South East London Commissioning Strategy Programme

Commissioning Strategy 2014-19
Appendices A, B and C

20 June 2014
Version 1.0 – SUBMISSION TO NHS ENGLAND
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## Individual Plans on a Page

This Appendix sets out the Plans on a Page developed by south east London CCGs and NHS England Direct Commissioning teams to support the development of the five year Strategy. The Plans on a Page were signed off as at 4 April 2014, with updated versions provided by Lewisham on 30 May 2014 and Bromley on 16 June 2014. These are as follows:

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**South East London CCGs**

**NHS England Direct Commissioning**
NHS Bexley Clinical Commissioning Group’s Vision is to: Enable Bexley’s residents to stay in better health for longer, with the support of good quality integrated care, available as close to home as possible, backed up by accessible, safe and expert hospitals services, when they are needed.

1. Delivered by: Collaborating with public health & the HWBB on supporting people to lead healthier & more independent lives (e.g. obesity, diabetes, exercise, smoking), improving services for cancer, cardiac CVD/CHD, older people, mental health & dementia, MSK, End of Life Care — promoting self-management in the below

2. Delivered by: New integrated models of care, with faster access to diagnosis, locally based, which promote health & self management, using prime contractor contracts for MSK, Cardiac, Ophthalmology. Mental Health & Children’s Services. Expanded Urgent Care Centres. See also 3 below.

3. Delivered by: Expanding our existing Integrated services for Older People with LB of Bexley community & social care 7 days a week services promoting “home is best”. In 2014 new conditions will be treated together with new services for palliative & end of life care. Plus delivering via prime contractor integrated care contracts shown under 2. above.

4. & 5. Delivered by: Ensuring high level of quality, performance and productivity by all providers of services & robust contract management. Development of integrated care prime contractor services with expenditure in line with capita needs and to reduce duplication and wastage. Improved performance within Primary Care. Market testing of relevant services. The CCG managing its expenditure within the levels of income and parameters set.

Governance arrangements: Local Quality & Safety Boards, Governing Body reporting, with leadership and involvement in major projects, Finance Working Groups, Community Based Care program and Implementation Executive Groups for South East London. Robust PMO processes. Local contract management groups. Integrated Care Collaborative with LB of Bexley. Plus Health & Well Being Board. Urgent Care network groups.

Success Criteria:
Measured against NHS Domains 1, 2, 3 & 4.
Specific KPIs established for each service (access, quality, clinical outcomes and patient experience). Introduction within new prime contractor contracts of higher levels of funding associated with clinical outcomes and patient reported outcome measures. Financial balance & sustainability achieved.

High level risks to be mitigated
• Maintaining and improving service quality and safety through significant service change
• Challenge inherent in implementing complex, interdependent, system wide changes
• Ability of providers to respond to changes
• Financial sustainability
APPENDIX A  Bromley CCG – Plan on a Page 2014/19

NHS Bromley Clinical Commissioning Group’s vision is to:
Improve health outcomes and reduce health inequalities across Bromley
Transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality
Create a sustainable health economy reinforced through collaborative working

Overseen through the following governance arrangements
- Integrated governance process
- Programme delivery structure
- Health and Wellbeing Board oversight
- Strategic programmes lead by clinical commissioners
- Joint work with the LA, PH and NHSE to understand system wide performance against national indicators

Measured using the following success criteria
- CCG reports a financial surplus in 18/19
- CCG Balanced Scorecard at Green or Amber/Green for all domains by year end 2014-15
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

High level risks to be mitigated
- Lack of capacity for change management across the health economy
- Provider engagement
- Additional financial pressures
- Maintaining and improving service quality through significant service change

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Improvement Ambition One
Securing additional life for the people of England with treatable mental and physical conditions

Delivered through intervention
- Develop integrated care pathway for cardiology
- Develop planned care pathways for MSK, Ophthalmology, Urology, and Neurology
- Develop primary care management of patients with long term conditions
- Further develop pathways for patients with diabetes
- Further develop IAPT services
- Review and design CAMHS
- Working with public health to tackle obesity, smoking
- Working with public health to develop earlier diagnosis of cancer
- Work with providers to increase the dementia diagnosis rate
- Further develop End of Life services
- Develop community based alternatives to mental health admission

Improvement Ambition Two
Improving the health related quality of life of the 15m+ people with one or more long term condition, including mental health conditions

Delivered through Better Care Fund (ITF)
- Facilitate greater opportunities for patients to self care
- Develop step down and discharge services
- MDT teams to support people with long term conditions
- Further develop integrated pathways for patients with dementia
- Develop step up intervention services; including acute based ambulatory care
- Re-commission 111 services
- Improved emergency care pathways: re-procurement of Beckenham Beacon UCC and further development of PRUH UCC

Improvement Ambition Three
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

Improvement Ambition Four
Increasing the proportion of older people living independently at home following discharge from hospital

Improvement Ambition Five
Improving the number of people having a positive experience of hospital care

Improvement Ambition Six
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and the community

Improvement Ambition Seven
Make significant progress towards eliminating avoidable deaths in our hospitals, caused by problems in care

Delivered through intervention
- Review capacity and disposition of paediatric and maternity services (SEL)
- Transforming cancer services (SEL)
- Achieving compliance with London Quality Standards (SEL)
- Improve the quality of primary care and community services by taking a population based approach to the design and delivery of services
- Primary Care workforce development programme
- Development of Orpington Health and Wellbeing Centre
- Further Development of Beckenham Beacon Planned Care Centre
- Review and develop children’s services, working with LBB
NHS Greenwich Clinical Commissioning Group’s vision is to:
• Secure the best possible health and care services,
• Developed with patients & public, & in collaboration with health & social care professionals & partner organisations
• In primary care and community settings when possible & in hospital when necessary to reduce health inequalities & improve health outcomes.

