South West London Sustainability and Transformation Plan

Croydon CCG Governing Body 24th May 2016

Croydon Health and Wellbeing Board 8th June 2016

Agenda

- Overview of the STP incorporating Croydon Sub Regional Plan
- Timeline
- Engagement
- Next Steps

What is a sustainability and transformation plan?

- NHS shared planning guidance 2016/17 – 2020/21 sets out new approach to ensure health and care services are planned by place rather than around institutions

- A plan to improve the way that health care services are delivered to ensure that:
  - the quality of services meets national standards;
  - we address future challenges such as obesity and diabetes by delivering services in the right way;
  - inequalities are reduced across the area;
  - we work within the available budget

- This is an opportunity to build or strengthen relationships - across health and local government – but also with patients, communities, staff and the voluntary sector.

Our plan should:

- be based on the geographical area of south west London - include all services across this area
- improve quality of care
- reduce waiting times for A&E, cancer and mental health
- address the sustainability and quality of general practice
- align with the CCG's 2016/17 Operating Plan
- reflect local Health and Wellbeing Strategies
- return the system to financial balance

Source: Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21; Joint letter re: Developing Sustainability and Transformation Plans to 2020/21, 16 Feb 2015

Planning levels that contribute to the STP

Existing SWL workstreams, e.g. Urgent & Emergency Care	Develop condition/ pathway specific quality improvement, productivity enabling plans. Input commissioners and providers across SWL.
4 x sub-regional planning groups:	Responsible for the development of sub-regional out of hospitals plans.
6 x CCGs working with local authorities	Responsible for the development of local cross partner preventions plans.

Four sub-regional planning footprints (borough not CCG combined pops):

Richmond and Kingston Planning Group

Population: **363,543**

Croydon Planning Group

Population: **376,040**

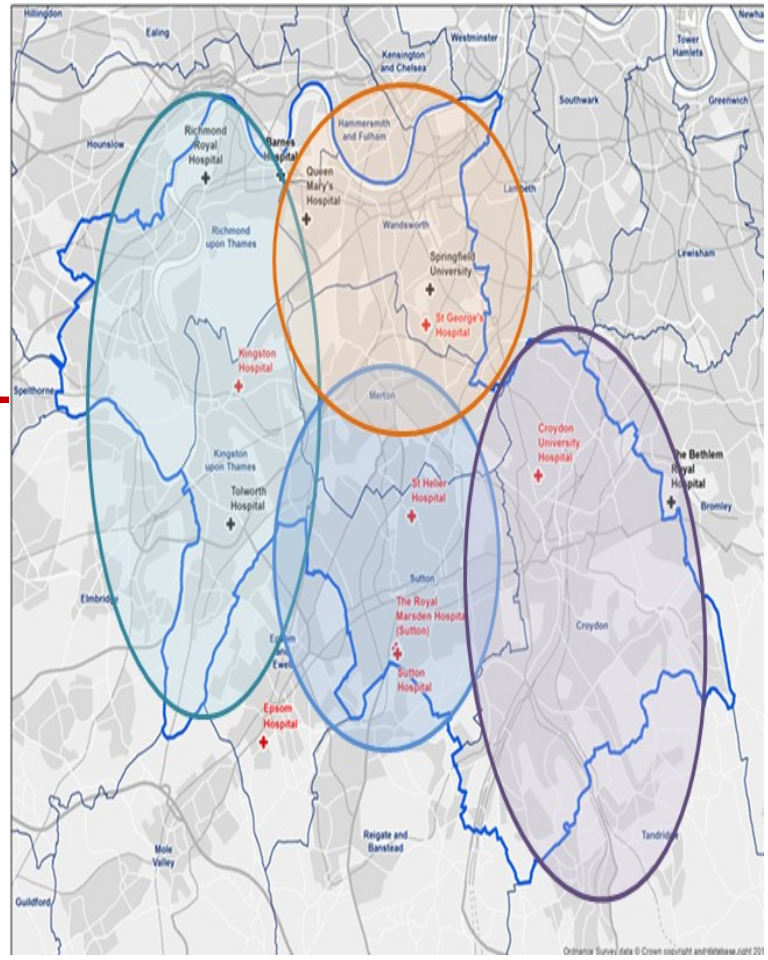
Wandsworth and Merton (*2/3) Planning Group

