aged 5 to 19. The proportion of working age people in Sutton is projected to rise over the next decade. People aged 85 and over account for 2% of the population in Sutton, similar to London and England.<br>The borough is moderately affluent with health outcomes among the best in London. Life expectancy is higher than average. However there are significant differences with and between wards in the borough. i.e. Nonsuch/Cheam are amongst the 20% least deprived wards in London whilst Beddington South/Sutton Central are among the 20% most deprived.<br>Sutton CCG spends more on prescribing and inpatients than similar areas of London. Across the CCG, prescribing expenditure rates range from £90 per head to £150 per head. The CCG spends significantly more on inpatient care for respiratory illness than similar areas of London.<br>The majority of deaths in the borough occur from Cancers – with up to 40% cause of loss of life per year. Circulatory Disease accounts for a further 29% of deaths, although this is significantly lower than the national average for heart disease and stroke.<br>Sutton continues to have high numbers of residents suffering from long term conditions, particularly Diabetes, COPD and coronary heart disease. We must therefore work to minimise the morbidity and mortality associated with these conditions, as well as concentrating on key risk factors for these conditions such as smoking, obesity and risky drinking behaviours to prevent increasing levels of disease in the future. |
| **Strategic context** | Sutton CCG is part of SWL STP CCGs but has developed local commissioning intentions to meet the specific needs of our population. We regularly engage with different stakeholders from our GP members to specific patient groups to determine where there are gaps in our services and what we need to commission in order to improve the quality of services we offer. In the last year 2016/17 we have been developing new models of care that look at both health and social care requirements of individuals so that we can develop integrated, person centred services. We are working into 2018/19 with our LTB to ensure that a new model of care is put into place that works with partners to develop accountable care for the Sutton population. The Sutton Health & care model is being developed to ensure those people with the greatest need receive a holistic, multidisciplinary service that works collaborative across partners with the patient at the centre.<br>Working across our partners in health and social care has enabled the CCG to develop a set of commissioning intentions that effectively meet the needs of our local residents in a way that is affordable, sustainable, of high quality and allows us to deliver our QIPP efficiencies and continue to improve performance against national targets. |
| **Financial context** | Sutton CCG ended 2016/17 in a balanced position but for 2017/18 has a gross QIPP savings requirement of £13.4 million in order to achieve plan, for 2018/19 we will need an additional QIPP delivery of £5.2m. Therefore continued work is being done through 2017/18 and into 2018/19 to ensure that the CCG is sustainable and contributes to the SWL financial challenge. We will continue to challenge ourselves and to gain the most value from all our contracts and we will work jointly with our providers to ensure we are making savings to re-invest into new models of care and innovative ways of working. The CCG has developed a QIPP strategy which sees dedicated clinical leads in a number of priority areas, we also have a joint QIPP/CIP board with ESTH to look at areas where we can make greater gain across the system by aligning cost saving plans. |