**Objectives**

1. **Prevention:** Reducing years of life lost through supporting people to lead healthier lives

2. **System Reform:** Implementing Community Based Care Strategy and improving integration

3. **Finance:** Financial sustainability for commissioners and providers

4. **System Performance:** Access to services (NHS Constitution)

5. **Quality of Services – Safety & avoidable harm**

6. **Quality of Services – Patient Experience**

7. **Quality of Services – Clinical Effectiveness**

**Delivered by:**

- **Prevention:** Collaborating with public health on supporting people to lead healthier lives (e.g. obesity, exercise, smoking, alcohol, drugs); improving cancer services, especially screening and early detection best practice commissioning pathways; supporting resilience in families

- **System Reform:** Implementation of CBC work streams; implementing and further developing local models of integration (Pioneer); improving unscheduled care (Right Care, First Time); self management and supportive technology; closer working between 1st and 2nd care; implementation of London Quality Standards

- **Finance:** Setting of robust commissioner financial plans (including achievement of control totals, 2% underlying recurrent surplus, and operating within running costs limits); robust contracts with providers; close management of commissioner QIPP initiatives and provider CIPs; managing financial risk across the health economy

- **System Performance:** Holding providers to account through robust management of contracts & close collaboration with providers and co-commissioners on resolving areas of concern; focus on turnaround on standards not met in 2013/14

- **Quality of Services – Clinical Effectiveness:** Commissioning services in response to identified need (JSNA), embedding quality in service redesign and procurement (e.g. clinically effective evidence based pathways). For commissioned services, quality is delivered by holding providers to account through Clinical Quality Review Groups; incentivisation of quality improvement through CQUIN; close monitoring of trends on safety (incidents, never events, HCAI); listening to patient feedback and improving performance against Friends and Family Test; close collaboration with co-commissioners and regulatory bodies (CQC, TDA, Monitor) to ensure issues are identified and tackled.

**Governance:** Local CBC Transformation Steering Groups for LTC, Mental Health, Unscheduled Care, Primary Care, Planned Care, Children & Maternity. These are mapped to the South East London wide Community Based Care Strategy work streams; Integrated Care, Primary & Community Care, and Planned Care

**Success Criteria:** Progress against locally determined ambition levels for outcomes; overall SMART metric will be CCG Balanced Scorecard for all domains at Amber/Green or year end 2014/15. Scorecard maps to **Objectives 1-7** as follows:

- Domain 1: Are local people getting good quality care? – Objectives 5, 6 & 7
- Domain 2: Are patient rights under the NHS Constitution being promoted – Objective 4
- Domain 3: Are health outcomes improving for local people? – Objectives 1 & 2
- Domain 4: Is the CCG delivering services within its financial plans? – Objective 3

**High level risks to be mitigated**

- Challenge inherent in implementing complex, interdependent, system wide change
- Maintaining and improving service quality through significant service change
### System Objectives

<table>
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<tr>
<th>Objective</th>
<th>Details</th>
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<tr>
<td>1. Reducing the number of years of life lost by the people of Lambeth and from treatable conditions.</td>
<td>Delivered through Integrated planned care adults (SLIC) for LTC &amp; Older People – @Home &amp; Rapid Response; Integrated care for children &amp; young people; Integrated mental health services – redesign of acute &amp; roll out of Lambeth Living Well Collaborative; Collaborating with public health on supporting people to lead healthier lives (e.g. obesity, exercise, smoking, alcohol, &amp; drugs); improving cancer services - screening and early detection; proactive primary care management of people with LTCs through the Primary Care Incentive Scheme.</td>
</tr>
<tr>
<td>2. Improving the health related quality of life of people with one or more long-term conditions - Develop and deliver planned care which reduces premature mortality and improves quality of life, reducing reliance on hospital services and improving the quality of primary care for physical and mental health.</td>
<td>Delivered through SLIC LTC &amp; Older People; Integrated planned care adults (SLIC) for LTC &amp; Older People – @Home &amp; Rapid Response; Pathway redesign including Respiratory, Cardiology, Diabetes, optometry, Gynae, Dermatology, Gastroenterology and Fitness 4 Surgery.</td>
</tr>
<tr>
<td>3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital covering for physical and mental health.</td>
<td>Delivered through SLIC LTC &amp; Older People; Integrated Children’s pathway; primary care development; @Home &amp; Rapid Response; Integrated care for children &amp; young people - Evelina Integration Programme for children’s services, redesign of children’s community services</td>
</tr>
<tr>
<td>4. Increasing the proportion of older people living independently at home following discharge from hospital - Improve the integration and quality of care for older people and reduce the number of avoidable hospital admissions and readmissions.</td>
<td>Delivered through SLIC LTC &amp; Older People; Primary care development; @Home &amp; Rapid Response; Integrated care for children &amp; young people - Evelina Integration Programme for children’s services, redesign of children’s community services</td>
</tr>
<tr>
<td>5. Reducing the proportion of people reporting a very poor experience care: Inpatient; Outpatient; Primary.</td>
<td>Delivered through Contractual levers implementation of London Quality Standards; CSU acute contract management / contract meetings; Quality Alerts action plans.</td>
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<tr>
<td>6. Making significant progress towards eliminating avoidable deaths in our hospitals – improving advanced care planning</td>
<td>Delivered through Contractual levers; Implementation of London Quality Standards; Contract for 7 day working in local acute and social care services; Roll out of CmC; Cancer pathway reinforced.</td>
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**Lambeth Clinical Commissioning Group mission:**

“`To improve the health of and reduce inequalities for Lambeth people and to commission high quality health services on their behalf`.”

**Vision:**

**People centred** – We will work to co-produce services, built around individuals and population needs, enabling people to stay healthy and manage their own care, **Prevention focussed** – We will prioritise prevention of ill health and the factors that create it, enabling people to live longer and healthier lives, **Integrated** – We will commission services in a way that brings service provision together around the needs of people and reduces boundaries and barriers to care, **Consistent** – We will promote high quality, accessible, equitable and safe services and reduce variation and variability in provision, **Innovative** – We will use 21st century technologies to provide better services, better information and to promote choices, **Deliver best value** – We will ensure we live within our means and use our resources well.