Population: **447,822**

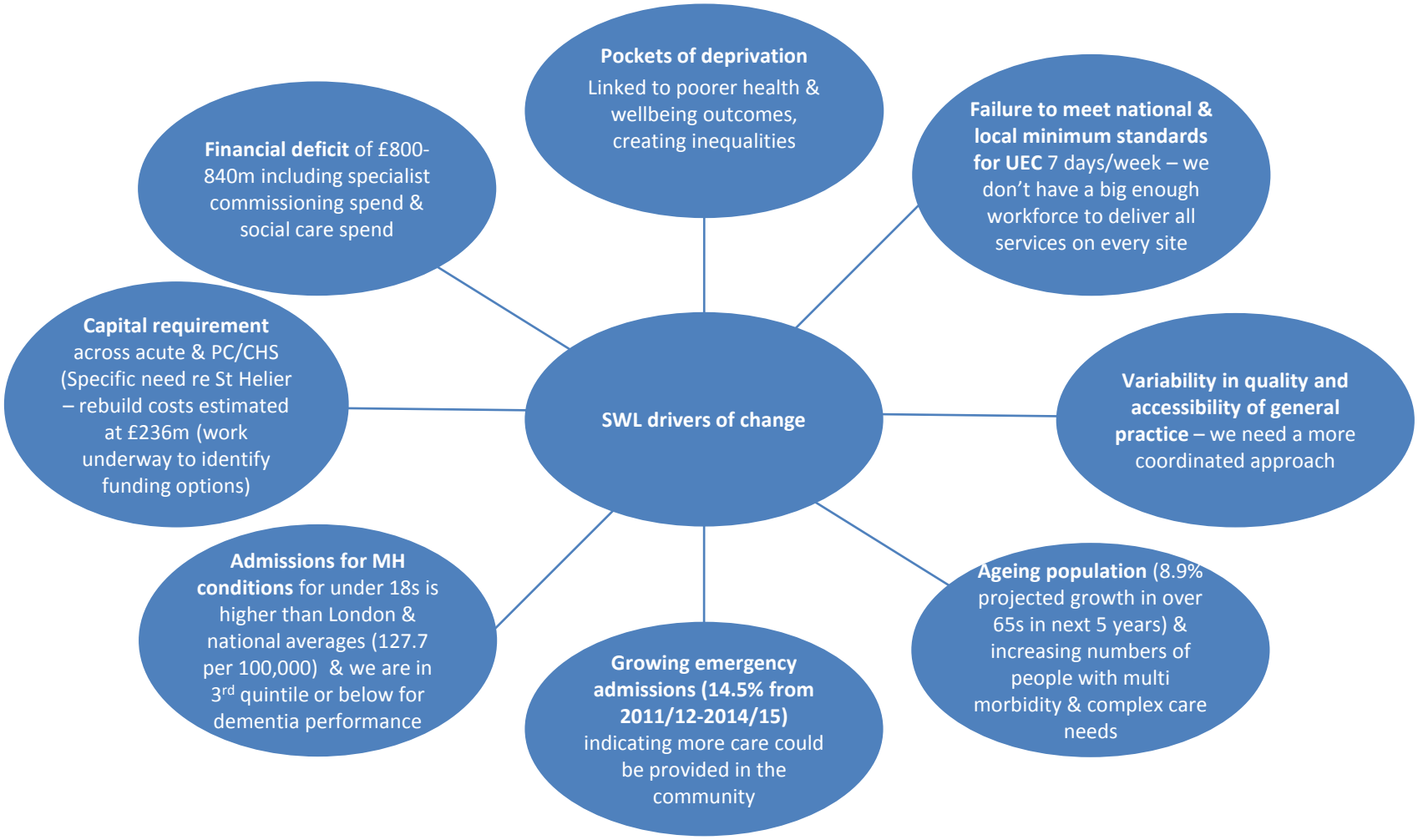
Sutton and Merton (*1/3) Planning Group

Population: **265,972**

Plus patient flows to ESUH from Surrey Downs CCG



Drivers for change in South West London:



Our three gaps - to be met through the STP

1. **Health and wellbeing**
2. **Care and quality**
3. **Finance and efficiency**

Our Health and Well Being Challenge

South West London

- Inequalities with pockets of **deprivation** across South West London
- **Behaviours** - Smoking, inactivity, poor diet and drinking too much
- **Growing and aging population with diabetes**
- **Cancer** is a major cause of premature death
- High **hospital admissions for mental health conditions for under 18s**
- **Prevention in early years could be improved particularly childhood obesity**