## Sutton summary

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| Through involvement of patients and carers | Through working in partnership with stakeholders | Through effective integration with social care and the voluntary sector | Through making best use of our people, buildings and digital opportunities | Sutton CCG and ESTH LDU will deliver…. | **Urgent and emergency care**<br>Our commissioning will focus on the joint work of our LTB partners to implement the Sutton Health & care model. Working firstly on a reactive model to avoid admissions and discharge patients in a timely manner. Other programmes of work include.<br>• Reviewing the UCC pathways that stream patients into a primary care setting and embedding this with the ESTH primary care streaming re-development project<br>• Reviewing and extending the frequent flyers initiatives worked up in 2017/18<br>• Undertake an in year review of our intermediate care beds<br>• Look at links across IUC and ED OOH provision to ensure full integration and efficiency<br>• Ensure the 'red bag' Sutton Vanguard scheme continues to impact on LOS and admissions to hospital. | • Reduced ED attendances<br>• Reduced hospital admissions<br>• Improved patient quality<br>• Reduced NEL admissions<br>• Keeping patients healthier at home |
| | | | | | **Primary care**<br>Our commissioning will focus on proactive care and enhanced capacity working at scale using our GP federation and pursuing work-streams that streamline patient care and offer greater quality of care, this will include.<br>• Continued development of the proactive model of care undertaking MDT approach<br>• Increased use of risk stratification tools to identify relevant patient cohorts<br>• Further work in the SIDCR – Sutton Integrated Digital Care record to enable clinicians to utilise more patient information across services<br>• Roll out and evaluation of social prescribing across health and social care including a greater emphasis on self-care and wellbeing<br>• Continued development and enhancement of extended hours access services<br>• Continued work on estate projects for primary care. | • Sustainable and improved primary care<br>• Increasing proactive patient care<br>• Reduction in patient admission and attendance at hospital<br>• Reduced variation of care<br>• Greater resilience and capacity in primary care |
| | | | | | **Mental health**<br>Our commissioning will focus on joining up approaches to physical and mental health management including those that fit with the Sutton Health & Care model. Improving access to effective crisis care and ensuring that admissions are reduced and that there is suitable support upon discharge.<br>• Continued work on dementia and IAPT national objectives and ensuring community MH provision can meet the demands of increased access by looking at innovative ways to work with different patient cohorts.<br>• Continued work on self-harm and suicide across Sutton using a multi-agency approach. | • Reduction in hospital admissions<br>• Greater resilience in crisis response for MH in Sutton |
| | | | | | **Children and young people**<br>Our commissioning will review all children and young people's services, including the main partnership approaches to working with children and especially complex children to ensure we have the right services in the right places to meet demands. This includes<br>• Continued work on ASD/ADHD pathway to meet growing demand and waiting lists<br>• Review 10 paediatric pathways into ED and set out guidance and update training for GPs by their hospital colleagues<br>• Review the requirements of complex children and how current specifications meet those requirements<br>• Develop a Sutton wide CAMHS transformation plan to jointly use as a blueprint for progressing children's services moving forwards. | • Reduced waiting times for ASD/ADHD<br>• Wider proactive support for self-harm and suicide<br>• Reduction hospital admission and attendances<br>• More joined up services for CAMHS |

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| | | | | | **Learning disabilities**<br>Our commissioning for Learning Disabilities will build upon the work undertaken as part of the LD Summit undertaken with all stakeholders in March 2017 to design services that are simple to navigate, effective and easy to access.<br>• Review the LD clinical health team and how it fits into other LD services in Sutton<br>• Ensure we have strong processes in place for people with LD so they can access the right services to support their health needs. | • Improved health outcomes for people with LD<br>• Greater parity of access for people with LD across primary and secondary care<br>• Improved local offer for people with LD |
| | | | | | **Planned care**<br>We will continue to work closely with ESTH through our QIPP/CIP group on planned pathways, to ensure we have the most efficient and effective pathways in place, reducing outpatient appointment and where appropriate moving care to a community or primary care setting. These include the following pathways.<br>• Diabetes<br>• Respiratory<br>• Gynaecology<br>• ENT<br>• Dermatology<br>We also wish to explore different ways of working including new and innovative health based technology that could benefit patients. | • Reduction in out-patient new and follow up appointments<br>• QIPP savings<br>• Improved outcomes for patients<br>• Reduction of gaps in service<br>• Reduced variation across pathways |
| | | | | | **Integrated community care**<br>Our commissioning for integrated community care will require ESTH, RMH and SWLStG to continue to work as part of the Sutton LTB to deliver a new model of care for Sutton residents that builds on the principles of an accountable care system. This will include.<br>• Ensuring Sutton residents are more proactive about their own health care particularly those with LTC<br>• Developing models of care that deliver healthcare closer to or at a residents home<br>• Ensure an integrated approach to admission avoidance and discharge to assess that patients are in hospital for as short a time as possible<br>• Embed the learning from the 'red bag' Sutton Vanguard scheme into other pathways of patient cohorts<br>• Looking at enablers to integration such as changes in workforce, use of technology to design more effect ways of working with patients. | • improved pathways for patients<br>• More patients able to stay at home<br>• More patients return home quickly<br>• Reduced admissions to hospital<br>• True integration of services<br>• Reduced death in hospital (EoLC) |