**Our Values:**

We will always tell the truth; We are fair; We are open; We recognise our responsibilities to service users and the wider public; We act responsibly, **with and for our member practices**, as a public sector organisation

**Interventions are delivered through the Lambeth programme structure of Integrated Care for Adults; Integrated Mental Health, Staying Healthy, Integrated Children’s & Young People and Primary Care Development**

**Overseen through the following governance arrangements:**

i. Programme Boards for Integrated Care for Adults, Integrated Mental Health, Staying Healthy, Integrated Children’s & Young People and Primary Care Development

ii. Finance & QIPP Group

iii. Integrated Governance Committee

iv. Governing Body

v. Community Based Care program and Implementation Executive Groups for South East London

vi. Lambeth PMO.

vii. CSU acute contracting support

viii. SLIC Programme Board with Southwark

**Measured using the following success criteria:**

i. Measured against NHS Domains 1, 2, 3, 4.

ii. Specific KPIs established for each service (access, quality, clinical outcomes and patient experience).

**High level risks to be mitigated:**

i. Maintaining and improving service quality and safety through significant service change

ii. Lack of capacity for change management across the health economy

iii. Provider engagement

iv. Challenge inherent in implementing complex, interdependent, system wide change

v. Ability of providers to respond to changes

vi. Financial sustainability
## Our Ambition: Success Criteria

To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period and to reduce inequalities within Lewisham. We will measure life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience, emergency admissions rates, and end of life care.

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<td><strong>Health Promotion</strong> - to contribute to the achievement of the Health and Wellbeing Board’s strategic priorities to reduce premature mortality and reduce inequalities</td>
<td>Support the Health and Wellbeing Board deliver its strategy to address wider determinants of health, promote health and tackle inequalities; increase the rate of early diagnosis and detection of cancer in Primary Care</td>
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<tr>
<td><strong>Maternity and Children’s Care in Hospital</strong> - to improve clinical standards and health outcomes and to pilot the ‘team around the mother’</td>
<td>develop and implement Integrated team ‘mother centred’ approach for pre, and post-partum care and providing continuity of services; support the work to improve children’s integrated care pathways for chronic disease management</td>
</tr>
<tr>
<td><strong>Frail older people</strong> – to improve care provided specifically end of life care, falls prevention and in local care homes</td>
<td>Improve systems, processes and care pathways to support people to die in the place of their choice</td>
</tr>
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<td><strong>Long Term Conditions</strong> - to implement integrated care pathways including for Diabetes, COPD, CVD, Stroke and dementia</td>
<td>Diabetes; cardiovascular disease; Respiratory/COPD; Dementia; HIV - secure the sustainable improvements in co-ordinated care pathways for adults with long term conditions</td>
</tr>
<tr>
<td><strong>Mental Health</strong> – to support mental wellbeing and shift more care to be provided in the community</td>
<td>Mental Health including depression/anxiety - commission an integrated system; integrated with primary and community care services where mental health services are on a par with physical services.</td>
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<tr>
<td><strong>Greater integration of health and social care commissioning</strong> – to support the delivery of all the above strategic priorities by providing different levels of advice, support and care from a variety of health and social care services to support independence and healthy choices for all.</td>
<td>Establish and sustain effective, integrated teams based in the neighbourhoods; commission a continuum of high quality, effective community based care services.</td>
</tr>
<tr>
<td><strong>Primary care development and planned care</strong> – to improve the quality and planned accessibility for all</td>
<td>Implement with Members the priorities to improve quality and health outcomes, access and continuity of care and reduce variation between practices</td>
</tr>
<tr>
<td><strong>Urgent Care</strong> - to ensure that the right care is delivered in the right place, at the right time by commissioning the best network of urgent care providers</td>
<td>support the urgent care network to be easier to navigate in hours and out of hours</td>
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### Collaborative Commissioning Programmes

- South East London Clinical Leadership Groups
- Lewisham Adult Integrated Care Programme (Better Care Fund)
- Maternity transformation NHSIQ Development Programme

### High level risks to be mitigated

- Local engagement and support for service changes
- Provider engagement and responsiveness
- Maintaining service quality and safety
- Financial sustainability
- Complexity and interdependency in system-wide changes
- Attract, train and retain staff across the health system
- Integration of interoperable information systems
### Interventions to deliver objectives

**Better early detection, case-finding & risk stratification**

- Provide a preventive strategy to contract for ‘every contact counts’ health advice interventions; pre-diabetic health checks; hospital providers implementation of NICE smoking cessation guidance.
- Commission A&E ‘front-end’ assessment and triage functions for patients with mental health conditions.
- Implement Joint Dementia Strategy to commission new community intervention services for people with dementia including a medicines optimisation programme; and specialist services for people with challenging behaviour.
- Programme of IT development to implement a system that will allow primary; community & hospital clinicians to view patients’ test and diagnostics result.
- Develop a primary care model of early diagnosis and integrated care for children with autism.
- Commission enhanced early detection; case-finding; care-coordination & risk management in primary care.
- Oversee extension of GSTT ‘@home’ programme including full roll-out of Homeward across Southwark.
- Commission a model of community-based integrated service provision structured on a locality/neighborhood geography to improve outcomes for patients with one or more long-term conditions (including mental health).
- Commission enhanced primary care support to Southwark care homes operating as part of a specialist multi-disciplinary model of care for patients living in residential accommodation in the borough.
- Commission for services 7 days-a-week in collaboration with Southwark local authority and NHS England commissioners to support admission avoidance and to improve discharge from hospital.

**Remodelling of psychological therapies pathway.**

- Work with providers to implement contractual requirements to drive secondary care productivity and efficiency savings.
- Scope system for referral review against agreed clinical protocols and to enhance use of Choose & Book across the health economy.
- Commission pathways for patients referred with common health conditions (e.g. diabetes; respiratory illness; gynaecology) to specialist services provided in community facilities in different locations of the borough.
- Decommission hospital outpatient pathways to reflect this change of provision.
- Review access policies including south east London Treatment Access Policy and consider management protocols and support pathways for people who smoke and require non-urgent elective admission.
- Implementation of the CCG primary and community care locality development plan and broader CCG Primary and Community Care Strategy.
- Commission enhanced diagnostic capacity in primary and community care settings.
- Design and deliver a comprehensive primary care workforce development programme.
- Contribute to shaping Southwark Council’s approach to commission enhanced community support services (home help and domiciliary services).
- Continued implementation of the service model for the Dulwich locality.