Croydon

- Increasing **deprivation** with significant deprivation in north of the borough, Fieldway, New Addington and Shrublands
- **Smoking**: Smoking prevalence in Croydon is close to the national average. (est 17.0% of adults smoke)
- **Obesity**: One in four children aged four to five years are overweight or obese, and one in three children aged ten to eleven years are overweight or obese. An estimated 62.1% of adults are overweight or obese. **Physical activity** levels are lower than the regional average
- There are 48,500 **over 65s** in Croydon and they represent approximately 1 in 8 of Croydon's population at present and projected to grow.
- **Diabetes:** Croydon has a higher prevalence of people with diabetes than London or England
- **Circulatory diseases, cancers and respiratory diseases** remain the cause of the majority of excess **deaths which contribute to the gap in life expectancy**
- Health Screening: Breast and cervical **cancer** screening rates are both significantly worse than the national average
- The **prevalence of severe mental illness** in Croydon is significantly higher than the national average, but similar to London. **Admissions for mental health conditions for under 18s** is higher than London and national averages.

In addition Croydon faces a number of other health and well being challenges

- **Significant population growth -** from 376,000 to 200,000 by 2022
- Over half of the population is from a **black, Asian and minority ethnic group**
- **Inequality in Life Expectancy**: Life expectancy is 9.1 years lower for men and 7.7 years lower for women in the most deprived areas of Croydon than in the least deprived areas
- **Employment**: Over a quarter of jobs in Croydon are estimated to pay below the London Living wage in 2014 and the proportion of people claiming Job Seekers Allowance is above the regional and national average
- **Housing**: Housing and homelessness represents a significant and growing challenge for Croydon in coming years. Homelessness has been increasing in Croydon over the past few years following a sustained decrease since 2003
- **Social Isolation**: Croydon has a lower rate of permanent admission into care homes, 421 per 100,000 over 65s compared to 465 per 100,000 in London and 651 per 100,000 in England. Only 44.3% of people have reported they have as much social contact as they would like, which is similar to the national average of 44.5%

Our Care and Quality Challenge

South West London

- **Failing minimum standards** for urgent care and emergency care in our hospitals including 7 day working
- **Variation in how primary care** is co-ordinated for patients and perceived perceptions of accessibility
- **Increase in emergency admissions, non elective bed days and bed occupancy**
- **13% of patients could have avoided admission and a further 42% could have benefit form early discharge**
- Poor **rate of admissions for people**

Croydon

- Of the 172 applicable **London Quality Standards,** Croydon Health Services met 99 standards and did not meet 61 standards (there is insufficient evidence for 12 of the standards)
- Number of **variations in primary care quality and performance**, including diagnosis, referrals, leading to varying experiences of care and outcomes for people
- Highest level of NEL Admissions in London
- 18% of patients could have avoided admission and a further 39% could have benefit form early discharge

In addition Croydon faces a number of other care and quality challenges

Independence and independent living

- **Patients living at home**: The percentage of older people still at home 91 days after leaving hospital was 65.3% in 2012/13 compared with 81.4% for London overall
- **Social care-related quality of life:** People report quality of life in 2012/13 was 18.4 compared to 18.7 the previous year and the national average of 18.8
- **Control over daily life:** The percentage of people who use services who reported control of their daily life decreased to 68.8 in 2014/15 from 74 the previous year and remains below the national average of 75.1

Patient experience

- **Access to GP services:** patient experience has fallen to 71.4% from 73.4% from the previous year and remains below the national average of 73.3%
- **Community mental health:** patient experience has fallen during 2014 from a score of 8.75 to 7 (out of 10)
- **Hospital care – inpatient**: patient experience has improved for 2014/15 to 70.5% from 67.1%. It is however below the national average 76.6%
- **Hospital care – outpatient**: patient experience has remained similar for 2014/15 at 74.4% however it remains below the national average 79.5%
- **Hospital care - A&E**: patient experience has remained similar for 2014/15 at 73% however remains below the national average 80.7%
- **Carer with social services**: satisfaction has fallen from the previous year to 25.5% from 29.9% and remains below the national average of 42.7%
- **People who use services with their carer and support:** satisfaction has improved to 59.9% in 2014/15 from 57.9% the previous year. It however remains below the national average 64.1%

Our Financial Challenge

South West London

Across South West London **the health and local authority pressure is £864m**. Of this:

- the **health 'do nothing'** financial scenario is £595m
- The **local authority challenge** is £128m*

Under this scenario, with activity continuing to grow the demand for beds would increase by an estimated 454 by 2020/21, requiring additional capacity across the provider sites.

Croydon

Financial Gap (5 Years) based on do minimum scenario

- CCG** = £53.8m
- CHS** = £80.8m
- SLAM** = £13.2m
- NHSE (Primary Care) = NIL
- LA Adult Social Care = £35.5m

Assessed Opportunities (5 Years)

- CCG = £17m
- CHS = £23.5m
- SLAM = £3m
- NHSE (Primary Care) = NIL
- LA Adult Social Care = £24m

* Due to budgetary processes this an estimate for 2019/10 and not 2020/21

** Source: Deloitte (8 March 2016) adjusted to remove all CIPs

The SWL Vision

Our Mission

Helping South West London's residents to start well, live well and age well

Our Vision

People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality, joined up health and care services when they need them that deliver better health outcomes at a lower cost of provision to the system

Service design principles

1. Care is patient centred & holistic

- Inclusive & recognises the role of family, friends, communities & voluntary organisations
- Joined up and crosses organisational boundaries, encompassing people's physical, mental and social care needs
- Easy to navigate

2. Care is proactive & preventative

- Focussed on enabling people to stay well and avoid healthcare instances
- Prioritises early detection – people have access to early support mechanisms
- Promotes self management – people are encouraged to take responsibility for their healthy lives

3. Care supports the quality of life and the outcomes people value

- People are supported to live life as fully as possible for as long as possible
- People are aware of the choices available and have greater control

4. Care is financially sustainable

5. Our staff and care givers feel supported and able to do their roles

Service development principles

1. We focus on **better health outcomes at lower cost of provision to the system**
   - We work in partnership across all health and social care organisations including the third sector to design and deliver the solutions
   - We make better use of resources, irrespective of the organisation
   - We plan for a changing environment
2. We will rapidly adopt **evidence based care** (where possible)
3. We maximise the use of **digital technology,** for the benefit of all stakeholders

Our vision & priorities to close the gaps on quality, health & finance by 2021

Our vision:
People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality, joined up health and care services when they need them

Prevention & Early Intervention

- Placing a greater emphasis on **prevention and early intervention** so that we can enable people to stay well and reduce the number of inappropriate health contacts
- High impact initiatives (Dementia; Diabetes; Childhood Obesity)
- Other national priorities (Smoking, Alcohol, Physical Inactivity)

Acute Configuration & Clinical Networking

- Improving the outcomes delivered in our acute services by optimising **site configuration and clinical networking**

Right Care in the Best Setting

- Delivering better health and social care services for when our populations need them, improving the patient journey through the system and **delivering the right care in the best setting**
- Transforming primary care
- High impact initiatives (Adult MH, CAMHs, Admissions & Early Discharge, Frailty, EOL, Care Homes, TCP)
- Other national priorities (Maternity, UEC, Planned Care, Personalisation)

Productivity

- Addressing the challenges of cost reduction, performance and operational improvement by exploring opportunities for collaborative productivity – both provider and commissioner

Workforce, IM&T and Estates Enablers

System Architecture & Organisational Structures

Finance

The CEO/COs agreed the following principles for the sub-regional plans which need to focus on whole system joined up working:

The scope of the sub-regional plan

Responding to the Clinical Board hypothesis about “delivering care in the best setting” including:

- Plans to avoid acute attendances and admissions
- Plans to enable earlier discharge from hospital
- Combining physical and mental health care elements
- Driving health and social care integration and connecting clinical with wider non-clinical support and assets in the community
- A particular focus on frailty and the development of locality teams

Plans should cover all population groups; children and young people, adults and older people.

The scope of the sub-regional plan

Other elements within the sub-regional plans and are being addressed on a SWL-wide basis, drawing on plans/initiatives developed by individual CCGs and Boroughs. These include:

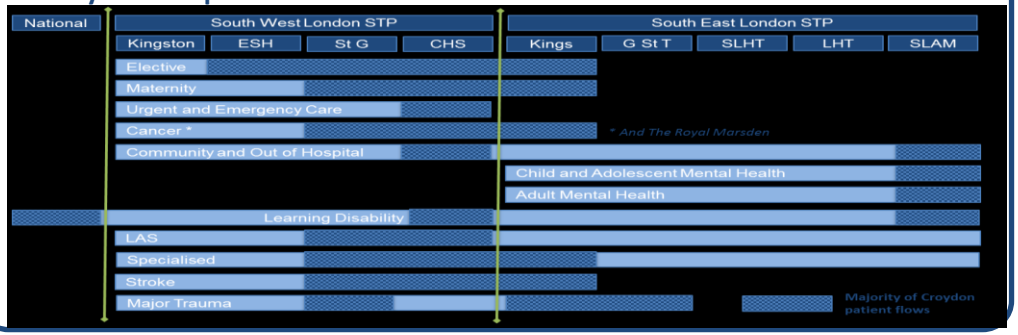
- Outpatient activity
- Productivity within organisations; CIP and QIPP
- Public health and long term prevention plans
- Primary care; implementation of specifications and development of GP federations