**Ensure local people can easily navigate the local health system and can access appropriate care when they need it**

- Review of urgent care pathway including A&E ‘front-end’; UCC and WICs and commission a model of care to enhance access; quality; % appropriate attendances.
- Complete inner south east London procurement for provision of NHS 111 service from April 2015.
- Commission London Ambulance Service to safely and effectively increase the proportion of calls treated ‘on site’ to reduce A&E conveyance rates.
- With social care services, commission new services targeted at people 'in-crisis'. This will be initially focussed on people with mental health, alcohol misuse issues and on those who are homeless.

### Ensuring we deliver our plan

**Overseen through the following governance arrangements**

1. The South East London Clinical Commissioning Board will be accountable to the Clinical Strategy Committee for the definition and delivery of the South East London 5 Year Strategy. The group will work with the South East London Partnership Group which will provide system leadership and oversight and with supporting groups and workstreams.
2. The CCG Commissioning Strategy Committee will oversee development of the borough strategy and operational plans. The CCG will work in close partnership with Southwark local authority and with the Southwark Health & Wellbeing Board in developing and then implementing plans.
3. The final CCG strategy will be endorsed by Southwark CCG’s Governing Body and then approved by member practices at the CCG Council of Members.
4. The delivery of key strategic change programmes will be overseen by the CCG Integrated Governance & Performance Committee, who will receive regular status reports from respective responsible programme groups.

**Measured using the following success criteria**

1. Delivery of all CCG system objectives.
2. Improve target outcome indicators from NHS Outcomes Framework.
3. CCG achieves financial surplus in all years to 2018/19.
4. No provider under enhanced regulatory scrutiny due to performance concerns.
5. No provider under enhanced regulatory scrutiny due to financial concerns.

**High level risks to be mitigated**

**Risk 1:** CCG does not achieve full delivery of key QIPP programmes, which poses a risk to the financial sustainability of the CCG.

**Risk 2:** There is insufficient support gained through the planning process from local stakeholders and the population. This could risk increased delay of implementation and increase the cost of necessary changes.

**Risk 3:** Service quality and safety is maintained and improved throughout the period of service change.

**Risk 4:** Transformation and service changes do not balance provision at the right stages of patient pathways. A risk that for periods of time there exists either excess or insufficient capacity to meet demand for services.

**Risk 5:** Technical and financial challenge of ensuring IT systems support effective integration of care pathways.

**Risk 6:** Implementation of service change may affect ability to recruit, train and retain staff across the health economy.

**Interventions to be delivered through Integration Transformation Fund (ITF)**

**Intervention 1 – Admissions avoidance programmes.**

**Intervention 2 – Reallocation services.**

**Intervention 3 – Southwark Carers Strategy.**

**Intervention 4 – 7 day working.**
Vision
Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Objective One
Co-ordinated Care
- Quality Standards and Outcomes
  - Ensuring consistency of service across London
  - Performance management
- Premises
  - Making best use of the assets available
  - Borough based strategic planning to inform investment decisions

Objective Two
Proactive Care
- Workforce
  - Commission and maintain a diverse primary care workforce that supports collaborative 24/7 working
- Technology
  - Joined up working that meets the needs of patients
  - Integrated systems and better data sharing

Objective Three
Accessible Care
- Commissioning and contracting
  - Managing the provider landscape
  - Redesigning incentives
  - Primary care contract that delivers national consistency which enables programme of change in local context

Objective Four
Collaborative models of delivery
- Stakeholder engagement
  - Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change
- Change management
  - Organisation design
  - Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Involvement in local Strategic Planning Group governance through Clinical Commissioning Board, South East London Partnership Group, and representation in supporting groups and workstreams

Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England’s ability to address and act upon poor quality (premises, clinicians, systems)
  - Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
  - Primary care system that prevents ill health and supports healthy lifestyle choices
  - Patients and stakeholders are at the heart of commissioning decisions

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years
Vision
Specialised services commissioned that consistently deliver best outcomes and experience for patients, within available resources

Objective One
Specialised services commissioned in London are consistently in the top decile for outcomes across all providers

Quality Standards & Outcomes
• Compliance with service specifications
• Consistent achievement of service standards
• Benchmarked outcomes in London, England and internationally, identifying the best practice to emulate

Objective Two
Continually improve patient experience for each individual

Patient Focus
• Engage patients in service/pathway development and contract management
• Through contract management, ensure patient feedback is heard and acted upon throughout providers commissioned

Objective Three
Maintain the integrity of the care pathway for patients of specialised services

Collaboration along Care Pathways
• Co-commission with CCGs and Local Authorities
• Develop and implement best practice patient pathways for individual services, ensuring they are incorporated into national service specifications

Objective Four
Contain the cost of specialised services through Quality, Innovation, Productivity and Prevention, in partnership with providers and other service commissioners

Performance Management
• Understand the cost of services commissioned
• Converge prices
• Alignment of incentives
• Contract management

Overseen through the following governance arrangements
• Contract Management Board
• On-going service compliance exercise against national specifications
• Quality Dashboards
• Quality & Safety Board

Measured using the following success criteria
• Delivery of QIPP & within budget for all services
• Patient feedback utilised to improve commissioning & delivery of services
• Objectives delivered
• Consistent tariffs developed & implemented

High level risks to be mitigated
• Alignment with national specialised services strategy due to strategy developments working to different timelines
• Resource capacity – improved matrix working and new ways of working
# Vision

**Working together to achieve excellence in Health in Justice outcomes for Londoners**

## System Objective One
- **To improve the engagement and support for those in contact with the Health in Justice system**

### Performance management framework
- Active management of contracts
- Consistent improvement in outcomes

### Pathway review
- Ensuring integration across pathways

## System Objective Two
- **To reduce reoffending for individual offenders**

### Multi-disciplinary working
- Understanding the workforce requirements
- Reducing duplication of work

### Early interventions and prevention
- Liaison and Diversion
- Review of mental health service provision

## System Objective Three
- **To improve the efficiency and effectiveness through better collaboration of commissioning partners**

### Commissioning improved health in justice outcomes
- Moving towards a single framework

### Improving victim experience and outcomes
- Working with vulnerable adults
- Understanding the support they need

## Overseen through the following governance arrangements
- Signed off via the London Crime Reduction Board
- Discussed through the Strategic Clinical Network for Health in the Justice system and for Mental Health

## Measured using the following success criteria
- Number of offenders going back through the system.
- Sustained engagement with CRC and NPS – no offending within a 12 month period and no duplication of services