Our emerging solutions (1)

	South West London	Croydon
Prevention and early intervention	▪ **Right care benchmarking** analysis to focus on areas of greatest impact to reduce elective and non elective admissions ▪ **Embed learning** from Sutton and Royal Marsden vanguard ▪ Joint focus with Local Authority through Joint Commissioning Executive & Transforming Care Board on **care home management**, and joint prevention initiative **targeting diabetes and living well with dementia**	**Benchmarking** ▪ Croydon CCG (and previously the PCT) has used benchmarking to target identify opportunities. At **25th percentile opportunity is £8m** ▪ Croydon: 1st Wave with new Right Care initiative – **MSK/T&O will be a priority for Rightcare approach** ▪ **Prevention, self care and shared decision making (Healthier Together Programme)** • **GP Collaboration to deliver Local Care Home Scheme to proactive manage and support residents**
Right care in the best setting	▪ **Locality teams**, responsible for providing prevention and proactive care aligned with GP practices, for population of 50,000 ▪ **Risk stratification to identify individuals with greatest need** ▪ **GP federations operating at scale**, working with a wide range of providers ▪ Prevention and Proactive care likely to be commissioned by **a long term outcomes based capitated contract**	▪ **GP collaborative working in networks** of approximately 50,000 – 6 existing networks across Croydon working in multi disciplinary (MDT) teams . Extend current risk stratification tools to in corporate focus on complex patients. ▪ **Outcomes based commissioning (OBC) contract for over 65s** expected to be awarded in October 2016 . The OBC Accountable Provider Alliance (including GP Collaboration & LA care) has extended its plans to do this includes **creating a multidisciplinary community hub - in each of our 6 GP networks** ▪ Reviewing the **Transforming Adult Community Services with the Transforming Care Board to extend the various initiatives** including the potential for **extending risk stratification to focus on prevention**

Our emerging solutions (2)

	South West London	Croydon
Site configuration / clinical networking	▪ **4 acute sites,** ie 4 A&E sites within South West London ▪ Sites may provide **different services and differing degrees of complexity** ▪ Improved **provider productivity** ▪ **Out of hospital transformation**	▪ **Croydon Health Services NHS Trust likely to remain an acute site** ▪ **Croydon footprint** below:
Population cohorts	▪ South West London will **focus on the particular population cohorts and condition pathways**	▪ Croydon priorities match these with **the additional priorities of Cardiology and respiratory disease**



	Cancer	Diabetes	Mental health	Frailty	Dementia	End of Life	Obesity	Cardiology	Respiratory
'Start well'			●				●		
'Live well'	●	●	●					●	●
'Age well'				●	●	●		●	●
Individuals with Learning Disabilities	← End to end care management →								

Our emerging solutions (3)

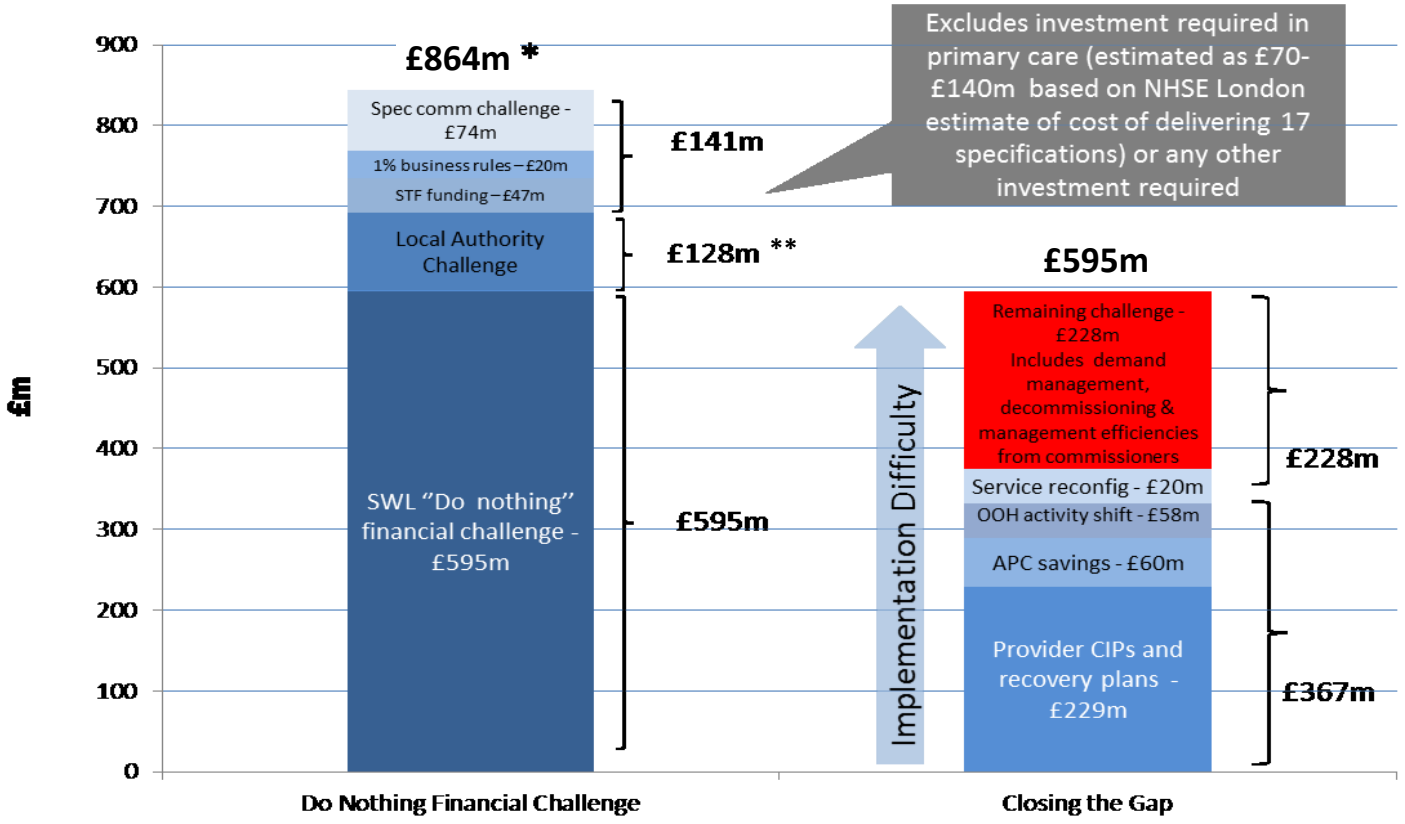
	South West London	Croydon
Organisational structure	▪ **Place based alliances** between CCGs, of sufficient scale for effective planning, likely to be 500,000 ▪ **Outcomes based commissioning** ▪ **Footprints evolve** over time ▪ Expect **budgets to be devolved** ▪ **Borough level CCG Governing Bodies will preserve assurance** and the democratic legitimacy	▪ Croydon health and social care economy provides a **significant single footprint** ▪ **Outcomes based commissioning (OBC) contract for over 65s** expected to be let in October 2016

Our emerging solutions (4)

Our financial base case indicates the scale of the challenge for SWL over the coming five years and the need for a radical and transformational approach to how we deliver health and care services.

As an SPG we are committed to establishing financial sustainability across providers, commissioners, and local authorities in SWL, and collectively targeting investment into the most effective areas of care, including a shift from acute to community provision.