## High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Data collection – consistency; measuring agreed outcomes.
- Engagement with key stakeholders to ensure the success of the strategy

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**Version 1, December 2013**
APPENDIX A  Public Health – Screening – Plan on a Page 2014/19

Vision

‘High quality, accessible screening programmes for all’

Objective One
Coverage and uptake should be increased to at least minimum target (dependent on service)

Integration across pathways
• Understand full pathway through to treatment
• Links with providers, IT systems, integration

Objective Two
High quality programmes that deliver the national standard measured by national service specifications and quality assurance processes

Reconfiguration of services
• Size and length of each pathway
• Locating services together? Determine how to best provide services across London

Objective Three
Service integration across partners within the pathway measured by pathway referral and treatment times

Communications and education
• Linkages and profile of the screening services
• Influence education providers to support wider education around screening benefits

Objective Four
Patient experience and values are integrated into the design and delivery of services. Measured through the Friends and Family Test and other patient experience metrics

Patient focus and clinical excellence
• Move to patient focus from client focused – how to put patient at the centre of delivery
• Performance improvement in providers

Back office functions
• All working to national / specified standards
• Potential to centralise back office functions
• Sharing data and lessons learnt between screening programmes

Overseen through the following governance arrangements
• Tripartite arrangement with Department of Health and Public Health England to define and deliver policy changes
• Signed off through the London Screening Programmes Board
• Overview and Scrutiny Committees and Health and Wellbeing Boards will support delivery of the plan

Measured using the following success criteria
• Delivery of the objectives
• Has met or exceeded coverage and uptake targets
• Detects and treats patients for preventable diseases
• Delivers value for money across all services

High level risks to be mitigated
• Information governance and IT
• Stakeholder engagement
• Skills, capability and capacity to deliver the identified changes
• The financial requirements may not support the optimum delivery of services
Vision

Empowering and saving the lives of Londoners from vaccine preventable diseases

Objective One
To improve patient experience and empowerment, measured through the MIMO and patient feedback

Empowering people
• Engage patients and the public in their own healthcare needs; service design and delivery (e.g. self administration)

Communications and education
• Profile of the immunisations programmes across the life course
• Education of general population including health literacy in schools
• Making immunisations a part of everyday life

Objective Two
To increase uptake and coverage across London (value dependent on service)

Evidence based
• Integrated information systems
• Targeted interventions for specific communities who are not registered with a GP
• Access to good quality on-line training
• Comprehensive stakeholder engagement

Objective Three
To have responsive, flexible and integrated services to maximise coverage across programmes, measured through coverage rates

Integration across services
• Within imms services and across other frontline services
• Widening access and choice where possible
• Links with alternative providers, including non healthcare providers

Technology
• To effectively utilise new vaccines as they become available
• To maximise utilisation of new evidence of at risk groups
• To enable different forms of delivery

Overseen through the following governance arrangements
• Overseen through the London Immunisation Board
• London NHS England senior team oversight
• National Public Health steering group
• Ongoing engagement with Health and Wellbeing Boards

Measured using the following success criteria
• setting up a citizen’s panel and using MIMO techniques to test people empowerment;
• nationally published vaccine uptake data;
• regular mystery shopping exercises;
• annual clinical audit

High level risks to be mitigated
• Information governance and systems
• Insufficient national budget allocation to cover London population, if using ONS data
• Inadequately trained immunisation workforce (existing and emerging) to deliver the identified changes
**Vision**

To empower all armed forces veterans to seek equitable access to NHS services, upon discharge

<table>
<thead>
<tr>
<th>Objective One</th>
<th>Empowering people</th>
<th>Overseen through the following governance arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustain community mental health contract until 2020</td>
<td>• Ensure robust and resilient commissioning of service model</td>
<td>• Overseen through the London Armed Forces Network, which meets quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective Two</th>
<th>Collaborative Commissioning</th>
<th>Measured using the following success criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain the Murrison protocol until 2020</td>
<td>• All 32 CCGs will be engaged with the evolving protocols</td>
<td>• NHS England commissioners commit to implement the Military Covenant and afford all veterans the opportunity for access to a GP practice, an NHS Dentist and a Community Pharmacy within 3 months of being discharged, or within four weeks of requesting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective Three</th>
<th>Choice</th>
<th>High level risks to be mitigated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure veterans have access to primary care facilities</td>
<td>• Each armed forces personnel will be signposted to local primary care providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establish a primary care register template for veterans, subject to a New Patient Registration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• London Armed Forces Network membership will support individual cases with their choices</td>
<td>• Inability to define and capture all veterans that currently live in London to ensure they receive the support required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective Four</th>
<th>Integration across services</th>
<th>Information governance and systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure transfer of Defence Medical Service (DMS) are completed in a timely manner</td>
<td>• DMS medical summaries are prepared as part of Transition process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DMS summary is securely transferred to named GP chosen by veteran</td>
<td></td>
</tr>
</tbody>
</table>
Vision for Southwark CCG:
• People live longer, healthier, happier lives no matter what their situation in life
• The gap in life expectancy between the richest and the poorest in our population continues to narrow
• The care local people receive is high quality, safe and accessible
• The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
• We make effective use of the resources available to us and always act to secure the best deal for Southwark

Vision for Lewisham CCG:
• Better Health - the Five Year Vision: To improve the health outcomes for our local population by commissioning a wide range of support to help Lewisham people to keep fit and healthy and reduce preventable ill health
• Best Care – the Commissioning Vision: To ensure that all services commissioned are of high quality – in terms of being safe, positive patient experience and based on evidence and good practice
• Best Value – the Financial Vision: - To commission services more efficiently, providing both good quality and value for money, by improving the way services are delivered, streamlining care pathways, integrating services

Vision for Lambeth CCG:
• People-centred – co-producing services and enabling self-management
• Prevention-focused – enabling people to live longer and healthier lives
• Integrated – reducing boundaries and barriers to care
• Consistent – reducing variation and variability in access and provision
• Innovative – using 21st Century technologies for better services, information and to promote choice
• Value for money – living within our means and using resources well

Vision for Southwark CCG:
• People live longer, healthier, happier lives no matter what their situation in life
• The gap in life expectancy between the richest and the poorest in our population continues to narrow
• The care local people receive is high quality, safe and accessible
• The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
• We make effective use of the resources available to us and always act to secure the best deal for Southwark

Vision for Greenwich CCG:
• Secure the best possible health and care services, • Developed with patients & public, & in collaboration with health & social care professionals & partner organisations • In primary care and community settings when possible & in hospital when necessary to reduce health inequalities & improve health outcomes

Vision for Bromley CCG:
• Improve health outcomes and reduce health inequalities across Bromley
• Transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality
• Create a sustainable health economy reinforced through collaborative working

Vision for Bexley CCG:
• Enable Bexley’s residents to stay in better health for longer, with the support of good quality integrated care, available as close to home as possible, backed up by accessible, safe and expert hospitals services, when they are needed.