** Due to funding processes t
£128m is an estimated positic
for 19/20 rather than for 20/2

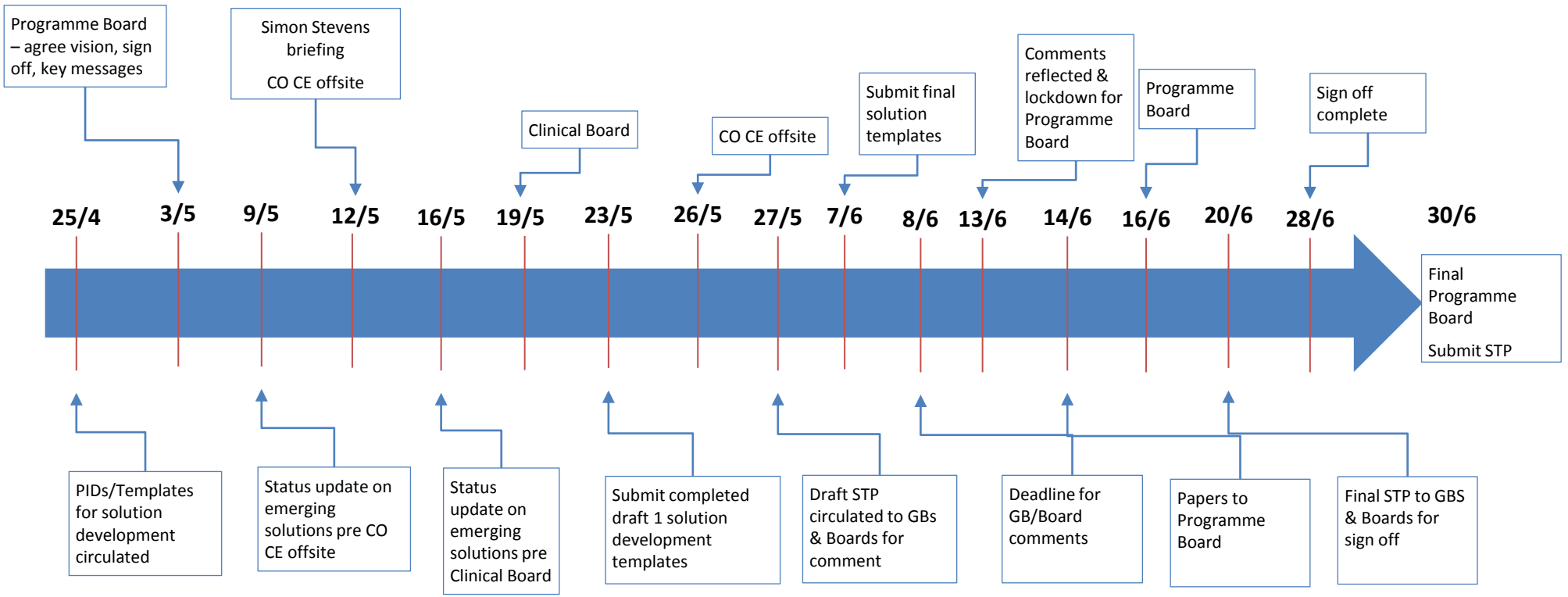


*** The total challenge is £736m - £595m for South West London and a further £128m for the Local Authority gap**

Estimated savings are initial high level hypotheses only – further work required to test as part of development of the STP

The financial diagnostic includes an overall capital requirement of approximately £685m (including the redevelopment of St Helier hospital). The do something scenario will consider the overall investment need (and funding source) is on-going.

Timeline for STP submission



Engagement - Developing the STP

- Letters sent to MPs, councillors 6th May
- Letter to voluntary organisations 9th May seeking views by 20th May
- Transforming Care Board Work shop – 11th May
- Draft available 27th May for LA Briefing & Reflection and Stakeholder comment
- Croydon HWBB Discussion – 8th June

Engagement - Ongoing

- Engagement on these issues have been on going for many years (SWL Issues Paper)
- Commitment to full public engagement and encourage local people to be involved (Croydon event held in 15/16)
- Various working groups include members of the public
- Patient and Public Engagement Working Group remains

Next steps

- The first draft STP will be circulated for comment by GBs/Boards and their members on 27 May with comments due by 8 June
- A final draft STP will be agreed by the Programme Board on 13 June before circulation to GBs/Boards by 20 June with sign off due by 28 June
- The final STP will be submitted on 30 June

Thank you

Any questions or comments?

Does the HWBB endorse this approach?

Appendix

Overview of Current and Planned Croydon CCG & Local Authority Out of Hospital Initiatives

Aim	Objective	Services Already in Place	Planned Initiatives	Time Scale for Delivery
A) Improving delivery of Preventative & Proactive Care	Single point of access	▪ Single point of assessment for healthcare needs	▪ Extended single point of assessment including access to social care provision or information	<1yr (Jun17)
	Consistent model for managing long-term conditions (including MH and LD) and frailty, including risk stratification, and the development of care plans	▪ Embedded risk stratification supporting proactive case management of people at risk of hospital admission ▪ GP Practice multidisciplinary team (MDT) care planning for at-risk people	▪ Expanded more holistic health and social care risk stratification models to support preventative care ▪ Extended models of MDT care planning ▪ Expanded preventative support for people at medium risk of admissions	<1yr (Jun17) <1yr (Apr 17) <1yr (Apr 17)
	Locality based teams, and Primary Care at the centre of highly coordinated multidisciplinary teams	• Integrated health and social care MDT's supporting proactive case management (supported by Community Geriatrician, Health Visitors for Older People, Community Matrons, and Social Care Workers) • Embedded GP Practice palliative care planning meetings with St Christopher's, Marie Curie, and District Nurses for end of life care (EOLC) patients • Provision of respite care in EOLC patient's own home during the day to support carers	• Expanded delivery of integrated care provision with full involvement from Mental Health and voluntary sector • Increased access to rapid community and primary care support, domiciliary care, intermediate care bed capacity • Increased preventative focus on care homes • Increased delivery of end of life care supporting people and carers in their place of choice	<1yr (Apr 17) <1yr (Apr 17) <1yr (Apr 17) <1yr (Apr 17)