Our collective vision for the South East London: In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:
• Supporting people to be more in control of their health and have a greater say in their own care
• Helping people to live independently and know what to do when things go wrong
• Helping communities to support one another
• Closing the inequalities gap between worst health outcomes and our best
• Making sure primary care services are consistently excellent and with an increased focus on prevention
• Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
• Developing joined up care so that people receive the support they need when they need it
• Delivering services that meet the same high quality standards whenever and wherever care is provided
• Spending our money wisely, to deliver better outcomes and avoid waste.
APPENDIX C - CLG impact on programme outcomes

Primary and community care

Key Impacts

The matrix below show how this strategic intervention contributes to each programme measure.

<table>
<thead>
<tr>
<th>Measures for system objectives</th>
<th>Level of Impact (H / M / L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>H</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>H</td>
</tr>
<tr>
<td>Gap in life expectancy</td>
<td>H</td>
</tr>
<tr>
<td>COPD mortality</td>
<td>M</td>
</tr>
<tr>
<td>Cancer mortality</td>
<td>M</td>
</tr>
<tr>
<td>CVD mortality</td>
<td>M</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>H</td>
</tr>
<tr>
<td>Excess weight (children / adults)</td>
<td>H</td>
</tr>
<tr>
<td>Alcohol related admissions</td>
<td>H</td>
</tr>
<tr>
<td>Making significant progress towards eliminating avoidable deaths in</td>
<td>L</td>
</tr>
<tr>
<td>our hospitals caused by problems in care</td>
<td></td>
</tr>
<tr>
<td>Increasing the proportion of older people living independently</td>
<td>H</td>
</tr>
<tr>
<td>at home following discharge from hospital</td>
<td></td>
</tr>
<tr>
<td>Reducing the amount of time people spend avoidably in hospital</td>
<td>H</td>
</tr>
<tr>
<td>through better and more integrated care in the community,</td>
<td></td>
</tr>
<tr>
<td>outside of hospital</td>
<td></td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>M</td>
</tr>
<tr>
<td>Emergency attendances</td>
<td>H</td>
</tr>
<tr>
<td>Increasing the number of people having a positive experience</td>
<td>L</td>
</tr>
<tr>
<td>of hospital care</td>
<td></td>
</tr>
<tr>
<td>Delivering the London Quality Standards and other agreed</td>
<td>M</td>
</tr>
<tr>
<td>quality standards</td>
<td></td>
</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions</td>
<td>H</td>
</tr>
<tr>
<td>(EQ5D)</td>
<td></td>
</tr>
<tr>
<td>Sustained financial balance</td>
<td>H</td>
</tr>
</tbody>
</table>

As the core of our integrated system model for south east London, Primary and Community Care has to potential to drive a significant improvement, either directly or in combination with Long Term Conditions and the priority pathways, across the majority of the integrated system objectives, for example:

- Primary prevention activities, together with social care, will have a high impact on:
  - key public health measures including smoking cessation, excess weight and alcohol related admissions
  - Reducing inequalities in health outcomes and life expectancy
- Increased community support and resilience, together with improved coordination of care and access to local services, will support the objectives of increasing proportion of people living independently at home and reducing time people spend avoidably in hospital
- Taken together with the impact of other priority pathways, Primary and Community Care interventions will have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions
- Through successful implementation of these interventions and corresponding changes driven through other Clinical Leadership Groups, Primary and Community Care will make a significant contribution to the overall sustainability of the health system
- Robust baseline activity data is needed to sufficiently inform the impact on activity especially in emergency admissions and emergency attendances
- The impact on each system objective will vary in the short, medium and long term, depending on the starting point of the individual programme
- Additional measures proposed by the group should include wider primary care activity such as mental health, patient experience of seamless care, pharmacy and end of life
- The impact of primary and community care is closely linked to social care so there is a need to reflect some of the social care objectives in the system objectives e.g. employment, housing, debt
Long term conditions, physical and mental health

The matrix below shows how this strategic intervention contributes to each programme measure.

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<th>Measures for system objectives</th>
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<td>Smoking cessation</td>
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<td>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
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</tr>
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<td>H</td>
</tr>
<tr>
<td>Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital</td>
<td>H</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>H</td>
</tr>
<tr>
<td>Emergency attendances</td>
<td>H</td>
</tr>
<tr>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>L</td>
</tr>
<tr>
<td>Delivering the London Quality Standards and other agreed quality standards</td>
<td>L</td>
</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (EQ5D)</td>
<td>H</td>
</tr>
<tr>
<td>Sustained financial balance</td>
<td>H</td>
</tr>
</tbody>
</table>

The Long Term Conditions (LTC) CLG in collaboration with the Primary and Community CLG and the Cancer CLG priority pathway will have a high impact on:

- Reducing the gap in healthy life expectancy between boroughs
- Increasing the proportion of people living independently at home following discharge from hospital and being able to self manage their LTC.
- With increased community support and resilience in place the CLG will improve coordination of care, access to local services and support the numbers of people living independently at home
- This will reduce the time people spend avoidably in hospital and have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions

Further specific measures the CLG are considering:

- Additional years of life for the people of England with treatable mental and physical health conditions
- Reducing Cancer, CVD and COPD mortality
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Potential savings associated with avoided hospital care, after costs of care in the community taken into account
- Savings associated with reduced acute bed days
- Reduction in delayed discharges to social care
- % of people with LTC who feel supported to manage their own condition
- Staff view of collaboration (requires further definition)
- No. of patients in cohort with a personalised care plan
- No. of multi-disciplinary care plans that have a nominated care professional as a lead coordinator.
- Proportion of service users independent following reablement
- Readmission within 1 year for patients who have completed reablement.
Planned care

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure. The Clinical Leadership Group is also developing its own measures and objectives specific to elective and diagnostics scope.

<table>
<thead>
<tr>
<th>Measures for system objectives</th>
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<tbody>
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</tr>
<tr>
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<td>H</td>
</tr>
<tr>
<td>Cancer mortality</td>
<td>H / M</td>
</tr>
<tr>
<td>CVD mortality</td>
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</tr>
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<td>Smoking cessation</td>
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<td>Alcohol related admissions</td>
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<td>H</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>M</td>
</tr>
<tr>
<td>Emergency attendances</td>
<td>M</td>
</tr>
<tr>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>H</td>
</tr>
<tr>
<td>Delivering the London Quality Standards and other agreed quality standards</td>
<td>H*</td>
</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (EQ5D)</td>
<td>L / M</td>
</tr>
<tr>
<td>Sustained financial balance</td>
<td>H</td>
</tr>
</tbody>
</table>

* = not London Quality Standards per se but emerging model characteristics are likely to drive quality and reduce variation against clinical standards generally e.g. NICE

Focus on faster access and reduced waiting time across the pathway coupled with standardised approaches will contribute to earlier detection and intervention for patients with cancer and other cohorts requiring elective surgery. This has the potential to contribute to improving life expectancy and healthy life expectancy.

Working towards a system where every contact counts with clear clinical signposting can help maximise the impact of smoking cessation and healthy weight with the patient being in the centre of the care pathway. This is also likely to positively impact COPD mortality and CVD mortality.

Standardisation will help to reduce variation and duplication which in turn will drive quality of services up with improved clinical outcomes (for example lower infection rates), potentially reducing the number of avoidable deaths in hospitals. This is also supported by getting a senior opinion early (from an expert not necessarily a consultant).

Increasing capability within the community for diagnostics and some minor elective work will help to reduce waiting time and cancellations will help reduce the amount of time people spend in hospital and improve the flow of the patients that present properly. This will also help to improve the quality of care and in turn improve patient experience through clear linear pathways.

Some reduction in emergency admissions and attendances as a result of improved access reducing the number of patients that need to be admitted as an emergency.

Ensuring that communication and sharing of information that occurs between secondary care, primary care and social care is the best it can be has the potential to drive prevention and discharge management. This will help to empower the patient to understand their condition and the critical things they (or their family) need to know to help manage their condition after an elective episode.

Collaboration between primary care and secondary care, with social care and social services has the potential to reduce the amount of time people spend avoidably in hospital (including reducing lengths of stay) and ensure that elderly patients are able / supported to live independently when moved back in the community. This also has the potential to prevent some admissions through patients being better supported.

Working together to address rising demand for elective care and diagnostics, delivering services more efficiently and effectively whilst maximising value across the pathway will help to deliver sustainable financial balance across the system.
There is a rapid 24/7 response to urgent care needs. The service model integrates fully with the development of Local Care Network (LCN) Hubs delivering more of urgent care closer to a patient’s home, particularly aiming to be the choice to go to for minor injuries and illnesses. Emergency Department (ED) specialists are able to be reached for advice and also can book urgent appointments with GPs for patients who need re-direction. Clear sign-posting and agreed ‘bundles of care’ ensure patients receive the right services in the right place. 111 plays an enhanced role in navigating and coordinating an appropriate response to urgent (and not so urgent) needs. LAS has access to patient information and is able to route to the right service for non-blue light calls, including LCNs.

Urgent care in the community is enhanced through the Rapid Access Service (Home Ward and Specialist Response clinics located in hospitals) which particularly aims to support elderly frail patients and those others with LTCs, complex health and mental health needs to avoid the need to present at an Emergency Department. This means fewer vulnerable patients need be spending time in Emergency Departments or admitted to wards whilst awaiting diagnosis, as well as supporting speedier discharge for patients who do need to attend EDs. This may increase life expectancy for those who are frail or with certain LTCs.

Fewer patients from care homes are presenting to ED and are assessed and treated at home through the ‘Home Ward’ team (Rapid Access Service).

Within EDs, improved streaming and flow, managed by an experienced Band 6 ED Nurse or GP provision at the ‘front door’ ensures patients are seen within the London Quality Standards targets and avoidable admissions are reduced. This is enhanced by Clinical Decision Units with beds, able to hold, assess and treat patients without admitting to wards, improving patient experience, avoiding admission and returning home faster. In place are links with 24 hr social care and the voluntary sector able to support the patient on discharge/return home where needed and reduce likelihood of re-attendance with the same urgent need.

Complex needs – including alcohol and mental health related admissions – are more effectively managed to avoid admissions through integrated planning and working between community and specialist services. There is likely to be a reduction in frequent attenders.

Investment in services providing rapid response in the community for more hours per day will impact patient outcomes and shift urgent care activity away from UCCs in particular and EDs.

The matrix below shows how this strategic intervention contributes to each programme measure.

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<td>H-M</td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (EQSD)</td>
<td>M</td>
</tr>
<tr>
<td>Sustained financial balance</td>
<td>M</td>
</tr>
<tr>
<td>CDU reducing use of acute admissions</td>
<td>H</td>
</tr>
<tr>
<td>4 HOUR TARGET</td>
<td>H</td>
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</tbody>
</table>
This matrix shows how this strategic intervention contributes to each programme measure. The strategic vision for maternity services is to place the needs of women and their families at the centre of maternity care. The model of care which is midwifery-led continuity of care includes neonatal care and early years up to 9 months. There are a number of key elements within the maternity service model which support the delivery of these overall programme measures.