Aim	Objective	Services Already in Place	Planned Initiatives	Time Scale for Delivery
A) Improving delivery of Preventative & Proactive Care	Locality based teams, and Primary Care at the centre of highly coordinated multidisciplinary teams	▪ Working with GP Practices to address primary care variations ▪ Rapid Response (nursing, and therapy) service ▪ New focus on preventative care for nursing care homes with nursing and speech and language therapy input ▪ 12 commissioned intermediate care beds and xxx reablement beds ▪ Rapid Acute Medical Unit (RAMU) service providing rapid access to specialist support	▪ Greater integration between the RAMU and other specialist services within the Edgecombe Unit ▪ Delivery of 8am-8pm GP access to patients 7 days a week in a hub model ▪ Increased patient engagement in self-management through Together for Health programme ▪ Increased use of technology to improve patient self-care and access ▪ Improvements in GP Practice variations using benchmarking information from the Atlas of Variation, and Commissioning for Value reviews ▪ Implementation of the 17 Transforming Primary Care London standards for Accessible Care, Proactive Care, Co-Ordinated Care for the whole population ▪ Development of Primary Care services and capacity to support out of hospital care	<1yr (Apr 16) <1-3yr (Apr 18) <1-3yr (Apr 18) <1-3yr (Apr 18) <1-3yr (Apr 18) <1-3yr (Apr 18) <1-3yr (Apr 18)
	Resilient and supportive communities		▪ As with PSS & APA Model of Care	<1-3yr (Apr 18)

Aim	Objective	Services Already in Place	Planned Initiatives	Time Scale for Delivery
A) Improving delivery of Preventative & Proactive Care	Activated patients, citizens and carers, supported by tools and resources to promote self-management	▪ Started implementation of the Together for Health programme to improve patient outcomes and experience. ▪ Commissioned asset based community connectors ▪ Piloting of group consultations for patients with a common long term condition in 6 GP practices ▪ Piloting of Health Help Now app to support self-care	▪ Expanded implementation of Together for Health programme across primary, community and acute care	<1-3yr (Apr 18)
	Shared responsibility, risk and incentive for all care professionals in the system to be proactively keeping people well (including hospitals)	▪ Implementing 10 year Outcome Based Commissioning (OBC) contract with the Accountable Alliance Provider to improve patient outcomes for people 65 ▪ Development of a jointly commissioned Mental Health Strategy ▪ Expansion of psychiatric liaison service ▪ £xxm of commissioned GP primary care incentive schemes to support out of hospital care	▪ Implementation of OBC contract and use contractual levers to further improve patient outcomes ▪ Implementation of the transformation programme for Adult Mental Health Services ▪ Greater integration of physical and mental health	<1yr (Oct16)

Aim	Objective	Services Already in Place	Planned Initiatives	Time Scale for Delivery
Improved delivery of Planned Care	**Delivering high quality planned care closer to home**	▪ Redesigned diabetes, cardiology, urology pathways supporting better management of patients at primary care level ▪ Service reviews in progress for ophthalmology, falls, anti-coagulation, stroke, respiratory, falls, obesity, cancer, and digestive systems ▪ Currently procuring new gynaecology, dermatology, Ear Nose and Throat, and termination of pregnancy services	▪ Implementation of pathway redesign to address priority areas of focus highlighted through the Commissioning for Value and ongoing service reviews, including: ▪ Trauma and Injuries ▪ Genito Urinary ▪ Neurological ▪ Respiratory ▪ Ophthalmology ▪ Falls ▪ Anti-coagulation ▪ Stroke ▪ Obesity ▪ Cancer ▪ Digestive systems ▪ Commissioning of new services to support delivery of care in the appropriate setting	
Improved delivery of Urgent Care Services	**Delivering integrated accessible urgent care services**	▪ Provision of GP Out of Hours, Urgent Care Centre, Minor Injuries Unit, Walk-in Centre services across Croydon by different providers	▪ Procurement of a new Urgent Care model focusing on integrated delivery	1 April 2016