Specifically:

- To develop maternity services and a workforce that promote healthy lifestyles which have a positive effect on the health outcomes for mother and child and the wider family.
- To work in conjunction with primary care and others to improve awareness of problems in pregnancy and the impact on outcomes caused by a range of lifestyle choices.
- Promoting early access to maternity services through a focus on hard to reach groups and supporting early identification of risk and consequent care plan development.
- Developing continuity of midwife-led care and reviewing maternity catchment areas in order to optimise integration with other services in particular health visiting, primary care, social care and children’s centres.
- The service model enhances specialist maternity services for high risk women or women with complex health needs including perinatal and post-natal mental health.
- Midwives will become part of the team around the child moving from maternity to community based services and will include a postnatal overlap and transition to health visiting and primary care linking into the broader locality/community network to support new parents and babies.
- Improved access to postnatal services will also support a reduction in neonatal admissions.
- Improved continuity of care and community alignment will help to ensure timely identification, referral and access to specialist services.
- Developing an approach to meet the required standards for consultant cover, particularly for high risk women that provides the maximum quality and safety for women and babies in hospital during and following delivery.

Normalising birth and supporting women to achieve the best possible outcomes for themselves and their babies is the focus of the maternity strategy. The successful implementation of the strategy will have an overall positive impact in improving the life chances and healthy life expectancy for local people.
Children and young people

Key Impacts

At the core of the children and young persons strategy is building community resilience and child-centred services. The service model particularly aims to deliver: early intervention; health care promotion and prevention delivered through Children’s Centres and GP (Local Care Network) Hubs; improved access ‘no wrong door’; effective assessment and coordination for children with Long term Conditions and Complex needs. These and a more effective interface between community and acute/specialist services will be impacting positively on life expectancy and healthy life expectancy.

Tackling ‘Toxic Stress’ and promoting emotional as well as physical well-being helps protect the child from adversity and reduces potential mental health conditions. The strategy presents a positive focus on mental health of the child and ensures their support networks help enable this. Up skilling the workforce across a number of system developments with regards to mental health will see an impact on the number of children and young people presenting to CAHMs services. Providing ill children and their parents/carers with psychological support in hospital and at home will improve healthy life expectancy and health-related quality of life.

An integrated paediatric assessment and coordination process, linked to safeguarding processes and the Single Plan for children with disabilities/special learning needs will improve access and outcomes for children and young people with long term conditions and complex needs. Specialist Paediatric Assessment Units (PAU) will improve outcomes and reduce unnecessary admissions in to acute services for children with urgent care needs. GPs will be able to access Paediatric consultancy and advice to deal with urgent needs locally.

Community Child Health Teams manage LTC pathways, providing Out of Hours support, easy access to Paediatric Specialists and paediatric specialist nursing in the community, improving time in hospital and supporting improved quality of life, parental support and therefore mental health and emotional well-being of children. This is supported through a strong link into education and the role Local authorities, public health, and health visitors play in supporting a child’s health needs. Services designed around the child and their support network promotes more informed life style choices This directly feeds into smoking cessation, excess weight, and alcohol related admissions within the cohort.

An effectively designed and coordinated community-acute / specialist interface model around PAU and Community Child Health Teams with paediatric team ownership from “front door” will avoid unnecessary admission and improve outcomes across secondary care. This will also speed up discharge ensuring the step down interface between secondary care and community will be efficient and effective. This will be supported by inreach to children with long term conditions in hospital from Community Child Health Teams ensuring services are centred around the child on discharge.

The model will support delivery of the London Quality Standards including specialist paediatric decision-making and cover for Emergency departments.

Ultimately with the reduction in avoidable acute admissions this aims to help to support a sustained financial balance.

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<table>
<thead>
<tr>
<th>Measures for system objectives</th>
<th>Level of Impact (H / M / L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>H</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>H</td>
</tr>
<tr>
<td>Gap in life expectancy</td>
<td>N/A</td>
</tr>
<tr>
<td>COPD mortality</td>
<td>N/A</td>
</tr>
<tr>
<td>Cancer mortality</td>
<td>N/A</td>
</tr>
<tr>
<td>CVD mortality</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>L-M</td>
</tr>
<tr>
<td>Excess weight (children / adults)</td>
<td>M</td>
</tr>
<tr>
<td>Alcohol related admissions</td>
<td>M</td>
</tr>
<tr>
<td>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
<td>H</td>
</tr>
<tr>
<td>Increasing the proportion of older people living independently at home following discharge from hospital</td>
<td>N/A</td>
</tr>
<tr>
<td>Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital</td>
<td>H</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>H</td>
</tr>
<tr>
<td>Emergency attendances</td>
<td>H</td>
</tr>
<tr>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>H</td>
</tr>
<tr>
<td>Delivering the London Quality Standards and other agreed quality standards</td>
<td>H</td>
</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (EQ5D)</td>
<td>H</td>
</tr>
<tr>
<td>Sustained financial balance</td>
<td>M</td>
</tr>
<tr>
<td>Mental health and CAHMs admissions</td>
<td>M</td>
</tr>
</tbody>
</table>
Cancer

Key Impacts

The matrix below shows how each of the strategic interventions for the Strategy contribute to each programme measure.

<table>
<thead>
<tr>
<th>Measures for system objectives</th>
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<tr>
<td>Increasing the number of people having a positive experience of hospital care</td>
<td>M</td>
</tr>
<tr>
<td>Delivering the London Quality Standards and other agreed quality standards</td>
<td>L*</td>
</tr>
<tr>
<td>Health-related quality of life for people with long-term conditions (EQ5D)</td>
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<td>Sustained financial balance</td>
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</table>

The vision of the Cancer Clinical Leadership Group is to make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience. To support this vision, an initial model has been designed that will focus effort in areas where the greatest improvement of outcomes can be made, in particular:

- The approach to early detection and treatment is a fundamental driver of the system objective to reduce avoidable cancer mortality and increase overall life expectancy
- Enhanced and coordinated care and support services within the community will have a significant impact on emergency admissions and emergency attendances, particularly at end of life
- The focus on transition from treatment living with cancer and the effects of cancer will also make a contribution to reducing the amount of time people spend in hospital and the proportion of older people living independently at home following discharge from hospital
- Enhanced support to patients, families and carers will support the ambition of increasing the number of people having a positive experience of hospital care
- Education and training within the workforce (including social care providers and voluntary services) will help support prevention objectives, in particular for smoking cessation.

* Cancer has no specific London Quality Standards, but is following the recommendations in the Five Year Cancer Commissioning Strategy for London

APPENDIX C - CLG impact on programme outcomes

DRAFT IN PROGRESS